

**MEDICAL PROFESSIONS  
IN INTERNATIONAL PERSPECTIVE**

# **MIDWIFE**

Edited by

**Małgorzata Nagórska**

RZESZOW UNIVERSITY PUBLISHING HOUSE

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RZESZÓW 2024

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Regional Council of Nurses and Midwives  
in Rzeszów

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Rzeszów University Publishing House, Rzeszów 2024

ISBN 978-83-8277-140-4 (on-line version)

ISBN 978-83-8277-181-7 (print version)

DOI: 10.15584/978-83-8277-140-4

2110

WYDAWNICTWO UNIwersYTETU RZESZOWSKIEGO  
35-959 Rzeszów, ul. prof. S. Pigoń 6, tel. 17 872 13 69, tel./fax 17 872 14 26  
e-mail: [wydaw@ur.edu.pl](mailto:wydaw@ur.edu.pl); <https://wydawnictwo.ur.edu.pl>  
wyd. I; format B5; ark. wyd. 16,5; ark. druk. 14,75; zlec. red. 80/2023  
Printing and binding: Drukarnia Uniwersytetu Rzeszowskiego

*In memory of my great-grandmother  
Salomea Białas nee Hićkiewicz (1876–1950),  
who practiced midwifery in Rymanów, Poland  
before, during and after WWII*



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# LIST OF ABBREVIATIONS

ADM	Advanced Diploma of Midwifery
AI	Artificial Intelligence
APHNMN	Act on Public Health Nurses, Midwives and Nurses
APEO	Portuguese Association of Midwives ( <i>pt. Associação Portuguesa dos Enfermeiros Obstetras</i> )
ASEAN	Association of South-East Asian Nations
Assist. prof.	assistant professor
Assoc. prof.	associate professor
BMA	Belgian Midwives Association
BMid	Bachelor in Midwifery
BScHME	Bachelor of Science in Healthcare Management and Economics
BSN	Bachelor in Nursing
ČAS	Czech Association of Nurses
ČAPA	Czech Association of Midwives
CBM	Central Midwives Board (CMB)
CLoCMiP	Clinical Ladder of Competencies for Midwifery Practice
COVID-19	<i>Corona Virus</i> Disease 2019
CU	Comenius University
CZK	Czech crown
dipl. bab.	Registered Midwife ( <i>diplomirana babica</i> (VS) or <i>diplomirani babičar</i> )
DSHS	State of Slovenes Croats and Serbs ( <i>cr. Država Slovenaca, Hrvata i Srba</i> )
EC	European Council
ECTS	European credit Transfer System
EU	European Union
EEC	European Union Council
EMA	European Midwifery Association
EQF	European Qualifications Framework
ETNA	European Transcultural Nursing Association
FFMS	Francisco Manuel dos Santos Foundation – ( <i>pt. Fundação Francisco Manuel dos Santos</i> )
FRCM	Fellow of the Royal College of Midwives
GHQ	General Headquarters of the Allied Forces
GPL	Good Practice Logo
GDP	Gross Domestic Product
HQF	Hungarian Qualifications Framework
IBCLC	International Board Certified Lactation Consultant
ICM	International Confederation of Midwives
INE	Office for National Statistics ( <i>pt. Instituto Nacional de Estatística</i> )
ISF	Synthetic Fertility Index
JFM	Jessenius Faculty of Medicine

KMSZTS	Chamber of Nurses and Health Technicians of Serbia
KMSZTS	Chamber of Nurses and Health Technicians of Serbia (sb. <i>Комора медицинских сестара и здравствених техничара Србије</i> )
MA	Master in Art
MCA	Medical Care Act
MCoC	Midwife-led continuity of care
MEXT	Minister of Education, Culture, Sports, Science and Technology
M.Ed.	Master of Education
MHLW	Ministry of Health, Labour and Welfare
MHW	Ministry of Health and Welfare
MSc	Master of Science
NHS	National Health Service
NMA	Nurses and Midwives Association
OE	Nursing and Midwifery Council ( <i>pt. Ordem dos Enfermeiros</i> )
OECD	Organisation for Economic Cooperation and Development
OKJ	Hungarian National Qualification Register
PGCEA	Post Graduate in the Education of Adults
PhD	Philosophy Doctor
PHW	Public Health and Welfare
PTP	Polish Midwives Association ( <i>pl. Polskie Towarzystwo Położnych</i> )
PTG	Polish Gynecological Society ( <i>pl. Polskie Towarzystwo Ginekologiczne</i> )
REPE	Regulation of Professional Practice of Nurses ( <i>pt. Regulamento do Exercício Profissional do Enfermeiro</i> )
RM	Registered Midwife
RN	Registered Nurse
SChNM	Slovak Chamber of Nurses and Midwives
SFR	Yugoslavia - Socialist Federal Republic of Yugoslavia
SNS	The National Health Service ( <i>pt. Serviço Nacional de Saúde</i> )
STTI	Sigma Theta Tau International
TB	Tuberculosis
UK	United Kingdom
UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visiting
UNFPA	United Nations Population Fund
WHO	World Health Organization
VND	Vietnamese Dong
VUB	Vrije Universiteit Brussel
YÖK	Council of Higher Education ( <i>tr. Yükseköğretim Kurulu</i> )

## PREFACE

*The profession of a midwife is both beautiful and difficult. In the midwife's hand is health and the life of two, and sometimes more people, (...) her conscientious performance of duties (...) brings true inner joy and real benefit to humanity and for this reason deserves universal respect.*

Henryk Jordan<sup>1</sup> (1842-1907)

*Nauka położnictwa dla użytku położnych* Kraków, 1872

In 2022, thanks to the cooperation and effort of many people, the first part of the *Medical professions in international perspective series* dedicated to nursing was published. The book describes the history, education systems and principles of practicing the nursing profession in 14 countries around the world.

The second part, which I have the pleasure to present, is devoted to midwives. The concept of Midwifery has ancient roots and midwives have been helping women during childbirth for centuries. Nowadays midwives' services are an integral part of health care in various periods of life. Midwives have always enjoyed great recognition and respect in society and this profession is seen as particularly attractive.

The term "midwife" has its roots in Old English. The word is a combination of two Old English words: *mid*: meaning *with*, and *wife*: referring to a woman. Therefore, *midwife* literally translates to *with-woman* or *woman who is with*. The term has been used in English for centuries to describe a person, typically a woman, who assists other women during childbirth. The role of a midwife involves providing care, support, and assistance to women before, during, and after childbirth. The etymology of the word reflects the close relationship between the midwife and the woman giving birth, emphasizing the supportive and caring role played by the midwife during the childbirth process.

I must admit that I have a very personal relationship to this book, because it concerns my profession. 35 years ago, I graduated from a school for midwives and started working in a hospital in the gynecology department. I remember how proudly I wore a white cap with a red transverse stripe – the symbol of midwives.

Since then, I have come a long way, I have worked in the maternity ward and in the delivery room, as a ward midwife in the gynecological ward, I also worked for

---

<sup>1</sup> Polish physician, gynecologist, professor of medicine, Jagiellonian University, Krakow

a year in a fertility clinic and finally I became an academic teacher. It was a long, not always easy, but beautiful journey, during which I experienced extraordinary moments full of joy and emotions. I was interested in medicine from an early age, and I chose the profession of a midwife carefully, but also a bit out of curiosity and a desire to learn about the “mystery of birth”. Over the years, I have witnessed many important changes in the midwifery profession and perinatal care in Poland. Especially the last two decades have been very important for our profession, as midwives have gained a lot of independence and many new competences.

Thanks to the involvement of 42 authors from 15 countries, I have the pleasure to invite readers to the second part of the book. I would like to express my heartfelt thanks to all those who accepted the invitation and described the profession of midwife in their countries. Thanks to you, we can learn more about the history and present of midwives in Belgium, Bosnia and Herzegovina, Croatia, Czechia, Hungary, Israel, Japan, Poland, Portugal, Serbia, Slovakia, Slovenia, Turkey, United Kingdom, and Vietnam.

I hope that this publication will become a valuable source of knowledge not only for midwives and midwifery students, but also for all those who are interested in the history and principles of this beautiful profession.

I would like to express my sincere thanks to all the Authors for their contribution to the publication, and to the Regional Council of Nurses and Midwives in Rzeszow for their financial support for the publication of this book.

I wish you an inspiring read.

*Małgorzata Nagórska*

# **MIDWIFERY IN BELGIUM**

## **1. Brief history of midwifery**

The historical evolution of the legal competence of the Belgian midwife has been described as a process of ups and downs but ultimately a progressive upgrade [1]. The most important historical milestone for the midwife was undoubtedly the law of 1818 on the practice of medicine, whereby the midwife became the practitioner of normal obstetrics, alongside the doctor. This law was followed by the establishment of midwifery schools throughout Belgium. A Royal Decree of 1924 determined that a midwife could only assist a ‘natural childbirth’, forbidding her to accelerate the birthing process with ‘instruments or by hand. Moreover, she was allowed to prescribe medication and perform an episiotomy, while the suture of the perineum remained a task of the doctor. Situations in which the midwife had to refer to a doctor were expanded in 1924, which somehow limited her autonomy [2].

As in most other Western European countries, there has been an important shift in midwifery care after World War II, when childbirth moved from home to hospital. The reason for this shift was the introduction of a compulsory health- and disablement insurance scheme, which specified that births in hospital and all specialist medical care would be reimbursed by health insurance, regardless of whether they were complicated or uncomplicated [3]. This decision was followed by an increase in the number of hospital births, obstetricians and maternity hospital capacity. Additionally, the midwifery profession became financially unattractive due to a change in the law in 1945. This affected the activities of the midwife in the 20th century and the number of midwives declined drastically.

At the national midwifery congress in 1946 the following three requirements were imposed to professionalise the midwifery profession: (1) the status of a professional health care provider - not a ‘compliant assistant’ -, (2) a full-fledged remuneration and (3) a solid education focusing on the medical, emotional and social aspects of pregnancy and childbirth. In 1962, a new legal framework provided for a wage increase and in 1964, standards for the recognition of hospitals were established and the presence of one midwife per 30 maternity women became mandatory. In 1967, the comprehensive Royal Decree No. 78 on the exercise of medicine, nursing, paramedical professions and medical committees declared the midwife a practitioner of medicine [1].

The Royal Decree of 1991 laid down the conditions for professional practice. The decision to revise the Royal Decree of 1967 was made because of progresses in medicine, the free movement of the diploma’s accordance with European Directive

80/154/EEC and the changed reality of midwifery practice. The minimal activities listed in Article 4 of the European Directive 80/155/EEC also required a review of Belgian legislation. The law of 13 December 2006 amended the Royal Decree No. 78 thoroughly and added a chapter ‘the pursuit of the profession of midwife’. This legislation provided for a clear demarcation between acts which fall within the autonomous competence of the midwife and acts that midwives may impose in a pathological situation under the responsibility of a doctor. New in this legislation was the possibility for the midwife to prescribe medication, to perform pelvic floor re-education and functional ultrasounds. Except as regards prescribing medication, implementing decisions are still lacking. The Royal Decree of 15 December 2013 defines the qualification criteria to be met by midwives in order to prescribe medicines. In addition, it is legally determined which medication they are allowed to prescribe in the context of the follow-up of normal pregnancies, the practice of normal childbirth and the care of healthy neonates.

The law of 10 May 2015 replaces Royal Decree No. 78 of 1967 on the exercise of health care professions. This law lists the conditions under which a person in Belgium may exercise a health care profession and the titles for those professions. It concerns the professions doctor, dentist, pharmacist, nurse, physiotherapist, midwife, health care and the paramedical professions. The Royal Decree of 31 January 2018 states that the midwife self is responsible for her continuous professional development relevant to her professional activities. The permanent training ensures that midwives are kept informed of evolutions in the professional domains of practice. A midwife is obliged to attend a permanent training of 75 hours over five years. Failure to comply with this obligation may result in the withdrawal of the professional title as a midwife. Another significant guarantor of the quality of the care provided in Belgium is the Health Care Quality of Practice Act of 22 April 2019, its implementation is still in progress. This includes for example a portfolio for all health professionals demonstrating their competence to practice and a carefully maintained and securely stored patient record for each patient [4].

Belgian midwives who have graduated after October 2018 are only allowed to practice nursing within the field of obstetrics, fertility, gynaecology and neonatology. This is considered by some as a further step in the profiling of the profession [1], others challenge this decision as it limits midwives’ professional domains.

### *Professional midwifery associations*

Belgium has three professional midwifery associations unique for midwives: the Flemish Organisation of Midwives (1,829 members in 2021), Professional Union of Belgian Midwives (800 members in 2021) and the French speaking Association of Catholic Midwives (105 members in 2021). These organisations are associated in the Belgian Midwives Association (BMA) representing about 29% of professionally active midwives (2,734 members). Membership to a professional association is not

mandatory for midwives and does not affect their licence to practise. BMA represents Belgian midwives in the European Midwives Association and the International Confederation of Midwives (ICM). Additionally, the respective midwifery associations are involved in various consultative bodies for maternity care in Belgium, such as the Planning Commission for midwifery workforce forecasting, Centre for the Study of Perinatal Epidemiology, Belgian Health Care Knowledge Centre [5].

The midwifery associations are, together with doctors and policy advisors, represented in the Federal Council of Midwifery, with advisory powers. Their mission is to give the Minister of Public Health, at the Minister's request or on its own initiative, advice on the practice of the midwifery profession and, advice on the accreditation criteria for these practitioners [4]. The Legislation on proportionality has impacted the work of advisory bodies since 2021. In accordance with the 2018 European Directive, the legislator must justify the proportionality of measures when they have a restrictive impact on access to or the exercise of any profession. Where this is the case, the body now has to demonstrate that they have an objective of general interest and are well justified. A proportionality test must therefore be carried out when the measure adds restrictive measures to the access to or practice of a profession. For example, the extending of the years of study and training hours or making the practice of a profession conditional on membership in a professional association falls under this proportionality law.

Both the Flemish Professional Association of Midwives and the Professional Union of Belgian Midwives publish a professional journal, respectively the *Tijdschrift voor Vroedvrouwen* (Journal for Midwives) and *Actualités Sage Femme* (News for Midwives).

## **2. System of education for midwives**

Midwifery education in Belgium, has undergone numerous changes in the past. The Royal Decree of 1 July 1908 on the education programme raised the final examination to a higher level and extended the contents of the study on anatomy, biology, obstetrics, hygiene and deontology. Midwifery education evolved from a two-year education in 1924 to three-year education in 1951. In 1957 midwifery education became a specialisation of nursing education, a three-year education with one year specialisation in midwifery. Midwives graduated from that time obtained both the diplomas of nurse and midwife [1]. Since 1994 midwifery education in Belgium is a direct-entry programme at bachelor's level and complies with the Bologna Declaration and the relevant European Directives [6]. With a strong focus on evidence-based practice, the programme equips midwives to meet the demands of modern maternity care [5].

Midwifery education is provided in 12 Higher Education Institutions in Flanders and nine in the French Community [7]. However, the length of the Flemish (180

ECTS, 3 years) and French Community (Walloon and Brussels-Capital Region, 240 ECTS, 4 years) programmes differ [8], although students need to acquire the same competencies [9]. Despite differences in the length of the programmes, Belgian midwifery students are educated to be autonomous practitioners in uncomplicated pregnancies and they are all expected to acquire competences in all fields of midwifery, according to national and European legislation, and the ICM Global Standards for Midwifery Education [10]. In spite of the medicalized context of maternity care, midwifery education succeeds in educating midwives who hold a woman-centred ideology [10].

Once the diploma has been obtained, the next step is the application for a licence to practice. In the area of healthcare, access to the profession is conditional on holding a licence. For professions without recognition of the basic qualifications as physicians, dentists, pharmacists, nurses and midwives, a licence to practice is issued on the basis of an exchange with the universities and university colleges through a portal developed for this purpose. Each proclamation period, institutions provide lists of students with a basic diploma. The access to the profession unit uses these lists to send licence to practice automatically (email or mail) shortly after the end of their studies [4].

Various Master's programmes, such as a Master of Science (MSc) in Nursing and Midwifery, a MSc in Healthcare Management, a MSc in Public Health or a MSc in Health Education and Health Promotion, are accessible for midwives but not restricted to midwives only [5]. Specialist or advanced roles for midwives are limited to management, research and educational functions. Advanced roles may include lactation consultants. The concept of further education (Masters and Doctorates), leading to advanced midwife practitioners still needs to be clarified. There is international consensus that a debate on the defining elements of advanced midwifery practice would contribute to advancing the professionalisation of midwifery globally [11]. However, advanced midwife practitioner specific master programmes are being planned in the near future [12].

### **3. The legal status of midwifery**

Midwifery practice in Belgium is determined by the European Directives, outlining 11 midwifery particular competencies, which are specified in national legislation [8]. Belgian midwives are legally autonomous and competent to practice independently in uncomplicated pregnancy, labour and childbirth. [13,14]. In Belgium, midwives are specialists in the field of physiology, and provide services both in hospitals and in primary care. They support, counsel and supervise healthy women and newborns, from preconception, during the pre-, intra, and postnatal period [9]. In addition, midwives practising in Belgium have responsibilities in obstetrics, reproductive medicine, gynaecology and neonatology [9].

**Table 1.** Overview of the professionalisation of midwifery in Belgium  
(adapted from Vermeulen et al. 2020); [5]

<b>Greenwood's sociological criteria for a profession [25]</b>	<b>Greenwood's sociological criteria adapted to the midwifery profession</b>	<b>State of the professionalisation of midwifery in Belgium</b>
The profession is underpinned by a defined and distinctive body of knowledge	What is the outcome level of midwifery education? Is midwifery education direct-entry? What is the impact of international regulation/legislation on midwifery education? Are there opportunities for postgraduate education? Do midwives perform research?	Bachelor degree Direct entry In line with EU Directives Master programmes and postgraduate studies are available Growing scientific midwifery body of knowledge
Professionals' authority is recognised by its clientele	Are midwives allowed to provide autonomous maternity care? Are midwives allowed to decide how they work in practice? Are other health professionals such as doctors and nurses involved in providing care to low risk women? Are midwives allowed to work in birth centres? Can midwives organise themselves in independent practices?	Limited authority due to organisation of health care Obstetrician-led maternity care Women consider obstetricians as the lead maternity care health professionals Women's knowledge about midwives' competencies is limited More autonomy in primary care
The profession is regulated by broader community sanctions	Are midwifery roles protected by legislation? Is the midwifery profession and practice regulated? Do midwives need to register/licensed to be allowed to practice as a midwife? Is there a lead midwife in the Government/Health Department/Education Department?	Midwifery is legislated and regulated and in line with EU Directives. Midwives need to be registered and licensed to practise
A code of ethics is adopted by the professional group	Is there a code of ethics for the midwifery profession? Is this code based on the ICM code of ethics for midwives or other? Is this ethical code for midwives only or is it shared with other professional groups?	A code unique for midwives (International Confederation of Midwives) is adopted

<p>The profession is characterized by a professional culture supported by a formal professional association</p>	<p>Is there a separate midwifery association?  Is the midwifery association part of a nursing association?  Does the midwifery association have an impact on the government with regard to midwifery?</p>	<p>There independent midwifery professional associations  Midwifery associations are influential  Not being united as midwives and the fragmentation of political landscape is a threat for the midwifery professionalisation</p>
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Maternity services in Belgium play a vital role in the hospital landscape with about 98% of births taking place in hospital [15]. The number of births per service ranges from 120 to 3,500 [16]. Home births are rare, numbering less than 2 percent in 2020; in Flanders n=406, 0.7% [17], in the Brussels Metropolitan Region n=105, 0.5% [18] and in Walloon n=212, 0.6% [19]. Homebirths are in general supervised by midwives working in primary care settings. To our knowledge, there are 13 birth centres and one alongside midwifery-led birth centre in Belgium [5].

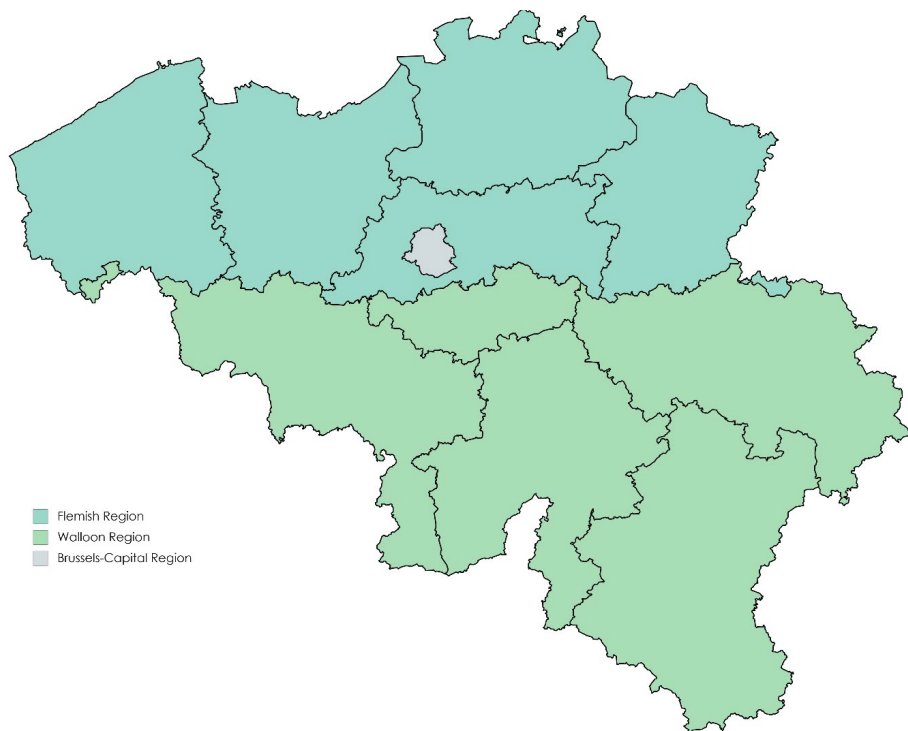
Nowadays, most midwives work in obstetrician led hospitals. Despite the medicalised care, Belgian midwives still hold a woman-centred ideology. However, a study of Belgian midwives’ views on maternity care revealed that neither medicalised or women-centred care is to be linked to a profession. Maternity care ideology is rather attributed to a person, not a profession. Both Belgian obstetricians and midwives can either hold a ‘medical’ or ‘woman-centred’ ideology [20]. Midwives’ degree of autonomy varies; in hospitals most midwives work under the authority of the obstetrician, although this might vary across hospitals and regions. Midwives in hospitals have limited control over their working conditions such as one to one care, continuity of care, or working hours, most of which is determined by hospital management. Primary care midwives tend to have more autonomy in the organisation of their work [5].

#### **4. Midwifery in numbers**

Belgium, is a Western-European country, bordered by the Netherlands, Germany, Luxembourg and France. Its political organization is complex and structured on both regional and linguistic grounds. It is divided into three highly autonomous communities and regions: Flanders (Dutch-speaking), Walloon (French-speaking) and the bilingual Brussels-Capital Region

Belgium has a population of 11,584,008 (2021), with 117,914 births in 2021 [21]. In 2019, 10,501 midwives were professionally active in Belgium, 70% (n=7,357 in Flanders), 23% (n=2,400) in Walloon and 6% (n=625) in the Brussels Capital Region. Of the total of all professionally active midwives, 78% (n=8,243) work in a hospital setting, 9% (n=990) in primary care and 12% (n=1,268) combine

both [22]. In primary care, midwives work independently on their own, in group practices or in public health organisations. Nearly all Belgian midwives are women (99%) [4].



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Figure 1. Belgium regions

In Belgium a large variability in caseload in maternity services is observed between regions, per year a median of 2,236 births in Brussels versus 864,5 in Wallonia and 800 in Flanders. The annual average occupancy rate of maternity services in Brussels (69.3%) is higher compared to Flanders (45.1%) and Wallonia (48.0%). [16] The average length of postnatal hospital stay after vaginal birth has decreased from 4.04 days in 2010 to 2.38 days in 2019 [23]. This reduction had an impact on the midwifery workforce [8], additionally recently a shift to primary care has been noted [22].

The high birth rate in Brussels is additionally due to a higher fertility rate in that region (1.82 children per woman in 2016 versus 1.66 in both other regions) and to the high concentration of hospitals. In Brussels, only 74.7% of the women giving birth live in Brussel region, compared to 92.9% of the women giving birth in Flanders and 93.9% in Walloon live in the same region. The Brussels region is

strongly international, on 1 January 2020 more than one third (35%) of the Brussels population did not have Belgian nationality (compared to 9% in Flanders and 10% in Wallonia). Among the non-Belgian population, two thirds (66%) came from one of the 28 Member States of the European Union. [24]

## **5. Challenges and prospects**

Challenges and prospects for the midwifery profession in Belgium are outlined using Greenwood's sociological criteria for a profession: (1) own body of knowledge, (2) recognised authority, (3) broader community sanctions, (4) own code of ethics and (5) professional culture sustained by formal professional associations [25].

The midwifery profession in Belgium is underpinned by a defined and distinctive body of knowledge. The education is a bachelor degree, direct entry and in line with EU Directives. Postgraduate study is available. A recent study (2022) found that Belgian midwives showed a positive attitude towards evidence based practices. Midwives with a Master's degree,  $\leq 15$  years since graduation and aged  $< 40$  years had better knowledge of evidence based practice. Nevertheless, postgraduate education to improve evidence based competencies in midwives without a Master's degree or who graduated more than 15 years ago were suggested [26]. Additionally, efforts should focus on strategies to overcome identified barriers to implement evidence based practise (lack of time, access and support) [26]. A legal basis for advanced midwife practitioner role implementation is lacking in Belgium. Remuneration opportunities for the non-clinical part of these roles (e.g. leadership and innovation activities) are missing [12].

The recent shift toward primary care for postnatal care in Belgium has resulted in a pivotal role for the midwife in this area. Belgian primary care midwives gained more competencies and autonomy, which is consistent with the findings of a recent European study [27]. Belgian women consider obstetricians as the lead maternity care professional while her knowledge about midwives' competencies is limited. A study in the Brussels metropolitan region found that women do not recognise midwives as the primary preferred health professional for uncomplicated labour or childbirth, and they do not consider midwives to play a central role in uncomplicated pregnancies [28]. A better understanding of the roles of midwives within the health system is desirable as they are a key component in the provision of safe and effective maternity care. Further research is warranted to monitor the further progression of the midwifery profession and explore Belgian midwives' autonomy in all professional settings. It might be argued that if Belgian midwives were the lead professionals in antenatal care this could instigate woman centred care, it could make women better informed about their care, their options and choices. If every woman at low obstetric risk saw a midwife during her pregnancy, it would evidently make midwives more visible in society [20].

The midwifery profession in Belgium is regulated by broader community sanctions. Midwifery is legislated, regulated and in line with EU Directives. Midwives need to be registered and licensed to practise.

A code of ethics has been adopted by the established professional midwifery associations. The ICM International Code of Ethics for Midwives has been adopted. To our knowledge it is not known how the ICM ethical code is enculturated in everyday practice in Belgium. The Flemish Professional Association of Midwives introduced in 2016 the Good Practice Logo (GPL) for primary care midwives. The GPL is a quality label for primary care midwifery practice which encompasses that midwives need to meet several prerequisites, e.g. compliance with the ICM code of ethics, evidence based and family centred care.

The midwifery profession in Belgium is characterized by a professional culture supported by three independent midwifery professional associations. Membership to a midwifery association is not mandatory and does not hamper midwives' professional practice. The midwifery associations are influential, but different views and the fragmentation of powers in the political landscape is a challenge for the midwifery professionalisation in Belgium.

Recently the Belgian Health Care Knowledge Centre developed scenarios for the future of maternity care in Belgium based on observation of past trends and developments in other countries [29]. The stakeholders involved, representing different professional associations and levels of decision-making, were overall convinced of the new, different scenarios, which will include a greater participation of midwives in maternity care. It is estimated that the demand for midwifery care in Belgium will increase from 11.4%, to 17.4%, between 2016 and 2026. This increase is mainly due to the expected rise in postnatal outpatient care activities [25]. However, a midwifery supply and demand projection exercise from the Belgian Federal Public Service Public Health, Food Chain Safety and Environment, concluded that the need for midwifery care by 2037 is expected to remain stable while the number of midwives active in health care is projected to increase by just over 30% between 2020 and 2037 in individual and full-time equivalents [4].

The status of the midwives employed at a hospital or in primary care will depend on whether future maternity care will be obstetrician led, midwife led or primarily organised through primary care professionals. Based on observation of past developments in other countries (e.g. the Netherlands, the United Kingdom, Sweden and Canada), and on the assumption that similar developments are highly probable in Belgium, it is anticipated that future Belgian maternity care will be marked by increased involvement of midwives, especially in postnatal care [29].

Current challenges to the professionalisation of midwifery in Belgium include limited recognition of midwives' roles by its clientele, limitations of midwives' competencies and autonomy, lacking development of advanced roles in maternity care practice and a lack of unity of the organisation and its members. Increasing women's awareness of midwives' competences, implementing full scope of

midwifery practice could strongly contribute to shared responsibility and autonomy and healthy interprofessional collaboration in maternity care [30]. Increased professionalisation may instigate more professional autonomy over midwifery practice as well as related working conditions, all of which support midwives to be adequately equipped as an equal partner in a changing maternity care landscape [5].

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# MIDWIFERY IN BOSNIA AND HERZEGOVINA

## 1. Brief history of midwifery

Children were delivered by experienced older women, who themselves had given birth several times, until the end of the 19th century on the territory of Bosnia and Herzegovina. These women were mostly self-taught and were popularly called *babice* (midwives). There is very little information on the work of those early midwives of ours, because they were mostly illiterate, uneducated, and superstitious women who performed their work based on folk experiences, transmitted by word of mouth. Childbirth was seen as an event filled with superstition and fear. Each region had its own specific customs. In some areas, a woman would give birth standing up so that the child would fall to the ground, to make it stronger, and in others the umbilical cord would be cut with an old machete, so that the son would be a hero [1] and, in the case of a difficult birth, the husband would try to ease the labour pains by firing a rifle [2].

These superstitions, like in other areas of the Balkans, were a reflection of a difficult way of life, the consequence of which was great backwardness in healthcare and a high mortality rate of both mothers and newborns [1]. At that time, a saying arose that a woman who is giving birth has one foot in the grave, that for the first forty days after giving birth the woman is in mortal danger. According to oral tradition, the positions in which women gave birth were quite different - they would give birth on a bed, on the floor, in a squatting position or crouching on their hands and feet. The woman would give birth next to the hearth with the help of a more dexterous village woman, often kneeling, fully clothed - she would just untie her belt and be bareheaded [2]. The place of birth was not exclusively in the house, women would give birth while working in the fields, by themselves and “without any help.” A difficult birth would be alleviated by performing various magical actions. In the villages of western Herzegovina, a woman kept “powers” on her person to facilitate childbirth [3]. In folk belief, certain properties were ascribed to the placenta and the umbilical cord, believing that they are integral parts of the embryo that have a certain influence on a person’s life. The placenta, as a part of the mother’s womb, was more connected to the mother, and care was taken as to where to bury it. Usually, the mother-in-law or husband would bury the placenta in the ground, somewhere to the side, away from the road or near a tree. The child’s umbilical cord would be cut with scissors by the woman who helped during the birth and it would be tied with

a thread [2]. Until the introduction of midwifery education, midwifery was a major public health problem that existed for centuries as a result of lack of enlightenment, primitivism, superstition, mistrust, and tradition [4].

The Croatian word “*primalja*” (midwife) means a woman who “receives” a newborn. Midwifery in Bosnia and Herzegovina has had its own special path of development and dates back to 1879, when the Austro-Hungarian government issued an order on medical and midwifery practice in occupied Bosnia and Herzegovina. Within the framework of the order and following the example of the rest of the Monarchy, the Austro-Hungarian government had the task of organizing women’s health care, and, together with this, a new period in the history of health care begins [5]. During the Austro-Hungarian administration (1878 – 1918), the health care system in Bosnia and Herzegovina underwent a radical transformation and modernization. The establishment of local midwifery staff was a long-term process, and, at the beginning of its administration in Bosnia and Herzegovina, the Austro-Hungarian government mainly relied on foreign staff. Given that women were reluctant to be examined by male doctors, positions were opened for female health workers in the districts of Tuzla (1891), Mostar (1892), Sarajevo and Banjaluka in 1899, in Travnik in 1902, and in Bihać only in 1908 [6]. By decree, the Austro-Hungarian government appointed nine official female doctors in Bosnia and Herzegovina (Bosnia and Herzegovina: 1878-1918), who were in charge of the special task of improving public health and hygiene among Bosnian-Herzegovinian women. Czech and Polish women, who completed their studies in Switzerland at the end of the 19th and the beginning of the 20th century, were hired as the first female doctors in Bosnia and Herzegovina. One of the nine female doctors employed by the Austro-Hungarian authorities between 1892 and 1918 was Bogusława Keckova. She came to work from Prague and, in addition to her medical title, she also had an Austrian midwifery diploma. Keckova acted as an Austro-Hungarian health care officer in Mostar from 1893 to 1911, where she initiated and improved public health and hygiene among women [7]. Apart from Mostar, Keckova also worked in Stolac, Ljubuško, Konjic, Bileća, Gacko, Trebinje, and Nevesinje and was met with conditions that were completely different from those she was used to. At that time, male doctors had to diagnose medical problems without touching or examining their female patients. Women knew nothing about hygiene or nutrition and had no access to education. In 1900, Keckova began teaching health care at the Girls’ Secondary School in Mostar, and her teaching included anatomy and practical care. She taught and published articles in Croatian. Her medical articles in the Mostar journal “*Osvit*” were among the first in Bosnia and Herzegovina to promote public health education aimed at improving the health of the population [7]. Knowing that there are not many trained midwives in Bosnia and Herzegovina, in 1885, midwife Antonija Savić came from the Croatian Vojna Krajina to Sarajevo, where she obtained a work permit to practice midwifery independently. In 1882, she successfully passed the midwifery exam at the Royal Midwifery College in

Zagreb - *Kraljevsko primaljsko učilište* (a five-month course). After Sarajevo, in 1911 she went to working Bugojno, then to Prnjavor in 1916. Although there were few midwives at that time, competitive fights still happened between them. An example of this can be the lawsuit filed by the municipal midwife Katarina Šušković Janjić against the midwife Antonija Savić. In that lawsuit, the municipal midwife Janjić, together with the district doctor Maor Lefković, accused midwife Antonija Savić of acting outside the scope of her authority. Furthermore, they stated in the lawsuit that she turned the dead baby and pulled it out by its legs, that she treated farmers for various diseases, and that she participated in abortions. Midwife Antonija Savić immediately filed a counterclaim against the two, receiving wide support from a group of influential citizens who condemned municipal midwife Katarina Šušković Janjić, accusing her of smuggling and regularly leaving her “workplace”. Furthermore, they claimed that the municipal midwife, as well as the district doctor, were incompetent obstetricians. The complaints were followed by a court investigation, which did not result in a judgment. Citizens wrote that they luckily had midwife Antonija Savić with them, who proved to be more competent in the end [8].

Until the opening of the National Hospital in Sarajevo in 1894, Alojzija Vensko was the only trained Bosnian-Herzegovinian midwife [9]. Noticing the issue of the lack of trained midwives, the authorities at that time raised the issue of establishing a midwifery school in Bosnia and Herzegovina, which turned out to be a good decision of the state. Thus, in 1894, the first midwifery school opened in Sarajevo, where midwives received organized education in their profession, with the aim of reducing the mortality rate of mothers and children in Bosnia and Herzegovina. Thanks to Dr. Otto Weiss, 150 midwives (10) were educated during the ten years of this school’s operation. The professional work of midwives was extremely important because only a small number of births were performed in the hospital. Professionally managed home births, as well as timely referrals to the hospital, significantly contributed to the reduction of maternal and child mortality rates [9].

Historically, it is important to mention the year 1898, in which the register of midwives was introduced in Austro-Hungarian Bosnia and Herzegovina. At that time, all midwives intending to legally engage in their profession must be registered in the register, and then become familiar with the new regulations and professional practice. After completing the training, each midwife would receive a midwifery bag for free use. Since then, midwives are obliged to check the condition of the bags (correct or dirty) and inspect them regularly, making sure that they have enough disinfectant and aseptic equipment. In addition to its original function as a container, the bag also became an administrative instrument to control midwives. In addition, the work of midwives is regularly controlled by health care officials [8].

In 1886, a city hospital, in which Austrian doctors and pharmacists worked was opened in Tuzla. Within this hospital, for the first time in history, a health care service for the protection of women was introduced. Given that women were

reluctant to agree to examinations by male doctors, the need for women in this profession was pronounced. The first female doctor, a gynecologist in Bosnia and Herzegovina, who worked in the Women's Health care Service in Tuzla, was a Polish woman, Theodora Krajewska, who came to Tuzla in 1893 [6]. Before the beginning of the First World War, there were 15 midwives in Tuzla, three of whom worked in the city, and the rest in the district headquarters of northeastern Bosnia [11].

The horrors of destruction and suffering resulting from the First World War (1914-1918) in Bosnia and Herzegovina were felt everywhere. In the country that was still part of the Austro-Hungarian monarchy, mass hunger, poverty and scarcity reigned. When it became clear at the end of the summer of 1918 that Austria-Hungary would lose the war, most Austro-Hungarian doctors left the country. Unlike doctors, many midwives remained in the field during the entire duration of the war from 1914 to 1918. The midwives remained in many places where the new post-war administration took over. After the First World War and the collapse of the Austro-Hungarian monarchy in December 1918, the State of Slovenes Croats and Serbs, and (cr. *Država Slovenaca, Hrvata i Srba* - DSHS)

DSHS was established, into which Bosnia and Herzegovina was integrated. The administrative and professional relationship adopted between midwives and the Austro-Hungarian monarchy continued after the war, and was officially adopted by the State of Slovenes Croats and Serbs (DSHS). This was particularly related to formal and technical aspects of the work, such as the regular control of the midwife's bag by health care officials [8].

How many midwives were there during the Austro-Hungarian era who remained in Bosnia and Herzegovina after the war? How many remained in the country in the first place? In the early 1920s, the newly established Health care Department for Bosnia and Herzegovina, which was established by the Provincial Government in Sarajevo, dealt with such issues, which were of great importance in terms of researching health conditions for mothers and newborn children. In this sense, in 1921, the Health Department in Sarajevo asked all district centers to submit the number and names of the remaining midwives. This request for the delivery of data was not responded to. Only the counties of Banja Luka and Travnik provided some incomplete data, so a systematic analysis was impossible. In mid-1921, a second request was issued asking for data on the number of midwives and all other medical personnel, including doctors and dentists. This time, a list was delivered. The obtained list of midwives contained 102 names, which was approximately the same number as that of midwives in Bosnia and Herzegovina in 1900. Comparing the names on the list with those from 1913 and 1914, it is evident that more than half of the midwives remained in the country and mostly in the same cities. The obligation to register midwives was still in force and it was adequately regulated. The novelty compared to the previous midwife reform from 1898 was reflected in the mandatory meeting between the supervising health care officer and

the midwife in question after the initial registration, which was a “prerequisite” for performing midwifery services [8].

In 1906, the model of the midwife’s bag was changed, and the regulations were adjusted accordingly. The revision of the midwife’s bag was harmonized in 1921. Namely, when registering the midwife’s personal data, the contents of the midwife’s bag were also recorded, which was considered a useful measure and a guarantee of stability in uncertain times [8].

Between the two world wars, the health conditions in Bosnia and Herzegovina were bad, social and medical diseases, tuberculosis, endemic syphilis, endemic goiters, parasitic diseases, fungal diseases, avitaminosis, and malnutrition ran rampant. Hospital facilities were dilapidated, so treatment procedures were often performed in improvised areas. The renovation of the premises and the recruitment of personnel took place in the period between the two world wars.

Thanks to Andrija Štampar, Minister of Health of the DSHS, public health care centers were established in many places in Bosnia and Herzegovina. In Mostar, a bacteriological station was opened in 1923, which was the first step in the establishment of a health care center. This created the foundation for improving hygienic conditions in the city and, especially, in the countryside, which led to a visible improvement in the health care of the population of the entire region [12]. In the same year, the National Health Center - *Dom narodnog zdravlja* was established in Tuzla, as well as the district bacteriological-epidemiological station [13]. Preventive health care for women developed significantly, and, in 1933, the “People’s Front for Women and Mothers of the City of Sarajevo” was founded in Sarajevo [14]. At the same time, a network of 25 hospitals was being developed in the next few years: one state, three regional, nine county, eleven municipal, and one special hospital for TB, followed by 27 general outpatient clinics and 64 public pharmacies. The number of civilian doctors rose to 383, pharmacists to 71, medical staff with a secondary school education to 47, and midwives to 110. The further development of health care was halted by World War II and that period was characterized by war destruction, with major consequences for health care, primarily the occurrence of large epidemics of typhus and smallpox, the dissipation of professional health care staff and, in general, an extremely poor hygienic and sanitary situation in the country [15].

After the Second World War in 1945, Bosnia and Herzegovina became one of the republics of the newly formed state of the Socialist Federal Republic of Yugoslavia (SFR Yugoslavia). Up until 1992, Bosnia and Herzegovina was a part of the SFR Yugoslavia. The referendum held on March 1, 1992, declared the independence of Bosnia and Herzegovina, and the separation from the SFR Yugoslavia was also the beginning of a bloody war (1992 – 1995).

Bosnia and Herzegovina, together with the countries of the former Yugoslavia, completely medicalized childbirth in the 1960s, 1970s, and 1980s. During the 1960s in Bosnia and Herzegovina, a large number of women gave birth in a hospital environment. At the same time, women continued to give birth at home

in rural areas of Bosnia and Herzegovina, mostly under the supervision of trained midwives. With the medicalization of childbirth, doctors began to take over the management of childbirth, which threatened the midwifery profession in Bosnia and Herzegovina. Management of low-risk pregnancies and low-risk births should always take place only with midwives, but in Bosnia and Herzegovina this is not the case, as a gynecologist is currently present at every birth [16].

## **2. System of education for midwives**

Already in the 18th century, there were schools in Europe where midwives could be trained. In 1894, a school for midwives was opened in Sarajevo, and it is considered to be the oldest state school in Bosnia and Herzegovina. After World War II, in September 1946, a two-year “School for Midwives” was opened, located on the grounds of the Obstetrics and Gynecology Clinic “*Jezero*” in Sarajevo. Female participants had to have completed at least elementary school and were not to be younger than 20 or older than 30 years of age. During their schooling, they were accommodated in the premises of the boarding school attached to the School, where they were obliged to live. They were educated at the expense of the budget of the Ministry of Public Health. The director of the school was appointed by the Minister of Public Health in agreement with the Prime Minister. The director had to be a specialist in obstetrics and gynecology, so the amount of importance attached to these institutions follows from all of the above [17].

The Midwifery School in Tuzla was founded back in 1947 and lasted until 1963, when it was merged with the Medical School. It was a boarding school located in the hospital grounds. In 1965, a four-year midwifery school was opened in Tuzla [18]. Aside from Tuzla, the Government of the Socialist Republic of Bosnia and Herzegovina established two more secondary medical schools, in Banja Luka and Mostar, by a Decree dated August 1947. The medical school in Mostar initially operated as a three-year school, and from 1949 the education lasted for four years [19]. In the following years, secondary medical schools for midwifery were opened in other cities in Bosnia and Herzegovina. It is important to emphasize that the continuity of training midwives in larger cities was occasionally interrupted, and that midwives were trained periodically, according to the needs of local health care. Midwives educated at a secondary level do not have the right to work independently and do not have the right to private practice. In Bosnia and Herzegovina, until 2014, midwives were trained to assist in childbirth of women under the supervision of a doctor, and to independently perform tasks of taking care for women, pregnant women, birth attendants, mothers, and newborns. Also, midwives with a secondary education, out of all profiles of health care workers, were the only ones who did not have the opportunity to continue regular education in their profession (undergraduate and graduate studies).

The European Union defined the criteria and standards of education that midwives must meet in order to be mobile in the EU. According to the directives of the Council of Europe and the Council Directives for Nursing and Midwifery, the education of nurses and midwives must not be at a level lower than a three-year study. Directives EEC/80/154 and EEC/80/155 refer directly to the profession of midwifery, prescribe the standards of midwifery education, and are mandatory for all member states [20]. The guidelines set by the European Union for the education of midwives are clear - midwives need to be educated at universities.

After a long lull, midwives in Bosnia and Herzegovina are realizing their professional aspiration, which is to train midwives according to European standards. In 2014, the first undergraduate university course in midwifery was opened in Bosnia and Herzegovina at the Faculty of Health Studies at the University of Mostar. The undergraduate study lasts three years, consists of a total of 180 ECTS credits and 4,600 hours of theoretical classes and practical training. The study programme is based on the recommendations of the World Health Organization and the Competencies of Midwives, which are prescribed by the EU Sectoral Directive 2005/36/EC [20].

The competencies that students acquire at the end of the studies are aligned with the new definition of a midwife adopted by the International Confederation of Midwives, ICM, which reads: “A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery. The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures [21].

According to the definition, the health care system in Bosnia and Herzegovina needs highly educated midwives who will master the specific knowledge and skills of midwifery care, but also the area of management and leadership, public health, and education. In 2022, the first generation of midwifery graduate students (Masters of Midwifery) enrolled in the Faculty of Health Studies at the University of Mostar. At the initiative of the Faculty of Medicine in Banja Luka, a four-year course in midwifery (240 ECTS credits) was opened in 2018. After Mostar and Banja Luka, in 2020, a four-year course in midwifery (240 ECTS credits) was opened at the Faculty of Health Studies in Sarajevo.

### 3. The legal status of midwifery

Bosnia and Herzegovina is located in southeast Europe. It borders the Republic of Croatia to the north, west and southwest, the Republic of Serbia to the east, and Montenegro to the south. Bosnia and Herzegovina is administratively divided into two entities: Federation of Bosnia and Herzegovina and Republic of Srpska, and Brčko District. In addition, the Federation of Bosnia and Herzegovina is divided into 10 counties [22]. All counties have their own legislative, executive, and judicial powers.

Given that Bosnia and Herzegovina is an extremely complex country in terms of its state structure, the legal regulations in the field of health care according to the constitutional decisions are under the jurisdiction of the entities of the Republic of Srpska, the divided jurisdiction of the entities and counties of the Federation of Bosnia and Herzegovina, or Brčko District [23]. Thus, three Acts on Health care (24-26), one Act on Nursing and Midwifery in the Federation of Bosnia and Herzegovina [27], and the Ordinance determining the procedure for issuing a license, as well as the content and appearance of a license for independent work in the Federation of Bosnia and Herzegovina, which all relate to the midwifery profession, are in force in Bosnia and Herzegovina at the moment [28].

In particular, legal regulations with an emphasis on the recently adopted Act on Nursing and Midwifery of the Federation of Bosnia and Herzegovina [27], still do not significantly affect the actual position of midwives in the health care system. And while midwives are recognized in the world as independent, responsible, and professional individuals who have a license to perform their work, changes in Bosnia and Herzegovina are slow and the midwifery profession is not gaining importance, or independence. The unevenness of the educational process, the competences defined by law, and actual practice put the midwives in a position that is far from what their professional identity deserves

There are multiple reasons for this situation. Midwives generally have a secondary education and are trained to work under the supervision of a doctor. Although a new category of midwifery graduates has recently appeared on the labour market, bachelors of midwifery, it is very difficult to find jobs in accordance with the acquired competencies. The scope of work of midwives with high school education is precisely defined, while midwifery bachelors and midwifery masters degrees do not have a regulated status and do not fully implement their competencies. The position of doctors in the management of low-risk pregnancies and low-risk births is still dominant and explicitly challenges the autonomy of midwifery graduates.

In the systematization of workplaces, health care institutions do not plan for highly educated midwifery staff, with the explanation that there is no clearly defined scope of work or legal basis, and that midwives with high school education are financially more profitable. So, in practice, there is a gap between acquired competencies and the actual position of midwives. This state of affairs is legally unacceptable and unsustainable, and efforts should be made to find effective mechanisms to improve the status of the midwifery profession.

The Act on Health care of the Federation of Bosnia and Herzegovina [24], the Act on Health care of the Republic of Srpska [25] and the Act on Nursing and Midwifery of the Federation of Bosnia and Herzegovina [27] made a significant regulatory step forward, obliging midwives who have passed the state exam to register at to the appropriate chamber in the register of midwives and thus acquire the right to work independently. Despite this legal obligation, midwives in Bosnia and Herzegovina are mostly members of the Chamber of Nurses and Medical Technicians and do not have the appropriate authorizations for independent work. Currently, in Bosnia and Herzegovina, only midwives from Herzegovina-Neretva County have a license for independent work issued by the competent Chamber, which was founded in 2014 in Mostar. Chamber members are midwives employed in the health care system, hospitals, health centers, and private health care institutions.

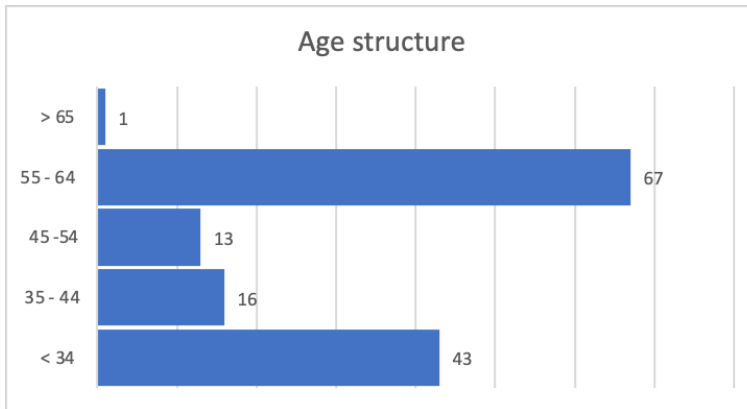
Despite the unsatisfactory picture of the actual position of midwives in Bosnia and Herzegovina, it may be said that, with the initiation of education at the university level and the passing of the Act on Nursing and Midwifery, the processes of strengthening the autonomy of the profession have been initiated. Further reforms that will regulate, in detail, the way midwives' function independently and perform their activities are needed. In addition, it is necessary to specifically define the status of midwives with secondary education who have more than 20 years of work experience in practice, and to create an administrative prerequisite for a legal solution and protection of this type of midwifery staff in the transition phase [29].

#### **4. Midwifery in numbers**

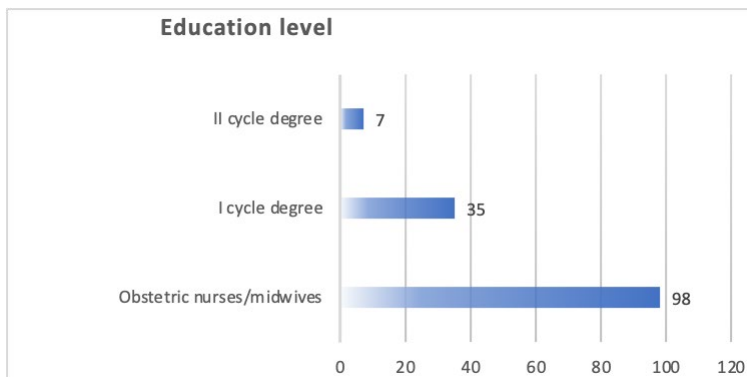
Each year, the Institute for Public Health of the Federation of Bosnia and Herzegovina and the Public Health Institute of the Republic of Srpska present statistical reports on the health status of the population. In addition to numerous other data, these reports also include data on the number of health care workers of all profiles with secondary, higher and university education.

In the Republic of Srpska for the year 2020, data related to the number of midwives working in the health system were presented. Three hundred and fifty-one midwives had a secondary education, while only 3 midwives had a higher education. Also, it was recorded that all midwives were female [30].

In the Federation of Bosnia and Herzegovina for the year 2021, there were 671 midwives who completed secondary education, 13 midwives who completed the academic study of the first cycle in the duration of three years, i.e., 1 midwife who completed the second cycle of higher education were recorded. It is indicative that all midwives are female, and that, according to the age structure, most midwives were of an older age. If we look at the age data, we can see that the largest number of working midwives, 249, is in the age group from 55 to 64 years of age, followed by the age group between 45 and 54 years of age, in which a number of 127 midwives was recorded [31].



Source: Chamber of Midwives/Midwives of Herzegovina-Neretva Canton (2023) [32].



Source: Chamber of Midwives/Midwives of Herzegovina-Neretva Canton (2023).

Herzegovina-Neretva County is one of 10 counties in the Federation of Bosnia and Herzegovina. In accordance with the current legal regulations, and on the initiative of midwives from the county, the Chamber of Midwives of Herzegovina-Neretva County was founded in 2014 (*Komora primalja/babica Hercegovačko neretvanske županije*). The membership register maintained by the Chamber contains detailed information on the number of members, age structure, level of education, and place of residence. Observed in the period from 2014 to the end of 2022, a total of 156 approvals for independent work were issued. Of that number, the total number of active members is currently 140.

The highest share of midwives is made up of those with a high school diploma - 98 of them, then 35 with a bachelor's degree in midwifery, and 7 midwives who have a graduate education mostly obtained at a related faculty of nursing. Due to the impossibility of vertical education in midwifery, one of the midwives obtained a Master of Science degree in Biomedicine and Health at the Faculty of Medicine in Mostar.

## 5. Challenges and prospects

Midwifery in Bosnia and Herzegovina was a contested and marginalized profession for a long time. In recent years, there have been a number of positive changes and favorable circumstances for the development of midwifery. Today, midwives have the opportunity to continue their education at undergraduate, graduate and postgraduate studies, which is a significant step forward in the development of the professional identity of midwifery. Despite the positive changes in the education of midwives, the midwifery profession still encounters a number of obstacles in the institutional and legislative sphere, as well as in the sphere of the relationship between institutions and the profession. In other words, midwifery graduates in Bosnia and Herzegovina still do not have the ability to independently determine pregnancy, provide antenatal care in physiological pregnancies, and independently lead physiological births and perform vaginal examinations.

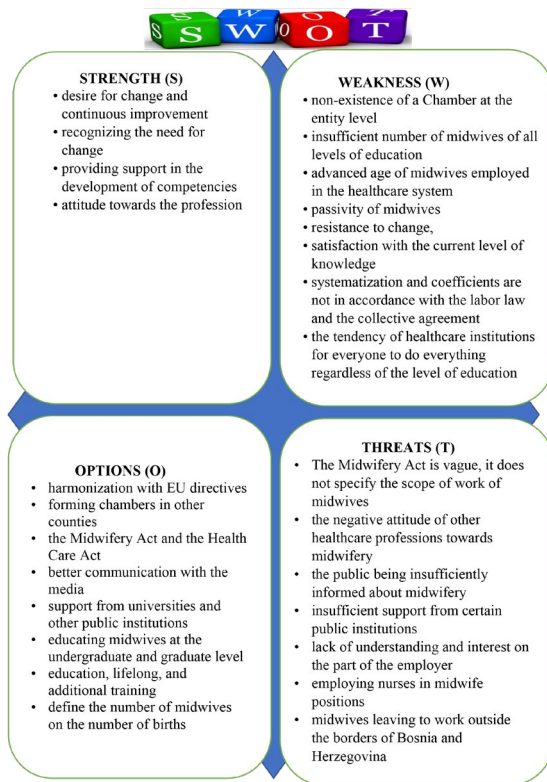
The opening of undergraduate and graduate studies in Bosnia and Herzegovina was documented as a significant step forward for the midwifery profession. In this context, opportunities for obtaining scientific titles for midwives are open and opportunities for midwifery research exist. Scientific and teaching literature in the mother tongue of Bosnia and Herzegovina is deficient, or rather non-existent. In the coming period, writing scientific and teaching literature should be a priority for midwives, especially those midwives who are engaged in teaching at midwifery faculties.

Data on the number of midwives in Bosnia and Herzegovina do not represent the credible state of the midwifery profession in the country (Federation of Bosnia and Herzegovina, Republic of Srpska, Brčko District). What are the actual numbers of the midwifery staff? How many midwives are still needed? What is the actual situation? What is the number of midwives in the delivery room in relation to the total annual number of births in a certain health care institution? It is not possible to answer these questions yet. There is no single national registry of licensed midwives in the country. An accurate and up-to-date data on the number of licensed midwives in Bosnia and Herzegovina is known only for the Herzegovina-Neretva County thanks to the register of the Chamber of Midwives of the Herzegovina-Neretva County (Federation of Bosnia and Herzegovina).

It is necessary to invest a lot of effort in advancing the midwifery profession in Bosnia and Herzegovina. One of the challenges facing the midwifery profession, as well as the Ministry of Health of both entities and the Brčko District, as well as the Institutes of Public Health in Bosnia and Herzegovina, is the collection of “real numbers” of midwives in order to assess the actual situation on the ground. What should also be taken into consideration is the fact that a number of midwives work in other jobs in the health care system. The formation of the national register of midwives will serve as a basis for planning the real requirements for new midwifery positions. We should strive to create a Chamber of Midwives, at least at the entity level of Bosnia and Herzegovina, which would maintain a unique

register of licensed midwives and, above all, create a stimulating atmosphere for the development of independent and higher quality midwifery. Article 11 of the Act of Nursing and Midwifery of the Federation of Bosnia and Herzegovina precisely defines: “Works and tasks to be performed independently by midwives, as well as tasks to be performed as part of the health care team, will be determined by a special regulation by the Federal Minister of Health on the proposal of the competent chamber.” In this context, the Act remained only “ink on paper”, because the competences of midwives cannot be defined due to the absence of a Federal Chamber, which is the only relevant authority that could make a proposal. This is another confirmation of the priority of the establishment of a Federal Chamber.

The unequal position of midwives in Bosnia and Herzegovina is currently expressed in terms of job systematization and non-compliance with legal regulations. This is primarily reflected in the employment of with a bachelor’s degree in midwifery in midwifery positions with high school and in the outflow of midwifery personnel (with high school or higher education) abroad. This unfavorable practice in hospitals indicates that there have been no systemic changes in defining the jobs of midwives and, ultimately, indicates a negative treatment of midwives, and an insufficient evaluation of the midwifery profession.



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## MIDWIFERY IN CROATIA

### 1. Brief history of midwifery

In Croatia, from very early times, there were capable and experienced women who helped in childbirth with their experience [1]. Near Split was found the tombstone of the midwife Elija Sotera, the oldest evidence of the existence of midwives, dating back to antiquity [2]

Following the division of traditional gender roles, in which the care of all those who needed the help of others was considered the woman's task, midwifery also became an exclusively female profession [1,3]. The practise of midwifery was a privilege of women. Men did not attend childbirth for social, traditional, and religious reasons [3-8]. To that extent, it is recognized as a female profession, and to this day there is no male equivalent for midwife in the Croatian language.

Throughout history, society has treated midwives differently. In some eras they were respected and educated, in others uneducated and hated, sometimes feared because they possessed knowledge and skills in areas of life unknown and mysterious to many at the time. In the Middle Ages, midwifery was neither an easy nor a harmless profession [3,9-12]. Although the great persecutions of witches took place later, in the 16th and 17th centuries up to the middle of the 18th century, and it had a significant impact on the Middle Ages [13,14]. Church and society encouraged the practice of burning witches, and many of the women sacrificed were also midwives based on the accusations that the witches were particularly fond of midwifery because it gave them the opportunity to use spells to deliver the child into the hands of the devil at birth by casting spells. Midwives not only knew about childbirth, which was often associated with magic at that time, but also had knowledge of medicinal herbs, from which they made medicines, love potions and abortifacients [9,15-17]. In the Middle Ages, it was the worst possible activity, declared as the devil's work and punishable in the worst possible way [13]. Evidence for this can be found in official documents such as the 1648 Inquisition textbook *Malleus Maleficarum*, which states that the Catholic faith has no more dangerous enemy than midwives [1, 3,18-21].

For many centuries midwifery was left to the labour and experience of initially uneducated and illiterate women who acquired their knowledge through oral tradition. Midwifery was passed "from generation to generation" [3,18,19,21], from grandmother to granddaughter, from aunt to niece, and at the same time it was often guarded as a professional secret [22-25], in the desire that it remain a family practice

[10,23,24]. In general, support for women during childbirth was based on “trial and error,” and the methods that proved more successful continued to be used in practice. Knowledge was inadequate, which, in addition to poor living conditions, often led to maternal and newborn deaths [1-3,18-20,26]. There were also trained midwives. However, they usually worked in urban areas, while in rural areas there was practically no medical care, so women continued to give birth without professional help. Often neighbours or relatives helped each other give birth, or women gave birth alone without assistance [18,20,22-24,27]. According to traditional beliefs, in order to protect the woman in labour from the dangerous effects of evil eyes and spells, she gave birth in a part of the room protected by spells [23,24] or outside the house, far away from the household. Very often childbirth took place in cow and horse stables [21,27] under unsanitary conditions, and the death of mother and child due to puerperal sepsis was attributed to unfavorable atmospheric and cosmic causes. It happened that assistance in childbirth did more harm than good [7-9]. How could it not hurt to press on the abdomen or back and blow into a glass bottle during obstetric care, so that the birth could proceed as quickly as possible. This kind of care often ended with complications such as rupture of the uterus and hemorrhage, and if you add to this the poor living and hygienic conditions in which people lived, the position of women in society and in the family, the primitive understanding of pregnancy and childbirth, all this has tragic consequences. If nature itself did not ensure a good course of birth, it often ended with a fatal outcome for the mother and the newborn [15,21,28].

Ignorant and uneducated people, when they had the opportunity to call a trained midwife for childbirth, preferred to call the village midwife. It was cheaper to pay them [26], and the consequences of their actions on the death outcome of mother and child were accepted on the principle of “God gave, God took away” and were not perceived as tragic [21,26]. Moreover, distrust of medical achievements, superstition or shame of women were the reasons why trained midwives often lost the battle with midwives of the people [26], and the same was considered as one of the most important social and public health problems [21,26].

In the 18th century, the Catholic Church had a significant influence on the regulation of the midwifery profession and took full control over midwifery. First, to supervise the work of midwives, and second, to bring it in line with the principles of Catholic faith and morals, thus preventing the high mortality of mothers and newborns. In some regions, the parish priest issued midwives a license, a recommendation to train or practice midwifery, called a Certificate of morality. During their activity, midwives were obliged to communicate regularly with the parish priest and to be present at baptisms. For these reasons, they were given the title of “ecclesiastical assistants” [1,18,27,28,23,24].

Thanks to the development of medical knowledge and the realization that human life is priceless and every person has a right to it, more and more attention is paid to midwifery [1,15,19,20]. Attempts have been made to solve the problem of high maternal and infant mortality through health education and training of

future midwives [26]. Since 1770, when Empress Maria Theresa issued the Public Health Law (*Normativum sanitatum*), which also applied to Croatia, then part of the Austro-Hungarian Empire, more attention was paid to midwifery. It was enacted primarily with the aim of eliminating the difficult health and socio-economic conditions in the countries of the monarchy. It focused on reducing morbidity and mortality rates in the population, especially maternal and infant mortality. It regulated the work of midwives and prohibited midwifery. The Public Health Law set conditions for training and required that a midwife pass an examination in front a physician in order to be licensed. Only licensed midwives who have been authorized to practice by a physician or health commission may now practice as midwives [1,3,7-9,18-20,23,24,26,28].

The implementation of the provisions of the above-mentioned law began in Croatia after the physician Joannis Baptiste Lalangue arrived by Imperial decree in Varaždin, the capital of Croatia at that time, in 1772, in order to carry out the necessary reforms in the health care system and to eliminate the difficult health and socio-economic conditions of the Croatian population. Immediately after his arrival, he advocated the establishment of a midwifery school in Varaždin and devoted himself entirely to the training of midwives and promoted the development of midwifery in the Croatian territories. He organized the first midwifery courses, led by Elizabeza Gaertin, a midwife from Varaždin, whom Lalangue sent to Vienna to train under well-known professors of obstetrics [3,15], thus laying the foundation for the systematic training of midwives. The one in Varaždin dated from 1776, but even these licensed midwives often had insufficient expertise, and their numbers were so small, especially in the villages, that they could not meet the demand - one midwife per village or at least one midwife for two or three villages, so maternal and neonatal mortality remained extremely high [26]. The difficult situation is best illustrated by the fact that despite the high birth rate (40-50 ‰), the population in Croatia was stagnating due to very high maternal and perinatal mortality [3,29-32].

Following the example of the Lalangue course for midwives, doctors were also organizing courses and training midwives in other parts of Croatia. The courses initially last fourteen days, and licensure was granted after passing the examination. During the training, it often happened that the midwives were examined and licensed by the local priest, so their expertise was still insufficient [18]. As a result, maternal and neonatal mortality was very high.

With the expansion of the network of midwifery schools, a legal provision was enacted in 1804 abolishing the holding of private midwifery courses, so that henceforth only midwives with formal training could provide midwifery assistance. More and more midwifery schools were opened, and by the mid-19th century there was at least one midwifery school in almost all provinces of the monarchy, except in Croatia and Slavonia, where there was not a single midwifery school. Therefore, wealthier women from Croatia were educated in Vienna, Pest and Ljubljana (since

its foundation in 1816), as well as in Trieste, but there were very few of them [18,23,24,29].

Besides the knowledge of foreign languages and finances, an obstacle to education outside Croatia was the generally weak literacy of women, which continued in our region until the end of the 19th century. As a result, there is still a shortage of trained midwives [4,18,23,24], especially in villages, where women giving birth still relied on themselves and the traditional knowledge of village midwives. Few of the existing midwives worked in cities, as they themselves come from urban areas. Therefore, rural women still give birth without professional assistance, and the problem was reflected in the extremely high mortality rate of young women and their newborns [1,3,4,7-9,18,28].

Midwifery schools were gradually being opened in present-day Croatia. In 1786, a midwifery school began operation in Rijeka, in 1821 in Zadar, and in 1877 in Zagreb. Although there was still a shortage of trained midwives in Croatia, the situation in midwifery was gradually changing.

Thanks to their expertise, midwives with a diploma from the Zagreb School of Midwifery could practice throughout Hungary, including the city of Rijeka, without a special additional license from 1904 [18,26]. At the beginning of the 20th century, midwifery care consisted of examining a pregnant woman immediately before birth and during the birth, which usually took place in the woman's home. The birth was managed by midwives, whose duties, in addition to managing the birth, included caring for the woman during the two-week midwifery period, instructing breastfeeding, cleaning the house, cooking, and doing the laundry [9]. The doctor was called only when labour stopped, and usually ended it with forceps, performing an internal turn, or embryotomy. Delivery in hospital maternity wards was reserved for women with a narrow pelvis or neglected mothers [1-3,18-20].

Before the World War II there were small private maternity clinics in the Kvarner region with one or two beds for mothers in labour. The most famous maternity clinic in the region was that of the midwife Antonija Gracijani, which had up to four beds for mothers and midwives. She monitored pregnant women and, in cases where she found a pathological condition, recommended delivery in the maternity ward of the Rijeka Hospital [15,18,20]. However, in the 1960's of the 20th century, midwives in Croatia lost their professional autonomy that had existed until then and the possibility to perform births independently in the mother's home, in outpatient and inpatient maternity wards [18]. Midwives, who until then were the main providers of maternal and newborn care [4], were now losing their role. Obstetrics evolves from midwifery and introduces the concept of perinatal medicine as a synthesis of maternal and fetal medicine and neonatology. It was a time when obstetricians assumed overall supervision of pregnancy and childbirth and midwives became their assistants [1-3, 6,12].

## 2. System of education for midwives

On the present territory of the Republic of Croatia, midwives were initially trained by local doctors and priests. At the beginning of the 18th century, midwives from Kvarner had to take an examination in Trieste, until 1755, when the Rijeka City Council requested the Intendantur of Trieste to conduct the examinations and issue the certificates of competence for midwives in Rijeka. The well-known obstetrician Dr. Severio Graziani [18, 33] was entrusted with this task, and Rijeka was granted the right to train midwives. After him, other doctors from Rijeka also issued certificates of competence of professional qualification to practice midwifery [33].

Aware of the fact that midwifery cannot be associated only with experience, but that the practice of this profession requires much more, and that only trained midwives can contribute to a better quality of work and a better status of midwives, midwives in Croatia have been receiving organized training for almost two and a half centuries. Just think of the fourteen-day midwifery courses of Lalangue, after which the participants were personally admitted license to work by Empress Maria Theresa.

According to the Rulebook for the Practice of Midwifery, the first in Croatian, written by Lalangue in 1785, midwives had to pass an examination once a year to renew their professional license [1,3,18,23,24]. Otherwise, they were threatened with the legal sanction. In the same year, an Imperial decree made it compulsory to take a midwifery examination in Vienna or Budapest as a prerequisite for entry into the civil service [10,18,26]. However, the reforms carried out indicate the activity of three groups of midwives: Midwives with a diploma from one of the universities in the region, midwives who obtained a license to practice based on an examination taken in front of a county doctor, but also midwives without a license who worked under supervision. While there were still areas where women gave birth alone and without professional assistance [26].

The oldest midwifery school started its work in Rijeka in 1786. It was opened on the initiative of the local authorities and served to educate women from Rijeka and the surrounding smaller towns. It was headed by Giacomo Cosmini, a prominent surgeon of the town [7-9,18,10,23,24,28], but as a private school and without state support it could survive only for a short time [18], and after his death in 1799 it ceased its work. After that, the training of midwives began in Zadar, based on a decision of the Austro-Hungarian Emperor Francis I of Habsburg. The education lasted 2 semesters or 8 months. The first teacher of midwifery at this school was Giuseppe Dell Oro, who was appointed professor of anatomy and surgery. It was founded in 1820 and operated until 1918, when it was disbanded during the occupation of Dalmatia by the Italians. During the following three decades of the turbulent period of Italian occupation and World War I and II, the school was closed and only resumed its operation in 1948 [18,28].

In Zagreb, the 30-year attempt to open a midwifery school finally came true when Ivan Mažuranić's ban was suspended. It was put into operation in 1877 as part of the newly established National Maternity Hospital and the Public Hospital of the Sisters of Mercy [10,18]. The first director of the college was Prof. Dr. Antun Lobmayer. The training was organized according to Austrian and German models, with the maternity clinics established as part of the midwifery schools, and the maternity clinics are also used for the training of midwifery students. Any married or unmarried woman between the ages of 20 and 40 who could read and write and was mentally and physically healthy could enroll in the college. She also had to present a certificate of good moral character issued by the municipal authorities and countersigned by the priest. A certificate of pregnancy also had to be attached. Since it was initially almost impossible to find educated women among the students, it was decided that rural women from the countryside who could not read and write could also enroll in the college, since female illiteracy was still a major problem in Croatian society [18].

Originally organized as a five-month course, the school term was expanded over time: to six months in 1918, to one year in 1919, to two years in 1946, to three years in 1958, and to a four-year school or high school education in 1964. As such, it still exists today. After one hundred and ten years of successful operation, it was discontinued in 1987, which soon led to a shortage of midwives. After protests by numerous prominent gynecologists and at the request of the Croatian Association of Midwife Nurses, the Zagreb Midwifery School resumed its work in 1991. It is the only secondary midwifery school in the country that continuously trains midwives, while in our larger cities training is sporadic, depending on the alleged needs of local health care. Therefore, even today, midwifery training exists at the secondary school level. During this time, the designation of the learned profession has changed, so that if the training follows almost the same curriculum, different professional titles can be found on the certificates, such as gynecological-obstetric nurse, midwife or simply midwife. As of the 2008/2009 school year, the acquired professional title after graduation from midwifery school is midwife - assistant.

In contrast, the Higher School for Gynaecological-Obstetric Nurses existed for only a few years, and the last generation of these senior midwives in the Republic of Croatia was enrolled in 1981. After that, it was discontinued, and the midwives had the opportunity to continue their education at a higher level only for a short period of time throughout history after the senior high school.

Thus, of all health care workers, only midwives had the opportunity to pursue higher education than secondary school. Although there were efforts to establish midwifery studies in Croatia, especially in Zagreb, at the end of the 20th century, they did not materialise.

The Faculty of Medicine at the University of Rijeka was the first to recognise the need for midwifery education at a higher level than high school and introduced a part-time midwifery degree programme in the 2008/2009 academic year. The first

part-time undergraduate programme in midwifery. The first in the country started as a part-time course, began to work at the Faculty of Medicine of the University of Rijeka and will continue at the newly established Faculty of Health Studies of the University of Rijeka from the academic year 2014/2015. [3,25].

During the years of its existence, there have been changes related to the additional adaptation of the study programme to the Bologna Process, with the main goal of creating a comparable, compatible and coherent system of higher education within the European Higher Education Area [3].

The curriculum is harmonized with Directive 2005/36/EC, the most important change being the harmonization of theoretical and practical teaching, with special emphasis on the competences to be acquired. The total number of hours of the course should be at least 4,600 hours, with 1/3 of the total duration of the course devoted to theoretical teaching and 1/2 to clinical practice, which has been implemented. Special emphasis was placed on the final competencies of midwifery graduates, defined in Directive 2005/36/ EC, in accordance with the Bologna Process, according to which all member states that signed the 2001 Declaration, including Croatia, were obliged to harmonize their higher education systems with those at the European level [3].

The study programme has been adapted several times to the new legal framework of the Republic of Croatia, especially to the Law on Scientific Activities and Higher Education, including the Law on Regulated Professions and Recognition of Foreign Professional Qualifications. Thus, the study programme of the basic study of midwifery has passed the domestic and foreign examinations.

Based on the new study programme, a regular in-service midwifery studies was introduced in 2011 in accordance with the first model of midwifery education of the Directive at the undergraduate level in a full-time programme of at least three years of full-time study with the existing 180 ECTS credits or 60 ECTS per academic year, i.e., 30 hours of workload per 1 ECTS credit or 5,400 hours of theoretical and practical training [3]. In addition to the existing regular midwifery degree programme, depending on the needs of the labour market and the personal needs of midwives already working in health care, a part-time degree programme and a differentiated programme for achieving horizontal mobility from professional nursing studies to professional midwifery studies, the so-called “bridge programme”, was opened. The latter study programme enables the acquisition of additional knowledge and skills for bachelor’s degree nursing graduates working in midwifery care, based on their previous midwifery education and previously acquired learning outcomes. The same applies according to II. with the training model from Directive 2005/36 EC, which lasts 18 months [34].

Undergraduate university studies in midwifery began in the 2011/2012 academic year at the University Department of Health Studies, University of Split [36].

The enrollment rate for all courses in Croatia is 15 to 20 students [34-36], according to the possibilities of acquiring the initial competences of the students

of the Undergraduate Midwifery Study and the possibilities of the Clinic of Gynaecology and Obstetrics of the Clinical Hospital Centre Rijeka and Split, where the clinical exercises take place. All this in order to maintain the quality of midwifery education.

### **3. The legal status of midwifery**

According to the International Confederation of Midwives, a midwife is a person who has successfully completed a midwifery education programme duly accredited in their home country based on the ICM Essential Competencies of Basic Midwifery Practice and the ICM Global Standards of Education for Midwives framework. A midwife is a person who has acquired the necessary qualifications to be registered and/or legally licensed to provide midwifery care and to use the title “midwife” and demonstrates competence in the practice of midwifery [37].

The midwife is recognized as a responsible professional who cooperates with the woman, provides her with the necessary support, cares for and advises her during pregnancy, childbirth, and the postpartum period, independently manages the birth, and cares for the newborn and infant. This care includes preventive measures, promotion of natural childbirth, recognition of complications in the mother and infant, access to medical care or other appropriate assistance, and implementation of emergency measures. The midwife plays an important role in health counseling and education, not only for women but also in the family and community. Their work should include prenatal education and preparation for parenthood and can be expanded to include women’s health protection, sexual and reproductive health, and child care. A midwife can work in any setting, including home, community, hospital, clinic, or health center. In this context, the Nursing and Midwifery Council [38] calls for programmes to educate midwives, regardless of the setting in which they work, that emphasize the acquisition of knowledge and skills to provide care in a physiological setting, with developed core competencies for safe practice, aware of their limitations, but also, last but not least, with developed skills that include empathy and communication.

The aim of the education of midwifery students in Croatia is to prepare them for responsible and professional practice of midwifery care, in which they perform evidence-based interventions, i.e. develop the professional identity of a midwife, following the example of countries with midwifery autonomy. In doing so, they demonstrate with their knowledge, skills, and attitude that they are able to take on tasks and responsibilities [39,40]. This is the practice in many parts of the world where midwives are the primary care providers in maternal and newborn care, and it is also supported by the World Health Organization and many international associations [37,38]. The benefits of midwifery to the health of women, children, and families in all countries and settings have been documented. These

include reducing unnecessary clinical interventions, increasing breastfeeding rates, improving treatment outcomes, and using health system resources more efficiently. Maternal and newborn care is provided by educated, trained, licensed, and regulated midwives.

Today, the profession of midwifery in the Republic of Croatia is regulated by Directives 2005/36EC and 2013/55EU. It prescribes the necessary education and professional competences of midwives, defines the profession at the national level and requires individual states to harmonize their legislation according to the provisions.

In 2008, with the establishment of the Croatian Chamber of Midwives [41], the Law on Midwives came into force, which was drafted in accordance with the provisions of Directive 2005/36 EC, according to which Member States must ensure that midwives have access to and can perform at least the following tasks:

- provision of sound family planning information and advice
- diagnosis of pregnancies and monitoring normal pregnancies; carrying out the examinations necessary for the monitoring of the development of normal pregnancies prescribing or advising on the examinations necessary for the earliest possible diagnosis of pregnancies at risk
- provision of programmes of parenthood preparation and complete preparation for childbirth including advice on hygiene and nutrition
- caring for and assisting the mother during labour and monitoring the condition of the fetus *in utero* by the appropriate clinical and technical means
- conducting spontaneous deliveries including where required episiotomies and in urgent cases breech deliveries
- 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
- 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
- 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
- carrying out treatment prescribed by doctors
- drawing up the necessary written reports.

The Law on Midwifery [41] prescribes as basic training in midwifery the completion of an undergraduate degree and the acquisition of a bachelor's degree in midwifery, according to which the practice of midwifery under Article 15b includes the independent practice of the following activities:

- act within the health care team in cases where a multidisciplinary approach is required; apply all acquired knowledge in the field of midwifery care in accordance with the principles of professional ethics and legislation, as well as knowledge in obstetrics and gynecology
- maintain medical documentation of midwifery care; plan, organize, and implement midwifery care; evaluate the midwifery care plan, analyze the conditions for its implementation, and perform clinical implementation of planned midwifery care
- educate on preparation for parenthood and childbirth and advise on breastfeeding
- establish pregnancy, care for physiological pregnancy and childbirth at all levels of health care, identify possible pathological changes in pregnancy and childbirth that should be reported to the physician; in emergencies, care for breech deliveries and perform manual exploration and emptying of the uterus
- if necessary, perform perineal incisions and perineal sutures and perineal tears 1. and 2
- participate as a member of the treatment team in the monitoring of pathological pregnancies and births and assist in the operative delivery of the child
- perform procedures for preoperative preparation and postoperative care following surgical completion of delivery and administer intravenous therapies
- supervise a healthy newborn and inform the physician of possible pathological conditions
- monitor the mother's condition after delivery and distinguish the physiological from the pathological course of delivery
- prepare and counsel a woman for a gynecological examination, counsel her and educate her about health maintenance, prevention of sexually transmitted diseases, family planning, and sexual and reproductive health
- perform oral and parenteral administration of medications prescribed by a physician

According to the amount of work that midwives should perform independently, a necessary level of training is prescribed, which requires a high level of education and involves the acquisition of a number of specific skills and competencies, all of which are prescribed in Directives 2005/36/ EC and 2013/55EU [34].

Annex V, item 5.5.1. The Directive establishes the training programme for midwives, according to which the training of midwives should ensure that the professional concerned has acquired the following knowledge and skills: thorough knowledge of the sciences on which the practice of midwifery is based, particularly midwifery, obstetrics, and gynecology; adequate knowledge of professional ethics and legislation relevant to the practice of this profession; adequate knowledge of general medical knowledge (biological functions, anatomy, and physiology) and pharmacology in the field of obstetrics and neonatology; and knowledge of the interrelationships between the state of health of human beings and their physical and

social environment and behavior; adequate clinical experience acquired in licensed facilities that enables the midwife to independently and autonomously provide prenatal care when necessary and to the exclusion of pathological situations, to attend births and their sequelae in licensed facilities, and to monitor labour and delivery, postnatal care, and neonatal resuscitation while waiting for a physician; adequate knowledge of health care personnel training and experience in working with such personnel.

According to the provisions of EC Directive 2005/36 in the training of midwives, theoretical instruction must be balanced and coordinated with clinical training in such a way that the acquired knowledge and experience can be applied in an appropriate manner. Clinical training shall take the form of practical training in hospital departments or other health care institutions approved by the competent authorities. As part of this practice, student midwives must participate in the activities of the department to the extent that these activities contribute to their education and teach them the tasks associated with the profession of midwifery. At the same time, the acquisition of competencies emphasizes the responsibility of institutions that train midwives. Accordingly, by integrating Directive 2005/36 into their curricula, all EU member states guarantee that they will achieve the same by harmonizing theory and practice during midwifery education. The contents listed in Annex V, item 5.5.1. can be modified according to scientific and technical progress, but in such a way that they do not go beyond the existing legal framework of midwifery education [34]. Quality assurance in higher education with the aim of continuous harmonization and improvement of educational standards is one of the basic strategic measures of higher education in the Republic of Croatia.

At the Faculty of Health Studies of the University of Rijeka, the study of midwifery began in the academic year 2019/2020. is the next step towards professional independence. The very possibility of a vertical continuation of midwifery education should produce personnel capable not only of leading midwifery care teams, but also of managing a midwifery department, clinic or institution. The need for well-trained midwives is particularly evident in the education system, where master midwives could take over the training of student midwives in the status of teachers or graduates of specialised courses in midwifery care, although it should be noted that until this graduate programme began, there were only five to six midwives in Croatian midwifery who had completed diploma training in other related professions. Diploma training in midwifery should also give midwives in Croatia the opportunity to work in science and research.

However, nearly half midwives are working in health care and maternity clinics and hospitals in Croatia have only a high school diploma, i.e. they do not have the necessary level of education to practice this demanding profession independently. According to the Law on Midwives [41], their education is based on the successful completion of professional training for the profession of midwife assistant in accordance with the current regulations of the Republic of Croatia. According

to this, the activity of a midwife's assistant according to Article 15a includes in practice the performance of the following tasks:

- act within the health care team under the supervision of a midwife and/or physician, apply all acquired knowledge in the field of midwifery care in accordance with the principles of professional ethics and law
- participate in education on health maintenance and prevention of sexually transmitted diseases, early detection of gynecological diseases and family planning, as well as participate in the implementation of educational activities in preparation for childbirth and parenthood
- prepare the pregnant woman for examinations and complementary tests during pregnancy
- prepare the room, instruments and material for physiological birth
- perform preoperative preparation and postoperative care for operative delivery
- prepare the patient for gynecological examination, auxiliary and special gynecological examinations
- perform personal hygiene of pregnant women, women in childbed and midwives, change and bathe newborns
- participate in the education of parents about the care of a healthy newborn and breastfeeding
- monitor the nutrition of pregnant women, mothers in labour and midwives
- monitor the general condition of a pregnant woman, a woman in labour, a midwife, and a healthy newborn during hospitalization/treatment; recognize pathological changes in vital signs and report them immediately to the midwife and/or physician
- prepare instruments and supplies for sterilization, prepare instruments and supplies for examination of pregnant women and for delivery
- perform asepsis procedures and hospital infection prevention procedures
- administer medically prescribed oral and parenteral medications (except intravenous).

#### **4. Midwifery in numbers**

During the pre-accession negotiations for joining the European Union, Croatia faced a problem related to midwifery. Namely, at that time, midwifery education was not regulated, and midwives trained in the education system of the former Yugoslavia were not recognized as graduates of midwifery. The closure of the “Health” chapter was postponed because not a single midwife trained according to the requirements of the European Union was registered in the country.

As of 1/16/2023, a total of 2,433 members were registered in the Croatian Chamber of Midwives, of which 333 had a high school degree, 361 had a bachelor's degree in midwifery, and 25 had a master's degree in midwifery.

## 5. Challenges and prospects

While the training of midwives in the Republic of Croatia has been harmonized with the provisions of EC Directive 2005/36, almost nothing has changed in practice [1,2,3,15].

Today, midwives in the Republic of Croatia have a completely different role than midwives in Europe. While in most European countries, especially in the old Member States, midwifery is a completely independent profession, where midwives provide comprehensive care during pregnancy, childbirth and the postpartum period, in the Republic of Croatia it falls within the scope and responsibility of physicians who specialize in gynecology and obstetrics. Since the accession of the Republic of Croatia to the European Union, midwives have not yet acquired the rights provided for in Directive 2005/36/ EC. More than ever before in history, bachelor degrees in midwifery in the Republic of Croatia are not independent and their competences are not recognized, and comprehensive care of pregnancy and childbirth is still the responsibility of specialists in gynecology and obstetrics [39,40].

The medicalization of childbirth introduced in the 1960s has certainly reduced perinatal mortality and reduced maternal mortality to isolated cases, mainly due to indirect causes, while removing mothers from natural childbirth methods. Fears that restoring midwives' professional autonomy would jeopardise maternal and perinatal mortality were unwarranted. For example, one can compare perinatal mortality from 2000, when it was 9.37 ‰ in Croatia, while in European countries with midwifery autonomy it was 3.65 ‰ in Finland and 3.87 ‰ in Austria [2,3, 42]. They are evidence that well-trained midwives can independently provide care during pregnancy, childbirth, and the postpartum period in accordance with the principles of safe motherhood as long as their condition is within physiological limits.

Although the existing Midwifery Law follows the provisions of this Directive and regulates and defines the activities of midwives, the Law is only a legal act for the application of which implementing regulations must be issued, which has not yet been done. Consequently, midwifery, as one of the seven regulated professions, still faces radical changes due to the integration of Directive 2005/36/ EC into the healthcare system.

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## **MIDWIFERY IN CZECH REPUBLIC**

### **1. Brief history of midwifery**

Midwifery can be described as one of the oldest medical disciplines [1]. Midwifery developed gradually in the Czech lands, although it was neglected for many centuries [2]. In ancient times, a woman probably gave birth alone without help. Only later, after more social development, did older experienced women begin to assist. The knowledge and experience of these women were passed on from generation to generation. [3] Lenderová et al. stated that until the late Middle Ages, childbirth was a matter of female sharing and took place with the help of relatives and neighbors. Initially, childbirth was entrusted exclusively to the hands of older women who had themselves already given birth [4]. These women had no basic training and were called lay (without specialized training) women; later on, they were called midwives [1, 5]. A new midwife could start her independent practice after four years interning with an experienced midwife [2]. Doležal reported that the first midwives in the lands of the current Czech Republic date from 1176, where the birth of Hroznata is mentioned [6]. Furthermore, he described a reference to the midwife of King Wenceslas (1284), who rewarded her: “To Elisabeth, who raised us from our earliest childhood, as an attentive midwife, until boyhood, we pass our building” [6]. By the end of the 16th century, eight texts for midwives, although primitive in content, had been published in Bohemia [7]. There were also books on obstetrics, written by Master Jan Hus Křišťán of Prachatice and Zikmund Albík of Uničov, that described various disease symptoms and also provided advice [6, 4].

Another author who dealt with women’s diseases was the Dominican scholar Albertus Magnus, who authored *De secretis mulierum* (On Women’s Secrets), which was repeatedly published in Czech [6]. At that time, medical doctors did not deal with obstetrics. This field was deemed unworthy of their status [5]. Care for women was provided by midwives, who, in case of complications, would ask men for help, but only exceptionally would they call for a doctor. In emergencies, midwives sought help from barbers, healers, or lithotomists. In cases of a non-progressive birth or imminent death of the mother, they solved the situation by dismembering the fetus and removing the parts with hooks, i.e., an end dismemberment abortion [4].

After the foundation of Charles University in 1348, the Faculty of Medicine wanted to have a decisive say in public health and thus achieve jurisdiction over doctors, barbers, and midwives. More in theory than in practice, obstetrics and gynecology had been taught at the university since its foundation. Practical

exercises could not take place because surgery and anatomy were taught by professors belonging to the church [1]. The education of midwives was limited to a treatise on childbirth [5].

In the 16th and 17th centuries, many writings on obstetrics were published, but midwives were usually limited to on-the-job training, and various superstitions since books on obstetrics were primarily written in German [4]. Because midwifery was performed by women who were often wholly illiterate, uneducated, very religious, and very superstitious, the level of obstetrics in the Czech lands was low [6]. In addition, available books were mostly written by doctors whose knowledge was only theoretical because it came from other books; they themselves had usually never seen childbirth [6]. Only later did surgeons write books of a practical nature [6].

The first book written in Czech was published in 1519 by the physician Nicolaus Claudian from Mladá Boleslav. It was a modified translation of Roesslin's work "The report on teaching pregnant women and midwives not so beneficial". The book was not particularly helpful since it did not deal with the anatomy of pregnancy and was full of myths and superstitions [6, 2]. Another book from that time, "The Rose Garden of Fertile Women" by Matouš Wolkenberger, was also full of mysticism and superstition [5].

From 1651, midwives had to present a certificate showing they had passed a professional examination; without the certificate, they could not help with childbirth. The examination was ordered by Ferdinand III [5]. From the middle of the 16th century, many towns began cooperating with physicians, who were then supposed to supervise healers and midwives. This supervision was to ensure patient safety. Physicians also took on the responsibility of testing midwives. At this time, we find the first guidelines and rules for midwives [4].

During the 18th century, almost no attention was paid to health issues. It was not until the reign of Maria Theresa that significant reforms were carried out that led to an improvement in health conditions [1]. The Theresian reforms were incredibly important for people living in the Czech lands.

"The living conditions of the midwives of that time were deplorable. They were mostly older widows who reluctantly, and sometimes against their will, practiced midwifery instead of begging. Without knowing how to read or write, they were unable to increase their understanding of obstetrics. Additionally, remuneration for their work was negligible" [5, p. 4]. Empress Maria Theresa's personal physician, Gerhard van Swieten, became her advisor during her healthcare reforms [8]. Gerhard van Swieten was a Dutch physician and obstetrician (a student of the prominent clinician and chemist Hermann Boerhaave) who recognized the dismal conditions of the Austrian health services, and one of his first actions was to improve obstetric care [1, 8]. The first step towards the professionalization of midwifery occurred by a court decree on 30 December 1745, which stated that midwives were to be educated on anatomy by a professor of anatomy and participate in autopsies

on female bodies [9]. The next court decree impacting midwifery was on 4 July 1748; it drew attention to the dangers associated with unprofessional care during pregnancy and delivery and emphasized the importance of midwives and birth assistants having professional educations [3].

Midwives were ordered to undergo detailed examinations in Prague, by the Faculty of Medicine or by Regional Health Commissions; without these examinations, they were not entitled to practice midwifery [1, 3]. In 1749, another court decree ordered that anatomy be demonstrated to midwives through the dissection of female bodies [6]. At the suggestion of Dr. van Swieten, a General Health Order for the Kingdom of Bohemia was issued by Empress Maria Theresa, which came into force on 24 July 1753 [5]. Lenderova et al. described this order as the first step towards the systematic development of obstetrics and the centralization of its control in the Czech Republic [3]. According to Tinkova the order states that every midwife is entitled to receive her education in her native language [10]. The General Order also dealt with the role of midwives and set out rules and guidelines that midwives must follow [1]. Midwives who passed their examination could wear a badge that distinguished them from midwives who did not pass the test. Those who did not have the exam were supposed to register for it [5]. The General Order also listed the moral duties of midwives: a midwife should live soberly, honestly, and Christianly since she must be available any time, day or night [10]. Midwives were also expected to be amicable and cooperative. The order also banned premature expulsion of the fetus and described obligations related to childbirth. The midwife was expected to arrive on time, and in patients with complications, they were to call a doctor immediately. The order also prohibited the administration of medicines to mothers and also provided guidelines concerning baptism of the child [5, 4]. These General Health Regulations were a milestone in the history of midwifery. In 1770, a health order valid for the entire Habsburg monarchy was issued, the *Generale normativum in re sanitaris*. This order precisely defined the duties of all healthcare workers, including midwives; it differed from the previous General Order only with regard to baptism [4].

The first teacher of obstetrics was surgeon Josef Molinari. In 1753 it was decreed that one of the five medical faculty professors would provide lectures to midwives, surgeons, and medics on obstetrics. Franciscus Dutoy was the first to be appointed to this position and continued until 1759; Ignatius Johann Ruth succeeded him. In addition to theoretical training, starting in 1783, the court decreed that midwives learn practical obstetrics. Ruth led a twice-weekly course at the Italian Hospital in Old Town, which at that time served as a shelter for unmarried mothers [5, 3, 10]. A new learning aid was used for this practical training; it was a leather model of the lower part of the female torso and was called a “machine.” The learning aid also included a model of the newborn [3]. In 1789, practical training was moved to the newly established maternity hospital at St. Peter’s Apolináře in Prague’s New Town [10]. From 1792 the practical obstetrics teacher was a prominent physician, Ruth’s pupil, Johann Melitsch, and in 1787 he founded a private outpatient maternity institute, where

he gave private lessons. The institute's main objective was to increase the number of skilled obstetricians [10]. In 1792, Johann Melitsch performed what may have been the first cesarean section; both the mother and child survived [10]. After Melitsch, Karel Fiedler, Josef Potel, and Antonín Jungmann served as the obstetrics lecturer [3, 1, 8]. Lenderova et al. states that throughout the early modern period, there was a difference between rural and urban midwives [3]. The skills of country midwives were based on their acquired experience, and the town midwives were subject to the control of a city doctor. A decree issued on 4 July 1748 required midwives to take a qualifying examination, with the process being supervised by the dean of the medical faculty and two senior faculty. Similar regulations implemented in 1783 applied to all women who wanted to be midwives in larger cities [10]. Thanks to greater earnings potential and the possibility of professional consultations with doctors, the situation for the midwives in cities was better than rural midwives. As a result, cities became overcrowded with midwives, while villages were almost without maternity aid. One way to bring about changes, especially improvements in economic conditions, was zoning. From 1791, each village was zoned to have a midwife [10, 4].

In 1804, the first curriculum for midwives was established; all midwives had to study in Prague, compulsory attendance was required for the entire theoretical course, and at least two months of practical training was also required [5]. In this period, a mere apprenticeship and examination by a regional doctor ceased to suffice; the court decree of 15 March 1805 banned all forms of private teaching of midwives by regional doctors and ordered compulsory completion of courses taught in Prague [10]. Poor women could receive financial support from their village, town, or nobility to attend the courses in Prague. However, this regulation was problematic for midwives from remote rural areas since it caused financial problems and led to lengthy separation from their families and farm [10, 3]. To pass the exam, midwives needed almost the same amount of knowledge and skill as obstetricians; for example, they had to demonstrate childbirth techniques on models or a dead body, they needed to demonstrate dexterity in manipulating a fetus during physiologically ongoing births, and have knowledge of theoretical, practical, and forensic medicine [3]. In 1811, Antonín Jungmann, the author of many professional publications and a Czech textbook for midwives, *Introduction to Midwifery*, was appointed professor of theoretical and practical obstetrics, and in 1839 he was appointed rector of Charles University. During his time at St. Apollinář's Clinic, there were 50,000 births, and thanks to his teaching activities, 8,276 midwives passed through the clinic in addition to medical students and surgical candidates [11, 12, 10]. [11] Doležal et al. states that Jungmann founded a distinguished school in Prague with an outstanding faculty. The school attracted students of obstetrics and gynecology from Poland, Denmark, Iceland, Norway, Sweden, and other countries [11].

Another important personality was František Jan Mošner, a pupil of A. Jungmann. In 1836 he published the textbook "Midwife," which described the different functions of obstetricians and midwives. Midwives are entrusted with physiological

births but must also understand pathological births. In the event of a pathology, midwives should call an obstetrician, and if they are not available, the midwife must also be able to deal with a threat to the mother or fetus [4]. In 1850, after Jungmann's retirement, the maternity clinic was divided by order of the Minister of Education into a clinic for training medical students and a clinic for teaching midwives [1, 5]. Near the maternity hospital, Helfert's house was rented for pupils, who could be called to assist with a birth at any hour. A senior midwife also lived in the house and taught pupils when professors were absent [1, 5]. The established Midwives Clinic (1850) was led by Jungmann's pupil Wilhelm Lange, and during his short tenure at the clinic, he drew up a proposal to reform the education of midwives; the proposal was utilized until 1920. The combined theoretical-practical training took place in four-month courses and were conducted in Czech and German; each course accommodated 60 pupils [4]. From 1852 three theoretical-practical one-year courses were held, alternately in Czech and German. Lang's successor was Professor Jan Streng; under his leadership, a new maternity hospital, called the Red House, was built in Větrov; the obstetrics clinic moved to this location in 1875 [1]. His textbook "The Midwives Book," published in 1852, replaced the already obsolete book by Jungmann [6]. After Streng's death, the clinic was led by Karel Pawlik, who is known for his technique for external palpation of the lower segment and the course of the cervical groove, whereby the position, posture, and entry of the fetal head into the pelvis could be diagnosed during an external examination of the pregnant woman) [6].

In 1891 it was decided that the Midwife Clinic would no longer be part of the Faculty of Medicine but would be separated as an independent Imperial Midwifery School in Prague; this was implemented at the beginning of 1892 [12, 4]. Professor Václav Rubeška oversaw midwife instruction at the school, and over his 28 years, the school graduated 5,000 midwives [4]. Václav Rubeška did a lot to improve the quality of midwifery education; he wrote the textbook *Obstetrics for Midwives*, which has been supplemented and republished, most recently in 1920 [4]. In 1893 there was a demand to divide the Midwifery school into Czech and German units. Due to a lack of funds, this requirement was never met [1].

All the above regulations concerned the training of midwives and service regulations. No decrees dealt with midwives' social status or improving their conditions [1]. In 1897 (10 September), the Ministry of the Interior issued "Service Regulations for Midwives," and the offices of district governors were obliged to instruct midwives on these regulations. These contained a detailed description of how to record birth data in new birth diaries and how to complete birth reports [3]. All midwives were required to purchase a copy of the regulations and follow them [5, 3]. The regulations consist of four sections:

1. Personal duties of midwives relating to the midwife's provision of instruments and aids, personal cleanliness, personal disinfection, and use and dilution of disinfectants.

2. How midwives should behave while caring for pregnant women and mothers.
3. Treatment of the child and the mother during the puerperium.
4. Duties and obligations of midwives, when to call for a doctor, where to announce the birth of a child, and how to keep a birth diary. This section was supplemented by provisions of the Criminal Code dated 27.5.1852 [5, p. 9].

Lenderowa et al. report that the authorities tried to force midwives to fulfill these obligations under duress of penalties for violating them. However, no regulation addressed three urgent existential issues of midwives, i.e., improving the quality of their professional education, equal distribution of midwives across regions, and their material and social security [3]. The poor social conditions of midwives were caused by an uneven distribution of midwives in rural areas; larger towns had more midwives than they needed, while smaller villages often had no midwives at all. Another problem was the absolute lack of security in old age and illness. That is why midwives tried to improve old age provisions and founded support associations. A support association was established in Prague in 1890 [5]. This resulted in an amendment to the Health Act and the establishment of a separate Ministry of Health. Some educated and active representatives of the midwives began to establish professional associations and publish magazines [3]. The Reich Organization of Austrian Midwives originated in Vienna, and the Association of Midwives in Austria was founded in 1903 in Brno.

In 1911, the first International Congress of Midwives took place in Dresden; it was attended by Pavla Böhmová, a former school midwife who had worked with Dr. Rubeška. After returning from the congress, she encouraged other midwives to establish their own professional organizations. The newly established Preparatory Committee drew up a program, which was adopted at the first constituent meeting. It was focused on more education for midwives, demanded updating of the previous midwife educations, higher standards for new applicants, an introduction of authorized fees, and the establishment of a committee to oversee the retirement of midwives at a certain age and the appointment of midwives according to individual districts and needs [5, 1]. In 1911, the “Provincial Union of Midwives” was established in Prague, and by 1913 already had 900 members [4]. In 1912, this organization began to publish a journal called the “Bulletin dedicated to the interests of midwives” [1]. The journal published articles that were supposed to review, and update information needed by midwives and also to advocate for better status [1, 5]. Midwives could turn to the magazine with various questions; physicians such as Dr. Rubeška, Dr. Pachner, and others also contributed to the magazine [5]. During the First World War, the Land Union tried to alleviate poverty among mothers and their children. In 1917 the Union was considered a representative of the state in front of authorities and the public [4]. During this period, Union officials demanded better education for midwives and the introduction of the title of “Midwife,” which was considered important in raising the status of midwives in the community [3].

In 1918, after the establishment of the Czechoslovak Republic, midwives had hoped for an improvement in their position in society. All associations in Bohemia and Moravia fought for this, and in 1919 the two associations merged into one association called the Central Union of Midwives (ÚJPA); the Union's publication was called the Bulletin [5].

In 1919, a proposal was submitted by the Ministry of Public Health and Physical Education to modify the education of midwives, seeking better-educated applicants and the introduction of entrance examinations to enter Midwifery school. The proposal also describes the Midwifery curriculum, limited the number of female pupils, and reduced the admission age (min 18 years, max 30 years). Almost simultaneously with this proposal, the Ministry issued a proposal to improve the social status of midwives by adjusting their salaries and work regions [3].

In 1922, the International Union of Midwives was established to raise the number of midwives to the appropriate level [1]. In 1923, the Central Union of Midwives was invited to cooperate by the International Union of Midwives and was invited to a congress held in Antwerp. Here the Central Union of Midwives received recognition for its exemplary work. That year, almost 4,000 midwives joined the Central Union of Midwives. In 1924, the International Union of Midwives asked the Central Union to organize a Third Congress in Prague (31.5.1925 to 2.6.1925). At this congress, the chairwoman of the NPI, Hana Lišková, was elected the first chairwoman of the international organization for another term of office [1, 5, 3]. The result of the congress was a resolution dealing with the training of midwives, which was to be based on science, the period of study was to be extended to 3 years; midwives were to be given the same general scientific status as nurses, and the protection and treatment of pregnant women, women in labour, and infants were to be entrusted only to midwives. The congress also demanded that midwives be entrusted with official activities and, on that basis, receive state benefits for sickness, disability, and old-age insurance [5]. On 9 November 1928, Act No. 200/1928, "On Auxiliary Obstetric Practice as well as on Education and Training of Midwives," was issued. With this law, all previous regulations were repealed. The new law defined the auxiliary obstetric practice as: "(1) independent assistance in normal pregnancy, childbirth, and the puerperium, as well as independent care of newborns and infants not requiring medical treatment; (2) assistance to a physician in the treatment of pregnant women, maternity women, postpartum babies, newborns, and infants; (3) necessary independent assistance in the cases listed in point 1, even if they are pathological, but only if there is a danger in delay, if it is not possible to call a doctor in time, and only until the doctor arrives" [3, p. 66]. The law stipulated that diplomas authorizing the performance of auxiliary obstetric practice may be issued only by state institutes for the education and training of midwives. The law also prompted the establishment of state educational institutions with at least ten months' tuition. The need for a two-year education was rejected because doctors were not interested in overly educated midwives [3]. Midwives were not very

happy with this new law. Although education was extended and improved, their social situation was not modified, and the law did not deal with sickness insurance and did not meet the requirements for a balanced regional distribution [3]. The law, however, allowed for a new name, i.e., Midwife [5].

During the Second World War, the only opportunity to do something for the Czech and Slovak nations was to take care of the new generation, which led to the establishment of counseling centers for mothers and children. The directive for the management of these centers was issued by the Ministry of Social and Health Administration on 5.6.1939. The main task of the counseling centers was the care of pregnant women, women during childbirth and the postpartum period [5, 1]. The education of midwives is also related to the establishment and activities of their professional organizations. The first association was the Association of Midwives in Austria in 1908, founded in Brno [5]. Eight years later, the Provincial Union of Midwives [1] was established in Prague. After the First World War and the establishment of Czechoslovakia, the associations united and formed the NPI, Central Union of Midwives, in which almost 4,000 midwives were registered in 1924 [1]. In 1948, the Central Union of Midwives was dissolved because all associations were merged into a single organization, the Revolutionary Trade Union Movement (ROH – cz. *Revoluční odborové hnutí /Revolutionary Trade Union Movement*. [13]. All associations remained in the ROH until 1990 [14]. After the dissolution of the ROH, the question of the emergence of a new professional organization arose. One of them was the Czech Association of Nurses (ČAS). In 1991, the Czech Association of Nurses was established, bringing nurses of various orientations and other non-medical professions together. Midwives could work in this organization in the gynecology and obstetrics section.

In 1997, midwives from the gynecology and obstetrics section of the Czech Association of Nurses withdrew and started an organization of midwives called the Czech Association of Midwives (ČAPA) [4]. This name was later changed to the Czech Confederation of Midwives, and in 2016 it was renamed the Czech Chamber of Midwives (ČKPA). The Czech Chamber of Midwives was a member of ICM and EMA. ČKPA is currently the longest-functioning professional organization of midwives.

In 2005, the departure of some members from the ČKPA led to another professional organization being established, i.e., the Union of Midwives [15]. Another professional organization, founded in 2013, was the Czech Society of Midwives. According to Act 96/2004 Coll, this organization can associate not only midwives but also other non-medical professions. The statutes of this professional organization state that the organization observes and adheres to the recommended procedures of the Czech Gynecology and Obstetrics Society and the Czech Medical Association of Jan Evangelista Purkyně [15].

Along with the establishment of professional organizations and activities, there was also an emergence of journals dealing with midwifery. The *Bulletin*, devoted

to the interests of midwives, started publishing in 1912; later (in 1917), the name was changed to the *Bulletin dedicated to the interests of midwives*. Finally, in 1945, its name was changed again, this time to the *Bulletin of the Central Union of Midwives*. The magazine was published until 1947. Later, the journal *Healthcare worker* (1951–1991) was published, which was not only a periodical for midwives but also intended for other healthcare professionals. In 1991, the magazine *Nurse* was published, which was intended for non-medical medical staff. The journal was published once a month and featured professional articles by nurses, midwives, doctors, psychologists, and other domestic and foreign experts. Its publication closed in 2014. In 1997, the Czech Association of Midwives started publishing the magazine *Midwife*, published six times a year. In particular, questions related to home births and the competence of midwives were addressed in this journal. Another magazine for midwives and nurses working in gynecology was *Modern Midwifery*, a magazine for midwives and female nurses. This magazine was published from 2003 until the end of 2006; it was initially free to female readers. The professional journal *Florence*, first published in 2005, is currently available and intended for general nurses and other non-medical healthcare professionals.

## 2. System of education for midwives

The training of midwives has come quite a long way. In the development of midwifery education, over several decades, there have been several changes in the length of midwifery training. The period after World War II, starting in 1945, was characterized by poor health of the population (especially from lack of food and healthy eating); only 20% of births were carried out in a medical facility. Healthcare facilities had to cope with numerous organizational and personnel obstacles. As far as midwifery was concerned, the most problematic was the education of midwives and the lack of doctors in connection with the closure of universities during World War II by the Germans [16]. Stembera further mentions that after 1945, 1,624 midwives were registered, of which more than 1,200 were poorly educated, and most were over 50 years old [16].

References to the dismal situation in midwifery education can also be found in the periodical *Rudé právo* from 1946 and the *Voice of the People* from 1947, which included calls to the then Ministry of Health to extend midwifery from one year to two years of study [17]. Gregusova et al. mentioned that until 1947 the midwife profession could only be performed by women who, after completing the “bourgeoisie,” completed their studies at a nursing school and subsequently passed a ten-month obstetric course [1]. After that, from 1947, the study period for midwives increased from 10 months to 2 years, which is how midwifery studies remained until 1955 [18].

The education and activities of midwives were also influenced by political situations, especially the first elections after World War II that occurred in

May 1946, which were won by the Communist Party (40% of the votes in the Czech lands and 30% of the votes in Slovakia) [14]. In 1948, the Communists consolidated their state power and participated in the creation of new legislation. Act No. 99 Coll. on National Insurance was adopted on 15.04.1948, which guaranteed healthcare during maternity, pregnancy, postpartum, and for nursing women after childbirth. It also dealt with the payment of the “childbirth” allowance to women. In 19.07.1948, Act No. 185 Coll. on nationalizing medical and nursing institutions was adopted.

Furthermore, Act No. 248 Coll. on the role of district midwives was accepted 25.10.1948. These midwives worked in rural districts of 2,000 to 3,000 inhabitants. No hospitals were established in these districts, so midwives were forced to provide prenatal care to women. This law also authorized auxiliary obstetric care and required that a district midwife prove her Czechoslovak nationality and that she had an impeccable character, was of good health, was not older than 45 years, and had a diploma in auxiliary obstetric practice. Midwives could obtain a diploma based on training that should not be less than two years [16].

Furthermore, [16] noted that Decree 1239/1949 set rules for reporting live and stillborn children. This decree required midwives to report births to the District National Committee and Registry Office within 24 hours of the child’s birth. Subsequently, within two weeks, the registry office sent a copy of the form to the Czech Statistical Office and the Institute of Health Statistics [16].

Vranova describes the education of midwives in the years 1955–1956 [4]. At that time, there was a change in the education of midwives. During the first two years, midwives were educated together with general nurses, and then the study was divided according to field, and midwives continued their studies for another two years according to their specialization. The graduates completed their studies with a school-leaving examination [4]. Vackova states that this system of education for midwives was only valid for one year [18].

Vackova reports that in 1958–1959, applicants for the profession of a midwife had the opportunity to complete a two-year post-secondary study programme [18]. Subsequently, since 1960, the study programme lasted four years and was completed by passing a school-leaving examination [19]. Ajglova further mentions that at the same time, future midwives could study a two-year post-secondary programme, which provided candidates with vocational education of higher quality [19]. It was possible to complete these studies until 1972. After 1972, it was only possible to obtain this education after graduation from high school, i.e., it was a two-year follow-up study programme [18].

Simultaneously with the change in study programmes, in 1965, the name of the midwife profession was changed to “female nurse.” The term “female nurse” was used until 1993 [20]. Along with the change in the name of the profession, there was also a change in the competencies of female nurses to include gynecological diseases [21].

Dolezalova further states that pediatric and general nurses (working in the delivery room) were offered a one-year study programme in the 70s to obtain a midwife's competencies [21]. Over the years (in 1972, 1976, 1988, 1992, 1996), changes in the education of female nurses have been made by the Ministry of Health in agreement with the Ministry of Education. The curriculum for female nurses, published in 1972, provides information on the education of female nurses in two-year post-secondary study programmes, in which some students completed their studies in high school. The two-year study consisted of basic specialized subjects (somatology, pathology, microbiology, epidemiological hygiene, health care organization, social and legal sciences, psychology, and pedagogy) and vocational subjects (gynecology and obstetrics, internal diseases, surgery, pediatrics, neurology, psychiatry, theory of nursing, care for women, and professional practice). Part of the study was the completion of a four-week professional practice after the first year's completion. After completing their studies in the 2nd year, students had to pass school-leaving examinations in gynecology and obstetrics, internal diseases, nursing theory, care for women, and professional practice [22].

Since 1976, study plans and curricula have brought innovations, namely that in addition to the two-year full-time study, female nurse trainees were allowed to study remotely while working. The graduates also completed this study with an oral school-leaving examination in the subjects of gynecology and obstetrics, and internal diseases. In addition, pupils took practical and written school-leaving examinations in nursing theory, care for women, and professional practice [23].

In 1988, valid curricula included basic pedagogical documents for secondary medical schools for female nurses and the subjects of first aid, clinical propaedeutic, nursing, and nursing care for the sick [24].

It is clear from the 1992 curriculum that the name of the profession of female nurse was changed to midwife [4]. The updated curriculum by the Ministry of Health was still a two-year post-secondary study. The new subjects taught were first aid, health care organization, clinical propaedeutic, and legal doctrine [25].

Starting in 1996, midwives were trained at tertiary professional schools, and the length of study was extended to 3 years. The number of intern births increased from the mandatory 15 physiological births to 30 completed births. The studies were completed by graduation, and the graduates received the title of certified midwife [4].

In 2001, after more than 100 years of effort to provide adequate midwifery education, the study was transferred from secondary schools to universities. Applicants for the profession of midwifery, whose studies were first started in the academic year 2001–2002, were educated in an accredited three-year bachelor's programme. The European WHO Strategy and Directive 80/155/EEC of 1980 were applied during the transition of studies to universities [26].

The conditions for completing the Midwifery study programme are set out in the Qualification Standards of the Ministry of Health of the Czech Republic [27]. These required that the student meet the study programme's objectives and the

predetermined obligations [27]. During the three years of study, the student should obtain a minimum of 1800 credits. Higher education is completed by a final state examination, which includes a practical examination, defense of the bachelor's degree, and oral examinations in obstetrics, midwifery, neonatology, gynecology, humanities, and midwifery theory [27].

It is essential to mention that, to prepare midwives to meet the complex healthcare needs of women, families, and entire communities, future midwives, should have a solid general education before embarking on their professional training. Therefore, the conditions of admission to midwifery training should be strengthened and require 12 years of general education or successful completion of an equivalent examination, except in the case of professionals already qualified as nurses responsible for general care. Under directive 2005/36/EU, midwifery training provides greater assurance that midwives have the basic knowledge and skills necessary for the practice of midwifery [28].

In order to ensure specialized education for non-medical healthcare workers, the Ministry of Health of the Czech Republic issued binding Methodological Instructions setting out the rules for the course of specialized educations pursuant to Act No. 96/2004 Coll. and Government Regulation No. 31/2010 Coll. in the Fields of Specialized Education and the Designation of Expertise of Health Care Workers with Specialized Qualifications. Accredited facilities and organizations entrusted with the provision and control of specialized education, such as the National Center of Nursing and Non-Medical Health Care Disciplines in Brno (after this referred to as NCO NZO), the Institute of Postgraduate Education in Health Care in Prague (after this referred to as IPVZ) and the participants of specialized education themselves, proceed based on this instruction [29, 30, 31]. Graduates of the Midwifery programme also have the opportunity for further education at universities, i.e., specialized education:

- Intensive care in midwifery
- Perioperative care
- Community care in midwifery
- Organization and management in healthcare
- Perfusiology

### **3. The legal status of midwifery**

In the chapter on the legal status of midwifery, it is appropriate to mention important laws and decrees that can be considered authoritative legislation in midwifery education. These decisive laws and decrees are:

- Act No. 111/1998 Coll. on Higher Education Institutions, as amended
- Decree No. 42/1999 Coll. on the content of the application for accreditation of a degree programme

- Decree No. 39/2005 Coll., laying down minimum requirements for study programmes to acquire professional competence to perform a non-medical health profession, as amended
- Act No. 96/2004 Coll. on non-medical health professions, as amended
- Decree No. 55/2011 Coll. on the activities of healthcare professionals and other professionals

The European Union framework regulates the training and practice of the so-called regulated profession of midwife under Directive 80/155/EEC, which specifies the nature and content of the minimum acceptable training programme as well as the performance of midwives [32].

The activities of midwives are given by Decree No. 55/2011 Coll. on the activities of healthcare workers and other professionals. Here it is specified that the midwife provides care to pregnant women, women in labour, and women until the sixth week after delivery. It educates women about lifestyle during pregnancy, breastfeeding, and preparation for childbirth and provides advice and assistance on socio-legal issues. The midwife can carry out family visits of pregnant women, women up to the sixth week after childbirth, and women with gynecological problems [33]. Her competencies also include the treatment of physiological newborns, support for breastfeeding, and preventing complications from a lack of pregnancy/childbirth-related education in women. The midwife can diagnose pregnancy, prescribe, recommend or conduct examinations necessary to monitor physiological pregnancy, monitor a woman with a physiological pregnancy, and provide information on the prevention of complications. The woman should be placed under a doctor's care in cases with an identified risk. Midwives work in all aspects of gynecological and obstetric care [33].

#### **4. Midwifery in numbers**

The total number of midwives in the Czechoslovak Socialist Republic (CSSR) was 4,748 in 1961. In 1971 there were 5,770 midwives in Czechoslovakia. Pope et al. (1981) noted that in 1978 there were 2,777 female nurses and 3,600 female nurses in the territory of Czechoslovakia working in polyclinics and regional women's centers, who provided care to women in gynecology and obstetrics departments. In 1981, the total number of midwives increased to 6,736.

The medical yearbook from 1989 states that 7,695 female nurses worked in Czechoslovakia. In this period, the republic was not yet divided into two separate units, so the number of female nurses was relatively high. The Health Care Yearbook of the CSFR (1992) showed that in 1991 there were 7,667 midwives in total [34].

After 1992, the number of female nurses (midwives) decreased. In 1999 there were 4,235 midwives, and 1,712 of them worked in the state health sector. This year, the average salary for secondary medical staff was 11,760 CZK. In 2009

in the Czech Republic, there were 3,921 midwives, and their average salary was 26,621 CZK [35]. At this time, the number of general nurses and midwives per 1 physician, including dental doctors, was 1.85 to 1. Stated differently, there were 36.5 physicians and 79.6 general nurses and midwives per 10,000 inhabitants. By 2019, there were 40 doctors, seven dentists, and 81 general nurses and midwives per 10,000 inhabitants in the Czech Republic. During this period, the Health Yearbook lists a total of 3,710 midwives. The average salary that year reached 37,978 CZK. In 2021, there were 3,855 midwives [35].

## 5. Challenges and prospects

Over the centuries, the development of midwifery has undergone a tremendous change from former lay assistants to women in childbirth to present-day university-educated midwives. Although midwives are well educated and have acquired competencies through university education in accordance with European directives, these competencies are not 100% fulfilled. In this context, we see challenges in strengthening the competencies of midwives, both in in-patient facilities and especially in community care. The document, Concept of Midwifery, which has not yet been created in the Czech Republic, would contribute to strengthening these competencies. Another way to strengthen the competencies of midwives would be to establish a Chamber of Midwives. The several professional midwifery organizations would, in our opinion, benefit from unification into a single professional organization. This would undoubtedly help achieve greater prestige for Midwifery in the Czech Republic and increase the quality of care for women and children in our country. Improving the quality of care provided by midwives is also related to research activities that need to be supported. The use of Evidence-Based Practice (EBP) and including and involving midwives from clinical practice would further these critical research activities.

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## **MIDWIFERY IN HUNGARY**

### **1. Brief history of midwifery**

The history of midwives can be originated in the age of ancient Hungary. In that time women gave aid in childbirth their knowledge came from their own experience and from their environment. There was more superstition than knowledge in their activities, they made up

for their missing knowledge with faith in supernatural powers and miracles.

Christianity appeared in the late X. century and the Benedictine monks appeared and later the doctors of other convent's. They dealt with only the academic questions of midwifery the real practical work was henceforward the task of maternity nurses. Firstly in 1552 there appeared an edict, which regulated the work of maternity nurses. This meant that those who wanted to work as maternity nurse in the future had to swear an oath to the main authority. The maternity nurses had no chance of organized training. That's why there was a high-death-rate in childbirth and in the period of confinement. At that time there were a lot of witch hunts, the protagonists of these hunts were unexperienced, unskilled, ignoramus maternity nurses, who used magic methods (1).

In these years the qualification of midwives showed a threefold division:

1. Licentiate in midwifery: it was the smallest group the members were from the citizenry. They had a command of the German language which was very important, because they were examined/tested by Universities from Prague and Vienna. They had high-level of academic and practical knowledge.
2. Midwives with scrip: they were secondary trained maternity nurses, there were less of them, they had only practical training being sent for 1-10 days courses to county-maternity nurses by the Chief Medical Officer.
3. Peasant midwives: They were the most common, they had less academic knowledge, but they had a lot of experience. There were the most complaints about them, a lot of women died in childbirth, they were the victims of the witch hunts. Among people, rituals took precedence over knowledge at that time [1].

In 1744, János Torkus Justus, who was Consultant of Bratislava wrote a book and he had more recommendations for the work of midwives. The local lieutenantcy accepted his recommendations and work out the regulation of midwifery work, and it was valid for the whole country In 1745 the regulation said that the maternity wives had to do exam in front of medical officer before they started to work. In 1748 there appeared an order, that, every midwife was obligated to take an exam. In 1755 came an order, which said the following:

- any person who wants to work the midwife, she has to pass an exam in front of medical officer,
- the fee of the exam was 2-6 goldcoins from Körmöc, this amount was for the training of midwives.
- the midwife has to be respectful to the medical officer and she has to fulfil orders exactly and immediately.
- if the newborn baby is weak or dying and the newborn is not able to wait for the priest, the midwife had to do the christening with normal water and she had to let the priest know (2).

In spite of the contemporary illiteracy, it was a great advancement, when in 1766 István Weszprémi, who was the Medical Officer in Debrecen, wrote the first Hungarian midwifery profession book, then more of them came. In 1770 in Nagyszombat, then a few years later in Kolozsvár midwifery training began [3].

Maria Theresia issued her famous Generale Directive, it was the first common public-health rule of law and it had a great impact on the improvement of Hungarian public health. The regulation part 4. Clause 9, which is named *Instructio obstetricum*, orders the application of official midwives with controlling powers. The most substantial was that the work of midwives was allowed with a degree and exam. This ambition was very good and modern, but it can become real only in the long-term (the contemporary midwives were illiterate, and it was difficult to get a primary school degree) [3].

In the beginning only a few midwives got degrees. The main reason was the language, because the education if the university was German. The government wanted to increase the number of qualified midwives, so an order was issued in 1771, it said that every midwife, who practices in Hungary, has to get a degree from Nagyszombat University medical school, except those who got degree in Vienna. Then the Lieutenancy ordered the application of district midwife. In the same year the sessional-unit examination was issued, which contained the modification.

- The person, who educates midwifery, is obligated to teach the anatomy and physiology of pelvis and hold a presentation about maternity.
- Practical presentations have to be done alongside the academic presentation,
- Object lessons have to be held with aids.
- The midwives have to know the physiology of the pregnancy, labour and the puerperium [4].

## **2. System of education for midwives**

According to the rules, the University in Nagyszombat had to do 3 courses every year. All women had to be able to read and write, but a literate teacher had to give lectures. The midwives had to take part in the University presentation with the student doctors. The orders said that the college students had to go to a maternity hospital in order to acquire the academic and practical knowledge and they were

allowed to go to exam after this. The students were obligated to do their exam in front of committee. The members of the committee were: chairman, dean and the teachers of obstetrics (5).

The subjects of the exam: anatomy of female genitalia, information about maternity, academic obstetrics, a presentation of regarding operations. Nursing of pregnancy, confinement of mother and newborn. Judicial information in case of infanticide.

After a successful exam the course ended with a swearing in and the handover of the degree.

At the beginning of the 19th century, in 1806 a new education edict (II. Ratio Educationis) was born, which increased the training of midwives to two courses yearly. The course time was 5 months. It considered the kind of gentile and the situation of multicultural, it became trilingual. The winter course, from November until end of March, was in German, the spring course, from April until the end of August, was in Hungarian, but when it was needed, the education was in Slovakian (3).

In 1813 a new comprehensive exam order was passed, it demanded more strict requirements against the medical students and midwives. According to this after the specified education, before the exam, the student was obligated to perform the obstetrics cases in phantom. He/she got a certificate after passing this and then was allowed to go to the exam. If the student wasn't able to solve the task, he/she was obligated to continue their studies. When the midwife students and the medical students learnt the academic judicial obstetrics curriculum, they took part in postmortem, furthermore they did postmortem with the permission of the surgeon and the dead persons relatives. This circumstance contributed the occasion of the fatal confinement (6).

Ignác Fülöp Semmelweis (1818-1865) fought against the postpartum fever and he recognized that there is connection between the practical education and maternal mortality in the Woman Clinic in Vienna. The college students examined every woman as a part of their practical education and they washed their hands with soap and clear water. When there were less students, the mortality statistics was less as well. This contributed to Semmelweis's revelation: Postpartum fever is caused by decomposing organic substances that get into the human body of the pregnant, and birthing woman and child. Most of the time this enters the mother's body from outside, but sometimes it is also produced in the person [1].

After the War of Independence of 1848-49, the new state, the Austro-Hungarian Monarchy was established as a result of the 1867 treaty, this created a new situation in terms of political, economic and social relations. It also brought significant change in Hungarian healthcare. One sign of this was that the work of midwives came under the jurisdiction of the Ministry of the Interior, and their training under the Ministry of Religion and Public Education and remained there until 1919. Based on the nineteenth paragraph of the article of 1868, the language of the lectures at the University became Hungarian again. In 1868, the National Public Health

Council was founded and in December of the same year, it presented a proposal to the Hungarian Royal Interior Minister regarding midwifery training schools in the territory of the Hungarian State. The proposal also listed the requirements related to midwives, among which the first was: Absolute health, sober living, easy apprehension, a certain degree of education and fluent reading and writing are necessary (7).

In 1875, the Minister of Religion and Public Education (Ágoston Trefort) published the temporary regulation of National Midwife School in 27.912/1875 edict, he fixed the framework of midwife training, the tasks, rights and obligations of participants. In 1889 appeared the 58.687 edict from Minister of Interior, which determined the ending of midwives' work, for those who had no qualification. A person could only continue midwife practice who had a degree or Chief medical officer qualification [8].

The appointed goal became true, midwives had to be in every settlements. In 1881 the annual budget provided for the founding of hospital and obstetrics department for midwives. The Minister of Religion and Public Education, Vilmos Tauffer (1851-1934) became the leader, whose task was the development of midwife training and organising in the country. The ministerial edicts are the first evidence of his successful work, which dealt with the determination of midwives' tasks and ethic questions (9).

In the 1890s there were more recommendation in connection with the reform or midwife training. The training, application and control of midwives were put under the authority of the Ministry of Health. Applicants had to pass an entrance examination. Only hardworking diligent students were admitted.

In 1890 the teachers of the university with the directors of the midwifery training institutes were summoned to write an uniformly usable midwifery textbook for training. The main leader of the midwifery training institute in Szeged was entrusted with the task. The textbook was published in 1902 under the title Hungarian Midwifery Training (10).

On the basis of decree No. 219.131/1918 IV of the Minister of Religion and Public Education, the head teachers of midwifery training institutes informed those, who are interested about the initial date of training, its duration, the language of teaching, the time and conditions of enrollment.

- I. age 20-35 (birth certificate required)
- II. good morals (moral certificate required)
- III. good health, complete physical integrity (official medical certificate)
- IV. school certificate, at least on the successful completion of the fourth grade. In the absence of such a certificate, corresponding sensibility (6).

In the field of midwifery training, the First World War marked a serious halt. Part of the educational institutions were used to care for wounded soldiers, medical lecturers were also called up as soldiers. Recognizing the importance of maternal and infant protection, the Hungarian government declared maternal and infant

protection a state task in 1917. Decree No. 39.088/1917 also provided for the organization of a national network and the training of mother and infant nurses. This task was entrusted by the state to the National Stefania Association. The association aimed to protect infants, reduce infant mortality and improve the health and vitality of infants. From then on, a new, qualified professional was involved in the care of the tasks around the birthing woman. The competence of the two cooperating specialists was determined, (midwife, nanny) [1].

As a result of the Treaty of Trianon, Hungary lost 2/3 of its territory, and this geographical change had political and very serious economic consequences. Some midwifery training institutes ceased, some were relocated to Hungary. To fill the gap, new schools were established in Szolnok and Szekszárd. From the academic year 1920/21, the Minister of Social Welfare uniformly increased the time of courses to 10 months. According to the instructions, it was not possible to apply for admission to the course during the year, and it was not possible to get involved. As an amendment to the previous regulations, the age limit for students was set between 20-35. It became a requirement that the moral life of applicants for admission be impeccable, and students had to prove this with documents. The lower limit of educational attainment was to complete 6 classes. New subjects were introduced, teaching mother and infant protection skills. Therefore, knowledge was expanded, and in smaller settlements, the protection of mothers and babies remained the task of midwives. They began naturalizing foreign midwifery diplomas. In 1931, at the suggestion of the directors of training institutes, the time of training was again increased: the period of study was divided into a theoretical and 2-month practical stage (7).

The Budapest Midwifery Training Institute used the aptitude test, which has already become common worldwide, in the entrance examination of applicants for the 1940/41 academic year, for the first time in Hungary. The admissions committee examined the applicants' tactile sensitivity, auditory pacing, attention concentration and manual ability.

The age limit for applicants increased from 1942 to 18 years of age. In September 1944, education still began, but by the spring of 1945, the training of midwives in the country ceased. At this time, an era in the history of midwifery training in Hungary came to an end.

The World War marked a change of era in the field of Hungarian midwifery training. As the first sign of modernization efforts, the gradual reduction of the hitherto traditional, but lacking adequate safety, home obstetrics began. At the turn of the 50s and 60s, almost 100% of births took place in an institute, and the training of midwives at the institute became a social demand. An incredible amount of scientific-technical progress and new knowledge led to a new therapeutic and diagnostic obstetric mindset and practice. This development should also be reflected in the education and training of midwives (5).

In Hungary, as in other states of Central and Eastern Europe, the second half of the 20th century began with a profound socio-economic system change. It was

within this framework that the general modernization took place. Plan management made health care a state task entirely, along with its organizational issues. At the beginning of the era, the damage caused by the war was almost immeasurable, the country lay in ruins. In 1944, the Temporary Government in Debrecen formed the Ministry of Welfare, which took over the health care of the civilian population, a task that had hitherto belonged to the Ministry of the Interior [3].

Regarding the training of midwives during this period, it continued the practice in the first two years (1945-47) (1935): the duration of the training was 12 months, which meant 10 months of academic and 2 months of practical preparation. The basic requirement for educational attainment was to complete the six general classes. Training took place in six places in Hungary: in the Women's Clinics of the Universities of Debrecen, Pécs and Szeged, which were organizationally attached to them, and in three independent Midwifery Training Institutes: Budapest, Szolnok and Szombathely [11].

The year 1947 was another significant stage on the path of reforms. The Ministry of Religion and Public Education, under the number 5710/1947, issued the new organizational regulations of the State Midwifery Training Institutes, under its direct authority and supervision, together with the related rules of study, examination and discipline. The study schedule, which included new elements, came into force from the 1947/48 academic year. The most important change was the increase in the training period from 1 year to 2 years. The new 24-month training consisted of 18 months of institute theoretical-practical courses and 6 months of compulsory hospital practice. At the end of the 18-month institute course, midwifery students passed a theoretical and practical exam, followed by taking the oath and taking vows. They received their diploma only after completing the period of practice [2].

In 1949, the supervision of midwifery training was transferred to the exclusive competence of the Minister of Welfare by Government Decree No. 3640/1949, and in 1950, Constitutional Amendment Act No. IV reclassified the Ministry of Social Welfare as the Ministry of Health. The actual organization of the Ministry of Health took place in 1951, when the II/2 division of the new ministry became the national manager and owner of secondary health education. [11].

For more advanced midwife training, the enrollment requirement had been determined by the elementary school to complete eight classes, but it was an advantage if someone had a higher degree. The aptitude test was also valid. The leadership of the state introduced centralizing and unifying efforts throughout the education system. Thus, secondary health education had become centralized.

It is a Hungarian feature that a new type of educational institution had been released within the domestic education system in the 1960s: the vocational secondary school.

In 1961, the new 'Operational Rules of the Health Schools', the Minister of Health, was completed by the Minister of Health No 22/1961. The most significant

innovation was the introduction of practical education in ward and classrooms. (successfully tried and proven since 1957). During the practical training in the training room, the theoretical and practical work were combined into the closest unit, and the students worked independently, according to what they had learnt, under the coordinated supervision of the clinical-hospital teaching midwife, teaching doctor and the school teacher. In 1963, the Ministry of Health's Department of Education published a new regulatory document entitled "Curriculum and instructions for midwifery schools". The document defined the training of prepared institute midwives as the goal of the education. Based on this, the midwives who had been trained to be independent (working independent) until then were exclusively trained to perform assistance and nursing tasks, all further activities around the birthing women became medical task (10).

From 1965 only matura examination applicants were enrolled in midwifery schools. In 1963, vocational high school training started on an experimental basis in one place, which was later expanded to 5 more training places from 1965, and from the following year, training started in 9 more places. With this form of education, the students acquired general knowledge and professional knowledge. The experiment ended with good results. After completing their studies, the students received a high school diploma/leaving certificate and a professional qualification for general clinic assistant and infant and child care jobs. From then on, these students could continue to study in specialized training as a midwife [1].

Vocational high school graduates had 1 year, 10 months of specialized training. For those who had a high school diploma or a vocational school qualification, the training took place in a 2-year full-time format. This training was only temporary, it was discontinued in 1977.

The largest number of students graduated from health secondary schools from 1972, with a high school diploma and a basic health qualification. In 1972, according to the order of the Minister of Health, these students could continue their education in 20 specializations, one of which was midwifery. The training was the responsibility of the health schools. In 1972, after a long break, again midwifery training in Hungary could continue, 1-year (10-month) specialization training courses for midwives who graduated from the health vocational secondary school started. The Department of Education of the Ministry of Health published a 40-page detailed curriculum of the midwifery specialization course [10].

Vocational secondary schools of health, which started operating on a mass scale in 1968, they released their first high school graduates and generally qualified professionals in 1972. The legal basis for this created by the Minister of Health 8/1972. instruction, which is „The new type of healthcare on the professional qualification and specialization for vocational secondary school graduates” appeared. According to the provision, you could obtain a professional qualification in 20 types of work, and among them were the midwives too. The locally competent Health Department was responsible for organizing the specialization courses. Vocational schools were

commissioned. Although the 2-year full-time education continued for another 5 academic years. In 1972, a new period in midwifery training began, which lasted 22 years. In the 1972/73 academic year started on the 1-year (10-month) specialization courses on the training of midwives who had graduated from the medical secondary school started. The Ministry of Health, the Department of Education published in a nearly 40-page detailed syllabus of the course for specialized midwives. This document defines the purpose of the training differently than in 1963, these midwives were able to perform their tasks independently. The training continued for 22 years in Hungary, the requirement had changed almost nothing. The earlier basic knowledge of a health vocational secondary school was expanded with theoretical knowledge, and with hospital practice. In several cases, the internship also became the students' future workplace [2].

In the 70s, edited by Sándor Treit, a 400 page-long curriculum was published, which included, in addition to knowledge of obstetrics and gynecology knowledge of medicine, obstetrics-gynecology psychology and newborn care. The theoretical knowledge, the clinical practice and the rapid development of diagnostics helped the appearance of new textbooks. Two obstetricians, László Lampé in 1981 and Zoltán Papp in 1992 published their textbooks intended for medical students. These textbooks were the basis, or their shortened version, served as the basis for midwifery education [1].

Higher secondary qualifications and a lot of practice gave midwives a basis to, mainly from around the 90s, show their work, domestic conferences, raised the prestige of the profession, and gave them financial and moral recognition. With the Hungarian regime change there was possible to learn about foreign practices and organize study trips. The demand for BSc midwifery education at the higher level and then at the college level appeared as a possibility. For this the ministry at that time provided all professional assistance, and even organized the preparatory professional negotiations.

From 1991, the written test based on the high school diploma and two-year full-time course tied to an oral entrance exam was used, initially only in the capital. The training provided qualification as a declared "midwife-technician".

Based on their experience, they started a three-year full-time, higher education based on graduation midwife training. The "euroconform" new type of training, which is aligned with European standards, is called "The professional requirements of midwifery training" 21/1994 Ministerial Decree of the People's Welfare regulates [10].

The new decree recognized training in the school system and outside the school system. On a temporary basis until 2000, it became possible to raise the educational level of previously graduated students, using "Midwives Bridge" programme. (Such training was held in several countries, for nurses and midwives to raise your training level). Vocational high schools continued to be the training institutes. With this degree, the healthcare workers had already obtained a higher qualification.

The decree entered into force from the 1994/95 academic year, which invalidated the midwifery specialist training's curriculum. A new type of training was started again, a six-semester training after maturity examination it based on central programme. The developer of the programme was the Nursing Department of the Ministry of Public Welfare. The recommendations of the European Council were already taken into account under developing the programme [10].

There was an increasing need and opportunity to start midwifery training at the BSc level. A suitable background for this was provided by medical colleges, established in the early 90s, operating alongside medical schools. In 1989 at a college and in 1993 the other 3 medical institutes BSc nursing education was also started in connection with the university. In parallel, from 2000 BSc midwifery training could start in Hungary. All the previous training had ceased.

The World Health Organization's (WHO) figures show that even though the global population has been growing, the number of midwives has been falling all over the world. In more than half of the WHO member states, the number of midwives per 1000 capita is less than three [12]. The number of properly qualified midwives greatly influences the mortality rate of new mothers and new-born babies. Looking at the figures of Eurostat, great differences can be seen in the number of midwives in the European countries. The leading countries, with 22.000 to 31.000 midwives, are the UK, Germany, Poland and France [13]. Hungary belongs to the group where Austria, Romania, Spain Latvia and the Netherlands can be found with 17 to 21 midwives per 100.000 inhabitants [13].

In Hungary, the Midwife Section of the Hungarian Nursing Association regularly observes the number of midwives working in hospital, and the level of their qualification. A conference lecture on midwifery, held in 2016, called the officials' attention to human resource problems such as ageing and the insufficient number of midwives (14). Data from 2021 showed that the number of working midwives decreased by 225 people (13.87%) from 2017 to 2021 with 1397 midwives working in the system. A decreasing trend in the number of midwives can be observed in almost all of the obstetric institutions that provide data, and the number of midwives is currently 1397 in Hungary [15].

In addition to the decreasing number of midwives, the rate of freshly graduated midwives is even worse because the number of midwife students has shown a negative tendency, too. The supply of midwife graduates will not be enough to refill the shortage because the number of midwife students participating in higher education is getting lower year after year. In five years, the number of midwife students dropped by 25% (16). In the last two years, the number of full-time midwives continued to decrease, while the number of correspondent students showed an increasing trend (Figure 1).

In Hungary, the University of Debrecen Faculty of Health was the first to launch the midwifery BSc training in the academic year of 2006-2007 with full time and part time programmes. Before that midwives participated in training providing

qualifications listed in the Hungarian National Qualification Register (OKJ). From 2010 on, the only way to obtain a midwife qualification is within the framework of higher education. Midwifery BSc training is part of the Nursing and Patient Care Bachelor training programme within the field of medical and health sciences training. The training programme consists of eight semesters. In line with the two-cycle Bologna-system, midwife students study together with nurse and paramedic students in the first three semesters. From the fourth semester they continue with the chosen specialization of midwifery and learn professional theoretical and practical subjects such as Obstetrics, Gynaecology, Professional Patient Care, The Ethics of the Profession or the History of Midwifery.

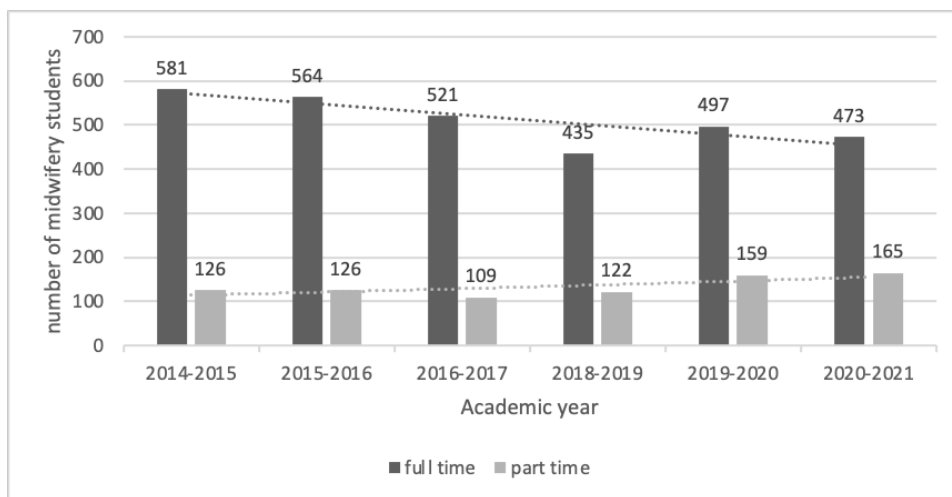


Figure 1. Number of midwife students in Hungary 2014-2021 (Source: Csetneki, 2021)

To obtain the bachelor degree, students must collect 240 credits by completing theoretical and practical courses and preparing their Degree Thesis. Practical courses include both demonstration tasks in the skill lab and hospital practice, too.

Teaching is provided by highly qualified professionals, the instructors of professional subjects are midwives or physicians with obstetrics and a gynaecology specialist exam and have gained valuable experience in a hospital. In the hospital, midwife-mentors help and supervise the students' work.

The curriculum and purpose of the training are basically determined by the Ministry of Human Resources Decree No.18/2016 (VIII. 5.) on the training and output requirements of vocational training in higher education, Bachelor's and Master's degree courses [6] as well as the Training Programmes of universities offering midwifery training [18].

The purpose of midwifery training is to train nursing and patient care professionals who, based on their knowledge of the health protection and restoration of health of

the individual, family, community and society, as well as health and social care, are able to provide preventive, curative, participate in care and rehabilitation work with independent responsibility. They can also apply their skills in practice in the country or institution where the applicable laws, guidelines and protocols allow this.

They are prepared to continue their studies in a master's programme. The content of the training is clustered around knowledge, ability, attitude and autonomy as described in the Requirements and Learning Outcomes, which are made up of general and profession-specific parts. Compliance with this set of requirements forms the basis of the midwife training curriculum.

The disciplines and fields of expertise that lead to midwifery qualifications within the training are the following: nursing sciences, theoretical and clinical medicine and midwifery skills.

In order to obtain the midwifery BSc degree, there is also a language requirement: a state-recognized complex exam in a living foreign language at intermediate level (B2).

During the training, great emphasis is placed on hospital internships, the duration of which is 14 weeks, as defined by the Ministry of Human Resources regulation, but the further requirements of the hospital practice are determined by the curriculum of the training programme.

The practical requirements for obtaining a midwifery qualification, which are uniform at the training sites and regulated by laws and regulations, can be found in the list below.

During hospital practices, midwives must fulfil and document, among others:

- pregnancy care of third semester pregnant women by providing at least 100 examinations;
- pregnancy care of at least 40 pregnant women;
- performing at least 40 deliveries independently;
- implementing episiotomy and suture;
- providing care for at least 40 pregnant women at risk or deliveries of high risk, and providing care for 40 mothers in puerperium of high risk;
- providing care for 40 gynaecology patients of high risk, and documenting them;
- providing care for 40 women with complicated pregnancy, and documenting them - as set in the training and output requirements [17, 19, 20].

Documentation needs to be done as required in the training programme, with signatures of hospital professionals and a strictly kept practical diary. These requirements are also the conditions for admission to the final exam in midwifery.

Another condition for admission to the final exam is the Degree Thesis on a topic closely related to the profession of midwifery, and the defense of it.

The state exam consists of three parts: the first part is the practical exam in the hospital, the second part is a written exam, and the third part is an oral exam. The practical final exam takes place at the hospital site, although during the epidemic of COVID 19, the practical exam took place in the skill lab. The result of the final exam is given by the simple arithmetic average of the grades obtained in the final

exam and the grade received for the defence of the Degree Thesis. The guidelines for the qualification of the diploma are described in the Study and Examination Regulations of the Universities [18].

The register of higher education qualifications includes the professional qualifications that can be obtained in bachelor's and master's programmes in Hungary. Qualifications in the Hungarian Qualifications Framework (HQF) comply with the qualifications in the European Qualifications Framework (EQF). Knowledge gained in vocational schools, vocational training in higher educational, in Bachelor's and Master's programmes are described in the Requirements and Learning Outcomes and are officially published by the minister responsible for education on the website of the ministry [21, 22]. The Hungarian Higher Education Accreditation Committee authorizes the start of Bachelor's and Master's programmes, and audits their operation at specified intervals [23]. Midwives with a BSc degree can work in hospitals, clinics, specialized clinics, special obstetric institutions, and participate in the process of pregnant care. Additional career opportunities are the completion of specialized courses within the framework of further specialized training, or joining a MSc course, or taking up a job abroad.

### **3. The legal status of midwifery**

15/2006. (IV. 3.) Ministry of Education decree on the training and output requirements of the bachelor's and master's courses - the issued decree defined the competencies of those with a BSc midwifery diploma.

#### **a) Knowledge**

- Has comprehensive knowledge of normal female life cycles, the physiological and pathological functioning of female reproductive organs.
- Knows the professional guidelines and protocols, international standards, basic paradigms and concepts of obstetrics and gynaecology routine care, legal regulations and opportunities to expand knowledge.
- Has extensive knowledge of women's health, its factors, and methods of health preservation and health promotion.
- Knows the areas of sexual and reproductive health, the concept, purpose, process and tasks of family planning, the principle, methods and techniques of modern contraception.
- Knows the methods of recognizing pregnancy, the environmental, occupational and genetic risks of pregnancy, the growth and development of the foetus, the indications and implementation of the mandatory and recommended screening methods.
- Recognizes endangered and high-risk pregnancies and special care needs.

- Has comprehensive knowledge of the processes of physiological and pathological labour and delivery, knows the tools and medicines used for resuscitation of a new-born, and the process of resuscitation of a new-born.
- Knows the physiological processes and possible complications and risks during the period of childbirth.
- Knows the diagnosis of gynaecological diseases, their examination methods, treatment principles, methods, procedures, prevention and rehabilitation options, as well as the anatomical and physiological phenomena of aging, the effects of menopause on mental and physical health.
- Knows the order and methods of gynaecological oncology screening.
- Possesses basic knowledge of the implementation and principles of obstetric and gynaecological surgeries and invasive interventions. Knows the methods and possible complications of surgical anaesthesia, aseptic work and sterility.
- Has comprehensive knowledge of diagnostic and therapeutic methods used in the field of obstetrics and gynaecology.
- Knows the documents used during prevention, care, obstetrics and gynaecology care, and the rules for maintaining and managing documentation.
- Knows the areas and methods of professional communication, client management techniques and concepts.
- Knows the professional vocabulary of the field.
- Knows the scientific theoretical background, approaches, conceptual system, types of research and their main methods of empirical research in his field of expertise.
- Possesses theoretical knowledge of economic, management, organizational and quality improvement techniques in healthcare.
- Knows the most important professional guidelines and boundaries of the midwifery profession, its connection to border areas, the profession's interest representation bodies, as well as the methods and possibilities of asserting interests.

#### b) Ability

- She separates physiological and pathological functions from each other and applies this knowledge in his professional decisions.
- Able to identify routine professional problems in her field, analytical and synthetic thinking, uncovering the specific needs of female patients and pregnant women, and setting priorities.
- She supports the realization of a healthy family life, the process of positive and negative family planning, it is able to carry out health education tasks and use helpful and advisory communication.
- Able to independently care for low-risk pregnant women, organize a birth preparation programme, support preparation for the role of parent, her activities include early recognition of complications and taking related measures.

- Able to provide complete information about screening tests to be performed during care and risk factors affecting pregnancy.
- She is capable of independent maternal and foetal monitoring, observing and detecting the progress of childbirth, as well as supporting the labourer.
- She is able to independently conduct a physiological birth safely, to carry out and provide episiotomy, and in an emergency (if a doctor is not present) to conduct a breech birth.
- Able to independently assess the condition of the mother and the new-born, provide primary and secondary care of the new-born, and ensure early direct contact between the mother and the new-born.
- Capable of neonatal resuscitation.
- Able to recognize emergency situations and initiate immediate measures.
- Able to monitor and care for the child, promote breastfeeding, perform tasks related to discharge (counselling, recognition of pathological symptoms, measures).
- Able to perform patient care according to the nursing process.
- Able to apply appropriate professional procedures and protocols.
- Able to independently perform gynaecological onco-cytology sampling.
- Able to prepare and prepare the female patient for surgery and professionally carry out post-operative nursing tasks.
- Able to work aseptically.
- Able to prepare, perform, evaluate and document the results of diagnostic interventions.
- Able to interpret data generated during health care and maintain documents related to independent activities in compliance with data protection rules.
- In his field of obstetrics and gynaecology, she can conduct adequate professional communication in both expert and non-expert circles.
- Able to apply client management techniques.
- Capable of understanding and basic analysis of comprehensive and special relationships and scientific knowledge in the field of obstetrics and gynaecology.
- Able to independently process literature sources appearing in library and electronic form, has the ability to think analytically and synthesize.
- Able to contribute as a middle manager in healthcare institutions (management, organization, quality improvement), able to make independent decisions.

#### c) Attitude

- Focusing on the protection of human life, it strives for constructive professional and helpful behaviour.
- Social and intercultural sensitivity, a non-prejudiced attitude characterizes, accepts and respects individuals and their culture and customs, regardless of their status, origin, or religious beliefs.
- In order to achieve a high level of care, she is open to learning about new procedures and professional innovations, and strives to develop his practical skills.
- Her holistic, reflective approach determines her decisions.

- She is committed to quality professional work, performs her duties accurately and reliably.
- Uses human and material resources cost-consciously.
- Committed to developing the individual's health behaviour.
- Her human-centered approach enables her to find adequate solutions related to the given problem.
- Committed to the proper management of documentation and open to monitoring and managing changes in documentation procedures.
- Receptive to learning and applying the scientifically proven professional foundations of health science.
- Open to critical consideration of others' opinions.
- She performs her work partly autonomously and partly cooperatively, in compliance with ethical standards and legislation.
- She represents the midwifery profession worthily with her work and role-conscious behaviour.

#### d) Autonomy and responsibility

- Performs health promotion and health education tasks with responsibility, independently or as a team member.
- Independently provides needs-based care and care during physiological pregnancy in accordance with the law, and assumes responsibility for its activities.
- Assumes responsibility for independent activities carried out in the health care system and outside of it (private provider, maternity hospital, home birth).
- Shows commitment to creating a safe and hygienic environment for obstetrics and gynaecology surgeries and special forms of treatment.
- She feels responsible for the work, results and failures of the professional group he leads.
- Takes responsibility for performing and evaluating independently performed diagnostic and therapeutic tests.
- Responsibly applies the tools and methods related to field of expertise.
- Takes responsibility for the accurate management and content of the health documentation.
- Capable of team work and cooperation, but at the same time has an independent human resources and economic decision-making opinion, and as a middle manager has responsibility for quality.
- Represents her profession in a responsible, scientific and practical way in all circumstances [24].

#### An addition

If someone wants to work as a midwife in Hungary, she must have a BSc or one of the diplomas obtained at an earlier age. In addition, she must be a member of the Hungarian Chamber of Healthcare Professionals. She must have a basic license or an operating license after five years, which is issued by the Office of the General Directorate of the National Hospital, at the request of the midwife.

## 4. Midwifery in numbers

According to the chamber register, a total of 2,442 midwives are registered in 2023. According to the data, 1,141 (46.7%) are under 44, and 1,301 (53.3%) are over 45. There are fewer workers in the younger age group, under the age of 44, than those over the age of 45, although the difference is only 6.6% (Figure 2).

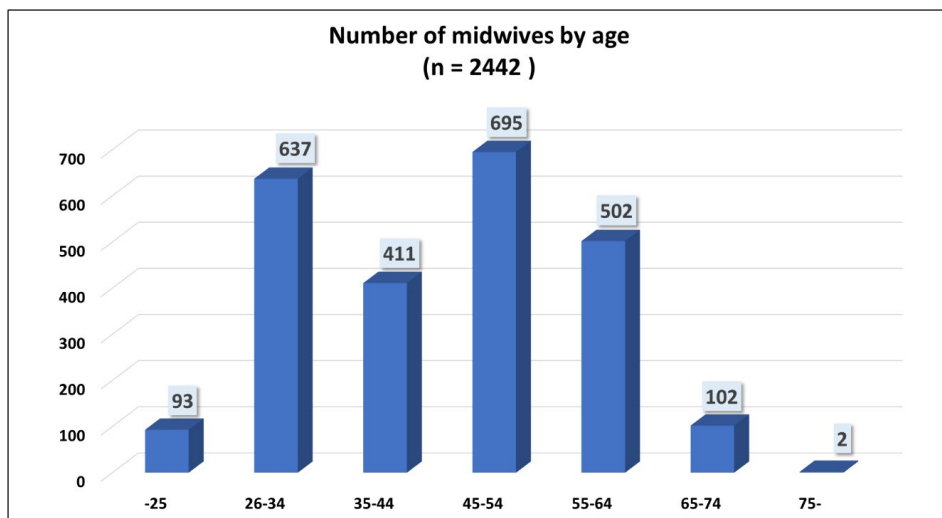


Figure 2. Number of midwives by age.

Source: Chamber of Hungarian Health Care Professionals (2023)

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## **MIDWIFERY IN ISRAEL**

### **1. Brief history of midwifery**

Israel is unusual in its very specific and unique system of education and recognition of the midwives' profession. Its uniqueness stems from the history of Israel as a country.

There were not many laws or treatises regarding midwives in Egypt, Mesopotamia, or ancient Israel. According to Gale (2022) although there are some artifacts of birth equipment from archaeology, the knowledge we have about midwives in ancient Israel primarily comes from discourses in the hegemonic domain, the realm of religious ideas, symbols, and ideologies. The Bible mentions midwives a number of times: According to Gen 35:16–19, when Rachel was experiencing an exceptionally hard labour, a midwife comforted her saying, “Do not be afraid; for now, you will have another son.” When Tamar was in labour with twins, one of them had put out a hand and a midwife tied a crimson thread around it, saying, “This one came out first.” When his brother came out later, his hand was tied with the crimson thread still marking him as firstborn (Gen 38:27–30). Midwives were thus responsible for determining the first-born. Exodus 1:15–21 relates the story of an oppressive pharaoh exploiting a foreign people to work in building projects and in the agricultural fields of Egypt. Threatened by the growing number of the Israelites, he commanded two midwives, Shiphrah (“Beauty”) and Puah (“Splendor”) to look carefully when they see the Hebrew women “on the birthstool”. They were ordered to kill the infant if it was a boy, but if a girl, let her live. However, the midwives feared God (*Elohim*), disobeyed the Pharaoh, and allowed their male neonates to live. We thus see that midwives were present in ancient Hebrew society, with a role and position of responsibility and relative power in a patriarchal system [1, 2].

The Late Ottoman Period, 1850-1918: At this point in time midwives were traditional or folk midwives, women with no formal training and for the most part illiterate and Muslim. They gained their professional knowledge through apprenticeship, or simple experience. These women were known as “dayahs” and were considered a friend of the family. They delivered the baby, named it, attended all ceremonies and arranged its wedding. The dayah's word was law, a figure of authority in the families she cared for [3]. All the descriptions of these women emphasized their advanced age, many of them being widows who turned to the profession as a means of financial independence [4].

In 1861, the Ottoman authorities issued a new regulation, which obligated the licensing of midwives [5]. This process did not include the dayahs, but only the

modern midwives who studied abroad. These midwives dealt only with their field of specialization and were present at birth [6]. Also existing in Israel at the turn of the twentieth century were the midwife-medics, or *feldscher*, women who were mostly immigrants from Eastern Europe and who had studied courses in medicine, midwifery, nursing and pharmacology.

In 1918, the Hadassah Medical Organization arrived in Israel and introduced a fourth model of midwife: the nurse-midwife. In the course of time, this model became the dominant one in Israel. In the same year, shortly after the beginning of British rule, the British published the Public Health Ordinance, which required midwives to present a diploma and receive a licence. The *dayahs* were, however, allowed to continue working.

In 1929, the Midwives Ordinance was enacted, in which two tracks of midwives were recognized: licenced qualified midwives, mostly nurse-midwives and registered unlicensed midwives, mostly *dayahs* [7]. All the midwives, whether licenced or not, were obligated to report to the authorities on births. The licenced midwives were required to have passed a mandatory course of study, but then had the right to practice midwifery throughout the country, whilst the registered midwives were limited to practicing only in certain areas and according to need. It is important to note that the Midwives Ordinance granted a licence to anyone who had studied for 6 months and thus ignored the nurse-midwife model of the Hadassah Organization.

Most midwives in the cities at this point in time worked independently and were reimbursed by their patients for their services. In Jewish settlements they were often paid by agents of the Baron (Rothschild) but also received reimbursement in kind from their patients in light of the fact that their stipend was not enough to support them. In the nineteen twenties hospitals began to establish delivery rooms and many of the licenced midwives who had up till then worked independently, began to work in hospitals [4].

The Ordinance, which is still in force, defines midwives' duties as:

- To examine a woman in regard to childbirth.
- To determine the woman's diagnosis.
- To write prescriptions for the woman.
- To treat her or the child.

Over the course of the last 93 years, the ordinance has been amended only four times, but it is important to note that today midwives work under the supervision of the Head of the Israeli Nursing Division in the Ministry of Health and are grouped together with nurses as working under the same framework of legislations. Furthermore, today the model of the nurse-midwife proposed by the Hadassah organization is the accepted definition of a midwife in Israel.

An important development in the field of midwifery in Israel was the establishment of the Israel Midwives Association in 1978. The goals of the organisation were defined as to advance the professional development of midwifery, to strengthen their professional standing, and to improve the care

provided to women in the course of their lives (IMA, 2022) [7]. The organisation is a standing member of the International Congress of Midwives, and in recent years, has become actively involved in advancing the role of the midwife in Israel.

## **2. System of education for midwives**

In Israel, before one can obtain recognition as a midwife, one must first become recognized as a registered nurse. This involves meeting all of the qualifications for nurses and passing the Israeli Licensing Examination. Therefore, the basic requirement for anyone interested in training as a midwife is qualification as a Registered Nurse and a Bachelors' Degree, which may be in Nursing or any other field. Courses for midwives are under the administration of the Nursing Division of the Ministry of Health. The decision as to when and where courses will be opened and the number of students admitted are the prerogative of the Nursing Division and are based on their estimates of the national needs for midwifery [1].

The Midwifery courses are held in nursing schools, where the formal instruction is performed, (375 hours, including lectures on most aspects of obstetrics, genetics, embryology, high risk pregnancies and care for the woman throughout pregnancy). The practical training is conducted in delivery rooms in various hospitals (636 hours, requiring her to care for at least 100 women in labour and deliver at least 50 babies). The course is a yearlong, and most of the students continue working as nurses during their training [1, 8].

In order to qualify to have a licence to practice midwifery in Israel the student must have first passed all the exams in the course and fulfilled all the requirements of the practical training. Obtaining the license to work as a midwife involves a two-stage test: theoretical and practical. The graduate must complete a national theoretical exam, and, if successful, pass a practical exam with clinical simulations of various obstetrical situations. On successfully passing this licencing process, the midwife receives a licence to practice midwifery in the state of Israel and is registered in the national registry of midwifery [9].

## **3. The legal status of midwifery**

Currently, Israel does not have a national Nurse Practice Act. This means that nurses practice under a clause in the Physician Practice Act that allows nurses to practice under medical supervision. It is hoped that in the future, a Nurse Practice Act will be enacted whereby nurses will have a stronger legal basis for practice. From a legal point of view, the status of midwives is different from that of nurses.

The Midwives Ordinance was enacted by the British Mandate authorities in 1929, in order to regulate the occupation of midwives who care for women in

pregnancy and birth and to improve the health of the country's residents. Under this Ordinance midwives are licenced to practice their trade, and so can still practice in the community and deliver in homes, though there are extremely strict and limiting regulations written by the Ministry of Health proscribing how this can be done. The order states that the midwife can "...examine, diagnose, prescribe medicines, cure or treat the woman in labour...". These are five typically medical activities [10].

#### **4. Midwifery in numbers**

As mentioned previously, since 1929, the ordinance has been amended only four times. Today most midwives work in hospitals. They are subordinate to the head nurse of the Ministry of Health and are listed in the nurses register in a separate section - midwives.

Israel today has the highest fertility rate in the OECD – 3.05 children per family – resulting in roughly 180 000 births per year. At the same time, Israel is the third from the lowest in the ratio of midwives to 1000 out of 19 countries [11-13]. The exact number of licenced midwives in the State of Israel is not known, though the estimate is that there are approximately 4000. The Israel Midwives Association, established in 1978 and active today in the continuing education and development of midwives, has approximately 1200 members, all licenced midwives, working in hospitals or in the community.

#### **5. Challenges and Prospects<sup>1</sup>**

The challenges and prospects for midwifery in Israel today are first and foremost changing the ratio of midwives to labouring women in delivery rooms. In Israel, where a socialist system of medicine is practiced, the number of midwives working in any delivery room is decided on the basis of the number of deliveries, and this has led to the current situation, where one midwife cares for up to three women in the delivery room at the same time. As a result, doulas have become increasingly common in Israel, both in preparing women for birth, in accompanying them, and in supporting them after delivery.

The second challenge is to reconquer the role of the midwife, which was originally defined as caring for women throughout their lifecycle, from menarche to menopause. This model is based on that which is proposed by the International Confederation of Midwives and the World Health Organisation and is Midwife-led continuity of care (MCoC) (ICM 2017). Currently, in Israel, midwives have been

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<sup>1</sup> Challenges and Prospects for Midwifery in Israel Today section is based on an interview with Ms Yifat Rubanenko, the President of the Israel Midwives Association (3rd February, 2023).

relegated to working in the delivery rooms alone, and doctors and public health nurses have taken control of pre- and post-natal care. Initial programs to begin follow up of low-risk pregnancies by midwives have begun, and though there is much work yet to be done, the midwives of Israel are confident that they will reclaim their rightful role as midwife - “with the woman”.

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## MIDWIFERY IN JAPAN

### 1. Brief history of midwifery

#### *(1) Regulations for Qualifications and Education of Midwives*

The term “midwife” (*Sanba*) had been popularised since the Edo period (1603-1868), which marked the beginning of the history of midwifery. In Japan, midwives were called *Sanba*. The first legislation regulating midwifery was the “Regulations for the Control of Midwives (*sanba*)” issued by the Ministry of Home Affairs on December 24, 1868. This regulation prohibited abortion and drug sales by birth attendants [1]. The “Medical System” (*Isei*) enacted in 1874, established the policy for the modern maternity care system. It stipulated the required level of education, qualifications, duties, and penalties for maternity care workers, and led to the establishment of maternity care centres and schools throughout the country [2].

The Regulations on Midwives (*sanba*) stipulated the requirements for the acquisition of business licenses (age 20 or older, those who had passed the midwife examination, and those registered in the midwife registry), medical treatment in abnormal situations, and prohibition of medical treatment (prohibition of surgical procedures, use of obstetric instruments, and administration of medicines) [3]. Prior to the enactment of the Midwife (*sanba*) Regulations, an individual could qualify as a midwife after completing simple written and oral examinations which were commissioned by the governor of each prefecture under the supervision of an obstetrician in that region, who would then issue a license to the midwife. Since regulations concerning midwives differed among prefectures, the Ministry of the Interior enacted the “Regulations for Midwives (*sanba*)” (Article 19) on July 8, 1899, to unify the qualification criteria. Simultaneously, with the promulgation of the Regulations for Midwives, the Regulations for Registration of Midwives, and the Regulations for Examination of Midwives were also enacted on September 6, 1899 [4].

#### *(2) Beginning Education*

To begin educating individuals to become midwives, a training school was established at Osaka Medical School Hospital in 1876 [1]. In 1890, after Dr. Gentatsu Hamada submitted a proposal to the government, the Tokyo Medical University Training School for Midwives was officially recognised as part of the Tokyo Imperial Medical University. At the time, there were several schools for midwives, but their teaching methods and facilities were inadequate, thus, the Tokyo Medical University Training School for Midwives was considered the foundation of midwifery education in Japan [1].

In 1911, there were 83 midwifery schools throughout Japan, most of which were private. These schools did not offer sufficient education for birth attendants, as they did not provide practical training in phantom exercises and deliveries. In addition, the length of training at many midwifery schools established during the Meiji period was not uniform across prefectures: 52 schools offered one year of training, six schools offered one year and six months, and three schools offered two years. Some schools also offered courses in anma (massage), nursing, and calligraphy, thus, there were disparities in the content of education [1].

### *(3) Post-World War II Reform of Laws and Regulations*

After World War II, the Public Health and Welfare (PHW) Department reformed the nursing system and enacted the Public Health Nurses, Midwives, and Nurses Act. The Public Health Nurses, Midwives, and Nurses Decree was enacted in July 1947 and became the Public Health Nurses, Midwives, and Nurses Act a year later. With the enactment of the new law, the existing rules for public health nurses, midwives, and nurses were abolished. The Public Health Nurses, Midwives, and Nurses Ordinance was characterised by the fact that women in the three categories were qualified as nurses, licensure was made a national qualification, and licensure was changed from a work license to a certification license. Under this law, a midwife is “a woman who is licensed by the Minister of Health, Labour and Welfare to practice midwifery or to provide health guidance to pregnant women, nursing mothers, or newborn babies” [5]. Thus, the midwives’ specialty was clearly defined. Although the Public Health Nurses, Midwives, and Nurses Ordinance is not significantly different in content from the former Midwives Ordinance, it is important to note that midwives were given the responsibility and authority to plan and conduct their midwifery education rather than placing their education in the hands of obstetricians.

### *(4) Establishment of the Japan Nurses Association and the Japan Midwives Association*

The General Headquarters of the Allied Forces (GHQ) issued a “Memorandum on Public Health Measures” in September 1945, establishing the PHW Department and placing it in charge of medical care, public health, and social welfare administration. A new nursing system was subsequently created in Japan and the “Nursing System Study Group” was established; it consisted of doctors, midwives, nurses, public health nurses, and Ministry of Health and Welfare (MHW) officials. The new institutional reforms of the MHW included the enactment of the Public Health Nurses, Midwives, and Nurses Law and the establishment of a professional organization called the Japan Nurses Association [1]. In Japan, midwives (sanba), nurses, and public health nurses were active in separate professional associations: the Japan Midwives (Sanba) Association (formed in 1927), the Japan Imperial Nurses Association (formed in 1929), and the Japan Public Health Nurses

Association (formed in 1941) [6]. On May 1, 1947, there was a partial revision of the Midwives' Regulations to make the term "midwife" (sanba) a synonym for "nurse." The organization became the "Japan Midwives, Nurses, and Public Health Nurses Association"; however, was later changed to the "Japan Nurses Association" at an ordinary general meeting in July 1948 [7].

The official journal of the Japan Midwives Association was "Health and Midwifery," published in 1957. In 1958, the name of the journal was changed to "Midwife" [7].

## **2. System of education for midwives**

After World War II, the reformation of Japan's health care system was directed by the United States which, at the time of the occupation, had no legal midwives. Under the American occupation policy, the fact that the majority of babies (approximately 98%) were birthed at home with the help of midwives was regarded as a problem [8]. The officers of the occupation positioned midwives as nurses in obstetric departments and made it a condition that midwives had to have a nursing certification; although midwifery had a longer history of independent regulation, education, and practice than those of nurses in Japan. Integration into the nursing profession influenced midwifery education in Japan. Before the American occupation, midwifery education without nursing education (direct-entry programme) was the only pre-registration programme for Japanese midwives. Today, all Japanese midwives are nurse-midwives, with compulsory nursing education.

In 2021, a total of 216 midwifery educational institutions and roughly five types of midwifery education courses were available in Japan. These ranged from one-year courses in four-year nursing education or one-year vocational schools to two-year postgraduate schools. More specifically, there were 43 one-year vocational schools (20%), three one-year non-degree courses attached to junior colleges (1%), 81 one-year courses within four-year nursing university education (38%), 41 one-year non-degree graduate course attached to nursing universities (19%), 48 two-year graduate schools including one professional graduate school (22%) [9, 10]. Under Japanese law, midwifery education should last one year whereas the minimum length for a post-nursing midwifery education programme should be 18 months according to the ICM Global Standards for Midwifery Education [11].

In Japan, one type of midwifery education course is integrated into the curriculum of a four-year nursing education. Midwifery education within nursing education usually occurs in the last year of nursing education. This means that midwifery education is less than one year in real terms. Research has shown the low quality of such educational programmes, which has been described as too short and too busy to

obtain enough knowledge and skills, as well as to accomplish the required credits and the required number of birth attendance [12, 13]. A survey in 2021 showed that under these programmes, the average number of births each student had delivered was 7.8 and ranged from one to 11 [10]. Over the years, the midwifery programme within the nursing education has attempted to improve, but as a pre-registration education, it is still substandard in terms of length, content, and quality [12-15].

Japan's curriculum is a credit-based system, and the total required credits are 31 credits namely: 20 credits for theory and on-campus practice with subjects such as "Fundamental Midwifery" (6 credits), "Diagnosis and Skills in Midwifery" (10 credits), "Community-based Maternal and Child Health" (2 credits) and "Midwifery Management" (2 credits) and 11 credits for clinical placement [16]. The timeframe for each credit is not unified (15–30 hours per credit for theory and 45 hours per credit for clinical placement) and the total credits do not always reach 1,000 hours. This type of midwifery education is far shorter than those of other countries. In the United Kingdom, for example, midwifery education requires at least 3,000 hours of an 18-month post-nursing education or at least 4,600 hours of a three-year direct-entry education. In New Zealand where they only have a direct-entry education programme, students are required to have a total of 4,800 hours, with at least 2,400 practice hours and 1,920 theory hours [17, 18].

In Japan, under the law, the required number of birth attendance during midwifery education is "about 10" [16]. However, many of the students and schools struggle to meet this requirement. To begin with, the time of the practice is too short to attend to 10 births. Other possible reasons include the decline of birth rates, the increase of high-risk births and the lack of human resources at birth facilities [10, 19]. There are around 800,000 births in Japan annually and low birth rate is not a unique issue for Japan; student midwives in other countries are required to attend approximately 40–50 births [14, 17, 18, 20]. Moreover, student midwives sometimes have placement only during the day shift due to safety policies and the shortage of training staff at birth facilities; yet, births may occur anytime, day and night, and often last longer than one shift. A midwifery education that is defined by following the rules and time schedules of birth facilities rather than the physiological needs of each woman's birth, could affect the philosophy and attitudes of future midwives towards midwifery.

According to a survey conducted by the Japan Society of Midwifery Education [21], only 33.7% of students answered that they can deliver babies (with a little advice) upon completion of the pre-registration programme. Less than 50% of students were confident that they could independently provide care with or without a little advice [14, 21]. In Japan, it is not clear whether that is the result of the midwifery pre-registration education or that the midwifery graduates are not competent due to insufficient education. Every year, over 2,000 students take the national exam and 99% of the candidates pass the exam. The certification of a midwife is permanent and there is no required post-registration training for midwives unless they take it on their own initiative.

Japan is the only country which does not have a direct-entry midwifery programme among the Group of Seven (G7) nations [22]. In Japan, the boundary between maternal nursing and midwifery is vague [23, 24]. In fact, discussions about the distinction between the two professions—nursing and midwifery—and the possibility of a direct-entry midwifery education are rare. The Japan Society of Midwifery Education has attempted to shift all midwifery programmes to a two-year postgraduate programme to meet the 18-month education standard of the ICM. However, the two-year postgraduate programme is tailored for a master's degree and therefore requires a master's research or thesis. As students have to complete both midwifery education and master's dissertation in two years' time, the programme can neither spend 18 months nor two years on midwifery education. Such an educational programme runs the risk of not having enough time and quality for both midwifery education and a master's degree course. For an autonomous midwifery practice to support a safe and positive birth experience for women, Japan's midwifery education must continue to seek improvement in all aspect of its existence.

### **3. The legal status of midwifery**

Legal aspects relating to midwifery services in Japan are regulated by “Act on Public Health Nurses, Midwives and Nurses (APHNMN) (1948)” [25] and “Medical Care Act (1948)” [26].

The APHNMN aims to improve the qualifications of nursing professions; public health nurses, midwives and nurses and thereby promote and improve medical care and public health. For midwives, the APHNMN stipulates the licensures, the duties and prohibited acts of midwives and the improvement of their qualifications. To become a midwife, students must complete at least one year of midwifery-related studies at a school designated by the Minister of Education, Culture, Sports, Science and Technology (MEXT) or be certified by the Ordinance of the MEXT and the Ordinance of the Ministry of Health, Labour and Welfare (MHLW), or graduate from a midwifery training school designated by the MHLW (Article 20) (Please see “System of education for midwives” for details). They must then pass National Midwifery Examination conducted by Minister of Health, Labour and Welfare (Article 7-2) and obtain both a midwifery and nursing license (Article 12-2). In Japan, nursing profession licenses are permanent, and improvement of qualifications is only an obligation (APHNMN Article 28-2 & Law on the Promotion of Human Resources Development for Nurses (1992), Article 6) [27].

The term “midwife” as used in the APHNMN means a woman who has acquired a midwife license from the MHLW to practice midwifery or provides health guidance for pregnant women, puerperal women, or newborn babies, as a profession (APHNMN Article 3). Furthermore, midwifery practice is a professional monopoly except when performed in accordance with the provisions of the Medical Practitioners' Act [28]

(APHNMN Article 30). It is prohibited to perform medical treatment except on the doctors' instruction. However, emergency first-aid treatment, umbilical cord cutting, enemas and other acts usually associated with the midwifery practice are excluded (APHNMN Article 37). In addition, midwives must seek medical attention when they recognise an abnormality in a pregnant woman, parturient woman, or puerperal woman, or a foetus or a newborn baby, and must not perform any treatment themselves, except for providing emergency first-aid treatment (APHNMN Article 38).

The Medical Care Act (MCA) (1948) provides various regulations for 'Birthing Centres' where midwives can perform services. The MCA was enacted in 1948 and is the core of the Japanese medical system, providing for the establishment and management of hospitals, clinics and birthing centres, the development and management system of these medical facilities, medical plans establishment by the prefecture, regulations on medical corporations, provision of information on medical care and penalties. A 'birthing centre' is a place, other than a hospital or clinic, where midwives provide their services to the public or to a specific group of people, and the number of people admitted to the centre must not exceed 10 (Article 2). It also regulates the advertising of its services (Article 6) and the procedures required at the time of establishment (Article 7).

In Japan, the legal status of midwifery services has not changed significantly, but education and practice have been evaluated in response to social conditions and changes have been made accordingly. In light of the recent increase in high-risk perinatal care due to the rise in the childbearing age and child abuse in community maternal and child health care [29], the practical skills required of midwives and their attainment targets at graduation have been changed to strengthen the need to consider women's lifelong health issues more broadly and the ability to respond to high-risk situations. In addition, the technical items and achievement levels for midwifery education have been set to include items that can respond to high-risk situations [30].

The Japan Institute of Midwifery has also established the Clinical Ladder of Competencies for Midwifery Practice (CLoCMiP) Level III certification system since 2015 [31]. Its collaborative organisations include Japanese Nursing Association, Japanese Midwives Association, Japan Academy of Midwifery and Japan Society Midwifery Education. It is a system to assess and certify "Advanced Midwife" that midwives have reached a certain level of competence in midwifery practice. As of 2022, 9,032 midwives have been qualified, 23.8% of the number of midwives in 2020, 37,940 [32].

#### **4. Midwifery in numbers**

There were 37,940 employed midwives at the end of 2020, or 30.1 midwives per 100,000 people in Japan [33]. This was an increase of 1,029 (2.8%) from the previous year (2018) [33]. In 2010, there were 29,672 midwives or 23.2

per 100,000 people, thus, there was an increase in the number of midwives. Considering the number of midwives per 100,000 people by prefecture in Japan, Shimane Prefecture had the highest number at 50.7, followed by Tottori Prefecture (46.4), and Nagano Prefecture (43.9) [33]. Conversely, Hiroshima Prefecture had the lowest number at 24.0, followed by Saitama at 24.1 and Ehime at 24.3 [33].

The number of nurses employed at the end of 2020 was 1,280,911 or 1015.4 per 100,000 people [33]. The number of employed nurses in Japan was approximately 33 times that of midwives. The ratio of male to female nurses in Japan was 8.1% for males and 91.9% for females. A total of 952,723 nurses were employed in 2010, or 744.0 per 100,000 people; this number is increasing [33].

The number of employed midwives by place of employment was 23,321 (61.5%) in hospitals, 8,562 (22.6%) in clinics, 2,369 (6.2%) in midwifery centres, 37 (0.1%) in home nursing stations, 23 (0.1%) in social welfare facilities, 354 (0.9%) in health centres, 65 (0.2%) in prefectures, 1,474 (3.9%) in municipalities, 29 (0.1%) in business offices, 1,562 (4.1%) in training schools or nursing institutes, and 144 (0.4%) in others [33]. The number of employed midwives by employment status was 30,570 (80.6%) for full-time employed midwives, 7,306 (19.3%) for part-time employed midwives, and 64 (0.2%) for others [33].

The number of employed midwives by age group was as follows: under 25 years: 2,232 (5.9%), 25-29 years: 5,797 (15.3%), 30-34 years: 4,920 (13.0%), 35-39 years: 4,836 (12.7%), 40-44 years: 4,963 (13.1%), 45-49 years: 4,802 (12.7%), 50-54 years: 4,050 (10.7%), 55-59 years: 3,052 (8.0%), 60-64 years: 1,841 (4.9%), and 65 years and older: 1,447 (3.8%) [33].

## **5. Challenges and prospects**

Japan faces many interrelated complex needs in the maternity sector. Obstetric and perinatal medicine has made remarkable progress, resulting in one of the world's lowest maternal and neonatal mortality rates. However, the number of high-risk pregnant women and newborns is increasing, and it is becoming increasingly important to provide seamless and humanised midwifery care throughout pregnancy, delivery and postpartum.

As in many other countries, the caesarean birth rate increased dramatically to 21.6% in 2020 and has nearly doubled in the past 20 years [34]. The rate of low-birth-weight babies (<2500 g; (9.4% of all births in 2018) also increased, with possible contributing factors including multiple pregnancies associated with infertility treatments and low maternal weight gain during pregnancy due to women's desires to be slim. The recent advances in neonatal medicine have made it possible to save the lives of more than 60% of low-birth-weight infants weighing less than 500g [35]. Women requiring medical care for themselves or their newborns experience enormous stress and anxiety, but the weakening of community ties and the difficulty for their

partners to participate in child-rearing due to the demanding work environment have resulted in the isolation of women, especially during the postnatal period.

Reflecting social needs, midwifery education in Japan included additional modules in its curriculum from 2022 to strengthen the ability to support high-risk pregnancies and neonates and improve perinatal mental health under the Regulation for Enforcement of the Act on Public Health Nurses, Midwives and Nurses [36, 37]. In particular, the profession considers strengthening clinical skills to understand the course of low-risk pregnancies, identifying and preventing deviations and deteriorations from low- to high-risk pregnancies, and responding to emergencies as essential for midwives [37]. During the COVID-19 pandemic, with limited clinical training for midwifery students, a growing emphasis has developed regarding technical training using simulation and virtual reality to gain these skills.

The challenge for midwives in Japan is ensuring a humanised birth, a unique characteristic of midwives, not only for low-risk women but also for women with high-risk pregnancies and obstetric emergencies. Humanised birth in high-risk pregnancies is more than simply curing a woman's illnesses [38]. It can be thought of as a sign of compassion, and because of its ever-changing complexity, it has not yet been clearly described in a clinical practice guideline [38]. There will be an increasing need to build evidence and lobby policy to maximise the application of these midwife characteristics in practice in Japan.

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## MIDWIFERY IN POLAND

### 1. Brief history of midwifery

Assisting in childbirth is one of the oldest medical activities. From the earliest times, the care of pregnant and childbearing women was carried out by women, they were healers or older experienced women. Little is known about the principles of operation and preparation of these women, but do we know about the low quality of this care and the associated high maternal and child mortality. Childbirth has been a dangerous experience for women's health and life for centuries [1, 2].

The first mention of obstetric care in Poland refers to the thirteenth century. In 1244, in Kraków, bishop Jan Prandot founded a hospital which, among other things, offered care and shelter to pregnant women. It should be added that there were no qualified midwives at that time [1, 3].

It was not until the sixteenth century that obstetrics developed and then in almost every Polish village or town there was a person assisting childbirth (*pl. akuszerka, baba, mądra, matrona, powitucha*). Mostly it was a middle-aged woman who was a mother herself. Often, midwifery passed from mother to daughter. The midwife's tasks, apart from assisting birth (*babienie*), included participation in important events, such as the baptism of a newborn and other religious ceremonies in which the mother took part after the birth of the child. Midwives also baptized newborns in special situations immediately after birth [4]. The first midwife known by name in Poland was the wife of the Kraków councillor Jan Ulla [1].

In 1534, Stefan Falimirz in the herbarium *Health Garden (Ogród Zdrowia)* published by the Florian Ungler publishing house in Kraków, published a chapter devoted to obstetrics *On giving birth to children (O rodzeniu dzieci)* [5, 6].

Structured education of women who obtained the title and qualifications of midwife after six months or a year of school, began only from the eighteenth century.

The first school for midwives was founded in Lviv in 1773, and in 1780 in Krakow at the Main School of the Crown the first Department and Clinic of Obstetrics was established, which was run by Dr. Rafał Józef Czerwiakowski, called the father of Polish obstetrics.

Schools for midwives (*szkoły babienia*) were established in Siemiatycze (1783 - 1811), Poznań (1799) and Warsaw (1802) [3, 6-9].

The first candidates for the profession came from poor environments of lower social classes, for whom obtaining midwife qualifications was associated with social advancement. Due to low interest, high demands were not placed on them. It was not until the 1860s of the nineteenth century that the requirement of

literacy was introduced for candidates. At the turn of the eighteenth and nineteenth centuries, the number of trained midwives increased [10].

Short 4-month courses for the company existed since 1859, they gave the right to practice the profession of „rural grandmother“ in small towns, but the graduates received only elementary practical preparation [11]. In turn, education in schools lasted up to 1 to 2 years and ended with a theoretical and practical exam [3, 7]. The first regulations for midwives were issued in Poznań in 1827, which defined the rules of teaching in a school for midwives and the rules for the recruitment of candidates [12]. It should be noted that the first schools for midwives in Poland were established at a time when Poland was under the domination of the three powers of Prussia, Russia and Austro-Hungary, for this reason a different legal and educational system was in force in each part [1, 6].



Ryc.1. Midwife's assistance during childbirth. Graphics from the sixteenth century. [4].

In the eighteenth century, several textbooks of obstetrics were created. In 1780, Rafał Czerwiakowski's textbook was published in Kraków *Początki sztuki położowania*. In 1884, a textbook for midwives by Jakub Kostrzewski was published in Lviv (Austro-Hungary) *Sztuka babienia ku nieuchronnej dzieci przy porodzie odbierających potrzebie a niemniej ku milemu rodzących pożytkowi*. In 1872 *Położnictwo dla użytku akuszerki* by doctor Henryk Jordan was published in Kraków [7-10, 13].

In 1905, the first trade union of midwives was established in Warsaw, which in 1920 was registered as the Association of Midwives of the Republic of Poland (ZAR) [6]. Its aim was to reduce the number of women in obstetrics without professional training. Trade unions also demanded an increase in the requirements for female candidates and an extension of the duration of their studies [1, 13]. In 1928, ZAR joined the International Association of Midwives in Prague. [1, 6, 12, 14].

In 1977, on the initiative of gynaecologist professor Ireneusz Roszkowski, the Section of Midwives at the Polish Gynecological Society (PTG) was established [1].

Twenty-two years later, on 10 April 1999, the Polish Society of Midwives (PTP) was registered in Lublin.

The main objectives of the Ovaria:

1. improving the quality of maternity care
2. professional development of midwives
3. participation in the creation of health programmes for women
4. compliance with the principles of the code of professional ethics
5. representing the interests of Polish midwives

The Polish Society of Midwives is a member of the International Confederation of Midwives (ICM) and the European Midwives Association (EMA) [15].

#### *Magazines for midwives*

In 1890, the first magazine for midwives was published, published in the years 1890 – 1913 in Russian (Russian partition) *entitled. Midwife*, whose editor was Polish doctor Paweł Ambrożewicz. In the years 1926 – 1939 *Przegląd akuszerski* (*Midwifery Review*) was published in Warsaw, it was the organ of the Board of the Association of Midwives of the Warsaw Health Insurance Fund and the Board of the Polish Midwives Trade Union. In the years 1927 – 1939 *Nowiny położnicze* (*Midwifery News*) was published – an organ of the Trade Union of Midwives based in Poznań. In the years 1928–1939, a monthly magazine addressed to midwives *Położna* (*Midwife*) was published in Kraków and Lviv, it was an organ of the Trade Union of Midwives of Małopolska [11, 16]. Noteworthy is also a scientific and social magazine: “*Głos Położnej*” (The Midwife’s Voice), the first issue of which was published in Warsaw in December 1936 [6].

In recent years, many publications on obstetrics have been published to this day in interdisciplinary medical journals, eg. *Problemy pielęgniarstwa* (*Problemy pielęgniarstwa*), *Pielęgniarstwo XXI wieku* (*Nursing of XXI century*), *Medycyna ogólna i nauki o zdrowiu* (*General Medicine and Health Sciences*) and others. Nowadays, a typical obstetric magazine is *Położna nauka i praktyka* (*Midwife, Science and Practice*) published since 2008.

#### *Stanisława Leszczyńska (1896-1974) – midwife in Auschwitz*

When discussing the history of Polish midwifery, one cannot ignore the heroic midwife Stanisława Leszczyńska. She graduated with honors from the school for

midwives in 1922 in Warsaw. During World War II in 1943, she was sent to the Nazi concentration camp Auschwitz, where in the years 1943-1945 she assisted over 3,000 births. Working in extremely difficult inhumane conditions and in the face of cruelty and genocide, she tried to give hope and support to mothers who gave birth in the camp barracks. She never obeyed an order to kill newborn babies. Thanks to her courage and sensitivity, she won the recognition and respect of other prisoners. After the end of the war, Stanisława Leszczyńska continued to work as a midwife until 1958, describing her experiences from the camp in the book *Report of a Midwife from Auschwitz*. She died on March 13, 1974. In 1992, the Catholic Church began her beatification process. On 8 May, three days after the International Midwife's Day (5 May), Polish midwives celebrate their holiday in memory of the birthday of Stanisława Leszczyńska [15].

## 2. System of education for midwives

After Poland regained independence on November 11, 1918, the organization of a new state began. From 1921, schools for midwives in Lviv, Kraków, Poznań, Warsaw and Vilnius resumed their activities. The period of study lasted from one to two years [18].

From 1928, when the regulation of the President of the Republic of Poland on midwives was issued, candidates for the profession had to have completed secondary education (12 years of general education) and a certificate entitling them to start education at a university [19].

The tasks of midwives included physiological childbirth, assistance in the situation of complicated and surgical birth. In large cities, there were maternity institutions in which births took place (15% of the total), while in the provinces, especially in rural areas, obstetric care was still provided by so-called "rural grandmothers" (babki wiejskie) without any qualifications. This period was characterized by high maternal and neonatal mortality, an increasing number of instrumental births and a negligible percentage of caesarean sections. During World War II, births mostly took place in homes.

After the war, from 1950, Delivery Chambers were created, in which midwives accepted physiological births, and in the event of a threat to the health of the mother or child, the woman giving birth was sent to the hospital. During these years Midwives working in the Delivery Room had great powers. She could perform incision and suturing of the perineum, manual assistance in gluteal births, manual extraction of the placenta. In the seventies, in connection with the creation of a large number of obstetrics and gynaecology wards in cities, the liquidation of Delivery Chambers began [1, 20].

After World War II, due to the extension of the vocational training cycle to 2.5 years, the competences of midwives were extended to include care for pregnant, childbearing, obstetrician, newborn and infant, with particular emphasis on

perinatal care. In addition, midwives took care of women with gynaecological diseases [6, 19, 21].

In 1945, the State School of Midwives was opened in Przemyśl, in the same year schools were established in Kraków, Białystok, Chorzów and Poznań. In the years 1945-1947, candidates were required to complete primary school and be aged between 18-35 years. In 1949, the Minister of Health issued an ordinance (of 4 July 1949), which introduced the obligation of an entrance examination for candidates, which covered knowledge at the primary school level [6, 21].

From 1958 to 2003, midwifery education programmes were implemented by Medical Vocational Schools and included 5 semesters of full-time training (2.5 years).

The professional status of Polish midwives since the pre-war years of the last century was very high. The Act on the Profession of Midwives of 1928 introduced and recognised the profession of midwife as independent and specified in detail the professional competence [6, 22].

In 1969, at the Medical University of Lublin, the first higher education in Poland for nurses and midwives was launched, graduates obtained the title of Master of Nursing. The condition for admission to the studies was passing an entrance examination, graduating from a medical school and having the right to practice as a nurse or midwife and completing a one-year internship in a medical institution [6].

On 5 July 1996, the Act on the professions of nurse and midwife was published, which defined professional competences, provided the basis for the development of independence of Polish midwives and made it possible for men to start their education in midwifery schools [1, 23]. A lot has changed, both in professional work and education. The first master's degree in Poland was established at the Faculty of Nursing of the Medical University of Lublin in 1996 [22].

Along with its accession to the European Union, Poland signed international agreements on the education and training of midwives and the pursuit of regulated professions in EU countries. Since 2004, through education at the university level, after a period of 3 years of undergraduate studies, the midwife obtains the professional title of bachelor of midwifery, and after another two years of studies supplementing the professional title – master's degree in midwifery [24-26].

The duty of every midwife is lifelong learning, which takes various forms: specialization, specialization courses, qualification courses, conferences, trainings. A modern midwife as a professional, a member of an interdisciplinary team, carries out her tasks by providing obstetric, neonatal, gynaecological and nursing care. The places where midwives are most often employed are: obstetrics and neonatal wards, neonatal intensive care units, pregnancy pathology wards, gynaecology wards, delivery room, operating room, gynaecological oncology wards and as community midwives [24-26].

According to the applicable regulations, the competences of a midwife include: diagnosis of pregnancy, referral for examination necessary for early diagnosis of high-risk pregnancy, monitoring of the fetus with the use of

medical equipment, care for a woman in physiological pregnancy, conducting physiological childbirth and puerperium, examination and care of a newborn and infant up to 6 weeks of age, health education of women (and their families) in the field of i.e. preparation for family life and methods of family planning, dietary counseling during pregnancy, taking necessary measures in emergency situations, until the doctor arrives, including manual extraction of the placenta and reception of labour from the pelvic position, prevention of female diseases and obstetric pathologies [24-27].

#### *Obtaining qualifications today*

Currently, education takes place at university level in the mode of three-year first-cycle studies and two-year master's studies.

The profession of nurse and midwife in Poland may be performed by a person who has the right to practice the profession confirmed or granted by the Regional Council of Nurses and Midwives. The right to practice the profession of midwife in Poland is granted to a person: 1) holding a certificate or diploma of completion of a Polish midwifery school or a certificate or diploma obtained in a country other than a Member State of the European Union, provided that the diploma or certificate has been recognized in the Republic of Poland as equivalent to a nursing school leaving certificate or diploma, in accordance with separate regulations, and that they meet the minimum education requirements specified in the regulations European Union law; 2) having full legal capacity; 3) whose state of health allows her to pursue the profession of midwife; 4) who shows an irreproachable ethical attitude [27].

A midwife obtains a vocational qualification after graduating from a midwifery school, which is an HEI providing education in the field of midwifery at the following levels: 1) first-cycle programmes; 2) second-cycle studies.

Training at the school of midwives:

1. lasts at least 3 years and includes at least 4600 hours of vocational training, of which clinical training is at least 1/2 and theoretical training at least 1/3 of the training dimension;
2. lasts at least 18 months and includes that part of the midwife's training programme which has not been followed by an equivalent training in a nursing school, in the case of a person holding one of the evidence of formal qualifications listed in Annex 5.2.2 to Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. UE L 255, 30.09.2005, p. 22, as amended. [28];
3. may last less than 3 years – in the case of midwives who hold a maturity certificate and have completed a post-secondary school or a post-secondary school providing for the profession of midwife, if after graduation the midwife acquires knowledge, qualifications and skills corresponding to the knowledge, qualifications and skills obtained after graduation, [27].

A midwife performs her profession with due diligence, in accordance with the principles of professional ethics, respect for the patient's rights, care for his safety, using the indications of current medical knowledge. A midwife during and in connection with the performance of activities consisting in the provision of health services benefits from the protection provided for public officials on the principles set out in the Act of 6 June 1997, Penal Code [29].

### **3. The legal status of midwifery**

The first legal regulation concerning the profession of midwife is the Regulation of the *President of the Republic of Poland on midwives* issued on 16 March 1928 [19].

The document defined the scope of duties and powers of midwives, obliged them to undergo courses and gave midwives considerable professional independence [19].

The subsequent Regulation of the Minister of the Interior of 2 May 1929 contained instructions for midwives, which obliged midwives to draw up lists and report the number of births admitted [21].

Further regulations were created only after 68 years. On 5 July 1996, the Act on the professions of nurse and midwife was published, which indicated what the profession of midwife entails, provided the basis for the development of independence of Polish midwives. [1, 23].

The profession of midwife in Poland is a regulated profession, i.e. it is a profession that cannot be practiced without meeting the conditions specified in a given country.

The status of midwifery in Poland is regulated by the Regulation of the Minister of Labour and Social Policy on the classification of occupations and specialties for the needs of the labour market and its scope of application [30]. According to its provisions, midwives without specialization, in the course of specialization or with the title of specialist, i.e.: organization and management, epidemiological nursing, gynaecological nursing, neonatal nursing, midwifery nursing, family nursing, health promotion and health education, and gynaecological and obstetric nursing.

A midwife is an independent medical profession whose aim is broadly understood health care for a woman, not only during pregnancy and childbirth. The profession of midwife is a unique profession, requiring special skills and predispositions. The work of midwives consists in providing health services aimed at ensuring safety and basic needs in the field of nursing, preventive, diagnostic, therapeutic and rehabilitation services. It also allows patients to perform these services independently, without a doctor's supervision. The basic legal act defining and regulating the rules for practicing the profession of midwife and indicating the roles and professional competences of midwives is the Act of 15 July 2011 on the

professions of nurse and midwife (Journal of Laws of 2011, No. 174, item 1039) [27]. Under the Act, the scope of duties of a midwife focuses in particular on:

1. Diagnosing pregnancy, caring for a woman in the course of a physiological pregnancy, as well as conducting tests necessary to monitor physiological pregnancy to a certain extent,
2. referral for examinations necessary for the earliest possible diagnosis of a high-risk pregnancy,
3. conducting physiological birth and monitoring the fetus with the use of medical equipment,
4. reception of natural births, if necessary also with episiotomy, and in emergency cases also delivery from the pelvic position,
5. taking the necessary emergency measures until the doctor arrives, including manual removal of the placenta and, if necessary, manual examination of the uterus,
6. caring for the mother and newborn and monitoring the course of the postpartum period,
7. examination and care of newborns and taking all necessary measures if necessary, including immediate resuscitation,
8. implementation of medical orders in the process of diagnosis, treatment and rehabilitation,
9. independent provision of preventive, diagnostic, therapeutic and rehabilitation services to a certain extent,
10. prevention of female diseases and obstetric pathologies,
11. recognizing in the mother or child symptoms of abnormalities requiring referral to a doctor,
12. providing obstetric and gynaecological care to a woman,
13. conducting educational and health activities in the field of:
  - preparation for family life, methods of family planning and protection of motherhood and fatherhood,
  - preparation for parenthood and full preparation for childbirth, including advice on hygiene and nutrition [27].

The following shall also be considered to be the pursuit of the profession of midwife:

1. teaching the profession of midwife or nurse and performing work for the professional development of midwives or nurses,
2. conducting scientific and research work in the field of practicing the profession of a midwife, in particular caring for a woman, newborn or family,
3. managing and managing teams of nurses or midwives,
4. employment in a medical entity in administrative positions where activities related to the preparation, organization or supervision of the provision of health care services are performed,

5. employment in entities obliged to finance health care services from public funds within the meaning of the provisions of the Act of 27 August 2004 on health care services financed from public funds or offices these entities serve, under which activities related to the preparation, organization or supervision of the provision of health care services are performed,
6. employment in public administration bodies whose scope of activity includes health supervision,
7. employment in social welfare homes specified in the provisions on social assistance, taking into account the professional qualifications of a midwife specified in the Act,
8. employment as a midwife in a crèche or nursery club referred to in the Act of 4 February 2011 on care for children up to the age of 3,
9. performing elected functions in the bodies of nurses' and midwives' self-government or performing work for the self-government,
10. appointment to perform an elected trade union function outside the workplace of a midwife, if the choice results in the obligation to perform this function as an employee, or performing a function in the management board of a company trade union organization, if the performance of this function is connected with exemption from the obligation to perform work [27].

In addition, the minister competent for health, after consulting the Supreme Council of Nurses and Midwives, determines by regulation:

1. the type and scope of preventive, diagnostic, therapeutic and rehabilitation services that may be provided independently without a medical order by a midwife,
2. a list of medicinal products and aids for which midwives are authorised to use themselves without medical instruction,
3. the types of materials that can be collected by the midwife for diagnostic purposes herself without a medical order,
4. a list of diagnostic tests to be carried out by the midwife herself – taking into account the necessary qualifications and the required range of skills and responsibilities [27].

Another important document regulating the practice of the profession by a midwife is the Code of Professional Ethics for Nurses and Midwives, last amended on 17 May 2023 [31].

#### **4. Midwifery in numbers**

Unfortunately, the number of midwives employed in Poland in the last 10 years has only increased slightly with a simultaneous increase in the average age of this professional group (Table 1).

Table 1. Number of midwives employed in Poland in 2012-2021. [32]

Status on	Number of employed midwives (thousands)	Average age (years)
31.12.2012	23 856	46.09
31.12.2014	25 567	47.21
31.12.2016	26 200	49.15
31.12.2018	27 555	49.98
31.12.2020	28 231	50.74
31.12.2021	28 899	51.06

Men are more and more common among registered midwives (Table 2).

Table 2. Number of registered midwives 2008-2021 by gender [32].

Status on	Number of registered midwives	
	Women	Men
31.12.2008	32 429	45
31.12.2010	33 477	50
31.12.2012	34 327	60
31.12.2014	35 389	65
31.12.2016	36 737	69
31.12.2018	38 240	75
31.12.2020	39 717	75
31.12.2021	40 512	77

The distribution of the age structure in the midwife profession indicates a lack of replacements of generations. The largest number of midwives is between 51 and 60 years, which includes 10 118 employed midwives. This represents 34.9% of employed midwives. Working persons, despite reaching pensionable age, constitute 25.81% and there are 7,483 of them (Table 3).

Table 3. Number of midwives employed by age bracket [32].

Age range (years)	Number of midwives	%
21-30	3 123	10.8
31-40	3 343	11.5
41-50	4 928	17.0
51-60	10 118	34.9
61-70	6 077	21.0
>70	1 406	4.8

By 2030, 60% of midwives will be of retirement age (Table 4).

Over 75% of midwives in Poland (as of 2021) have higher education, most of which have a bachelor's degree (Table 5). The decreasing number of people with

secondary education is related to the end of education at this level in Poland. The Bologna Process m.in influenced the current shape of the midwifery education system in Poland, which resulted in locating the education system for Polish nurses and midwives after 2004 only at the higher level.

Table 4. Forecast of the average age for active midwives [32].

Year	Forecast of the average age of midwives (in years)
2023	51.3
2025	52.2
2027	52.8
2029	53.4
2030	53.7

Table 5. The structure of education of midwives in the years 2014-2021[32].

Year	Level of education		
	Average	Bachelor degree	Master's degree
2014	2 8307	5 358	1 789
2016	2 7631	6 675	2 500
2018	2 6816	7 586	3 352
2020	2 6224	8 605	4 963
2021	2 6324	8 694	4 987

Midwives are obliged to constantly update their knowledge and professional skills and the right to professional development in various types of postgraduate education. Using these rights, they systematically improve their qualifications by participating in various forms of postgraduate education. Most often they use specialization training and specialized courses. The purpose of the specialisation is for the midwife to obtain specialist knowledge and skills in a specific field of nursing or field applicable to health care and the title of specialist in this field, while the specialist course aims for a nurse or midwife to obtain the knowledge and skills to perform specific professional activities when providing nursing, preventive, diagnostic, therapeutic or rehabilitation services [27].

Table 6. Number of midwives who have completed each type of training [32].

Year	Type of completed postgraduate education			
	Specialization training	Qualification course	Specialized Course	Refresher course
2014	560	640	2364	1659
2016	630	384	7070	2168
2018	1741	527	5675	1117
2020	1130	383	3669	298
2021	1051	426	5024	711

According to the Organization for Economic Co-operation and Development (OECD) from 2016, there are 5.2 nurses per 1000 inhabitants in Poland. The EU average is 9.4. A very worrying phenomenon is the low average age of death of midwives. A statistical nurse and midwife lives shorter than a statistical Polish woman. The Supreme Chamber of Nurses and Midwives, after analyzing the data received for the period from 2016 to 2021, calculated that their average age at the time of death is 62.3 years (Table 7). These data are much lower than for the entire population, because the median age of female death, according to the Central Statistical Office in Poland, is 81.8 years. In 2021, there was a significant increase in the number of deaths of nurses and midwives. The causes of this phenomenon have not been studied, but it should be remembered that many medical workers have died during the pandemic and that the average age of the entire professional group is constantly increasing. A thorough study of this phenomenon requires separate research. The age of death test applies to all persons who have ever had the right to practise as a nurse or midwife and are entered in the register, regardless of whether they continued to practise their profession. The analysis therefore includes data on persons deleted from the register and even persons whose right to practice the profession has expired, but there is no annotation about the date of death [33].

Table 7. Number of reported deaths of nurses and midwives [32].

Year	Number of deaths	Average age
2016	963	58.7
2017	762	60.73
2018	1 021	60.82
2019	968	62.64
2020	1 195	63.85
2021	1 606	64.89

## 5. Challenges and prospects

Modern times bring new challenges for Polish midwives. Among the biggest problems are the lack of generational interchangeability in a profession that will peak in the next decade and the fact that there are still unspecified differences in competences and scope of activities for midwives with different qualifications. Regardless of this, the profession has changed, and the most important positive change is the increase in the status of the midwifery profession.

Midwives are constantly gaining knowledge and improving their qualifications by participating in various types of courses, trainings and specializations. They implement new solutions into practice. They organize numerous meetings, symposia, conferences and obtain degrees and academic titles. Polish midwives are professionals with high professional qualifications, and their qualifications are recognized in all European Union countries.

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30. Rozporządzenie Ministra Pracy i Polityki Społecznej z dnia 7 sierpnia 2014 r. w sprawie klasyfikacji zawodów i specjalności na potrzeby rynku pracy oraz zakresu jej stosowania (Dz. U. z 2018 r. poz. 227) z późn. zm.).
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33. Raport Naczelnej Rady Pielęgniarek i Położnych, Pielęgniarka, położna zawody deficytowe w polskim systemie ochrony zdrowia, NIPiP, Warszawa, kwiecień 2022.

## MIDWIFERY IN PORTUGAL

### 1. Brief history of midwifery

The history of women's care during childbirth, in every country in the world, is based on continuous improvement that comes from ancient times when women helped each other at the time of birth. These women obtained an accumulation of knowledge about childbirth, based on empirical experience and on the transmission of this knowledge from generation to generation, from mothers to daughters, from grandmothers to granddaughters. The acquired knowledge was perfected as well as the quality of the activity practiced, by the older midwives.

Obstetric care was thus entrusted to skilled or curious women, also known as "*matronas*", "*curiosas*" was the term most used in Portugal to describe these women who helped others during childbirth, without a professional title or certification and without having any type of instruction on pregnancy, childbirth or postpartum care.

Over time, some of these women saw recognition and social approval, understood as someone with unique and essential vocation and resources, demonstrated during their practice, thus justifying the training of midwives. This period is designated by Marinha Carneiro [1] as the "primacy of experience".

In Portugal, according to historical records, the 1st Regiment of Midwives of Lisbon emerged in 1572. A candidate for the position of midwife was obliged to submit to an examination before the Physicist of the city, who, in case of approval, granted her an official certificate, an indispensable requirement to present in the Chamber, to take the oath and only then exercise functions becoming an "examined or sworn midwife". The regulation of midwifery activity in Portugal begins then, like other arts and crafts existent at that time, thus achieving the status of a trade from the Middle Ages. The "*matrona*" did not disappear, but was placed under surveillance, obliged to justify her interventions and answer for her actions.

Only in the 17th century (1631), according to Portuguese legislation, was the midwife included in the official list of professions, namely in the Regiment of the Chief Surgeon, regulator of the power of surgeons over the healing arts (bleeders, pharmaceuticals, midwives ...) and guarantee of regulation for obtaining license and practice of examined midwives" [2].

It is not known which knowledge constituted the examiners, nor how they were articulated with the knowledge of midwives, or what was the subject of the

examination. The most important thing that was done in this area was to bring the midwife (who traditionally was confined to spaces of domestic life) into the respective public system of trades [1].

## 2. The education system for midwives

Formal education of midwives began in 1836, at the Royal Schools of Medicine and Surgery in Lisbon and Porto and at the Faculty of Medicine in Coimbra, similarly to what had already been happening in other European countries since the 18th century [1].

In these schools, where the «Obstetric Art» was being developed, surgeons began to organize both medical-surgical courses for doctors and courses for midwives, with specific and separate theoretical lessons for midwives, who practised in hospital wards. This new education model, which went through a formal training process, gave rise to the «qualified midwife» [1].

The classes were taught by the professor responsible for the module “Delivery and Birth”, who programmed the contents and number of lessons, who read and orally transmitted the theoretical classes to the students who, in turn, needed to present a “Certificate of knowing how to read and write, passed by a Public Professor, after taking an exam.”

The regulation of the course for midwives taught in those three schools was approved by the Decree of October 28, 1903, where it was defined that “From 1905, only candidates with the 2nd degree of primary education”, the equivalent today to the 1st cycle of basic education, would be admitted to the course [3].

The course lasted two years: in the 1st year, the course was coordinated by a substitute professor of Surgery, and in the 2nd year by the titular professor of Obstetrics (article 1). Although it was up to the school boards to define the respective programmes, the regulations for the midwifery course stipulated that, in the 1st year of the course, subjects should be restricted to “whatever is most elementary and more properly related to pregnancy and normal deliveries”; the 2nd year, in turn, was devoted to the study of dystocia births, exercises with mannequins and clinical assistance [4].

At the beginning of the 20th century, with the end of the Monarchy in Portugal and the establishment of the 1st Republic in 1910, there was a qualitative leap in maternal and childcare, with the creation of Maternities in Coimbra (1911), in Lisbon (1932) and in Oporto (1935). The creation of these maternity hospitals, as organizations under the tutelage of the State, also contributed to the training of doctors and midwives.

In terms of training, there was a growing integration of midwives in the nursing field at this time.

In 1919, it became necessary to have a Nursing Course in order to enrol in the Childbirth Courses taught at the Faculties [5]. The midwife<sup>1</sup> had to have had

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<sup>1</sup> For the authors the term Midwife is equivalent to Especialista em Enfermagem de Saúde Materna e Obstétrica

previous training in nursing, that is, the midwife candidate should demonstrate skills in the area of general health care and the hospital environment, as a condition for being able to access the knowledge and practices of specific care related to childbirth, now in a broader perspective, as this care had been extended to pregnancy, the postpartum and the newborn.

Age requirements for admission, it ranged between 21 and 35 years old (except for the specific cases of married women with their husband's consent, in which the possibility of admission at 19 years old was open). Furthermore, other admission prerequisites were a certificate of no criminal record, up-to-date vaccination, good morals, robustness to exercise the profession, and qualifications corresponding to the 4th grade exam or admission to the Lyceum [1].

After the end of the 2nd World War, maternal and infant mortality rates in Portugal continued to be very high, with rates that contrasted with what was happening in Europe. In Portugal, the lack of care during pregnancy and childbirth was notorious for most of the population. The majority of women birthed at home, often unassisted. The State decided at that time to create home support for childbirth, assisted by Qualified Midwives, in order to mitigate the problem. By 1974 the percentage of homebirths decreased to 43% and in 1990 it no longer had statistical expression (INE, 2013).

In 1943, faced with the depressing situation of mothers and children and the scarce results of its small intervention policy, the *Estado Novo* founded the *Maternal Institute* [6]. Among other purposes related to medical and social care in maternity and early childhood, it was responsible for organizing and directing intern courses for Childcare Nurses. However, the Maternal Institute had to adapt to the impositions of the nursing education reforms of 1947 and 1952, which established a three-year General Nursing Course (from 1952) and the creation of specialties: the child care nurses thus lost its initial format, with its specific valences having to be adapted to the new specialization format. For these structural reasons, the Childcare Nurses course, in its initial format of a three-year integrated training in maternal and child care, only operated for a few years (until 1952, concluding the open courses before this date). These courses, which ran from 1946 to 1952, were basic courses, lasting 3 years. No specific training was a prerequisite, as this would be provided during the course and only the 1st cycle of high school education was required, as it was for the General Nursing Course.

In 1947, the Nursing Assistant course was created due to the great shortage of nurses in the country. This is how the Course for Auxiliary Nurses-Midwives [7] appeared, with a duration of one academic year, including an internship. These courses for auxiliary nurse-midwife, although more productive at the beginning in terms of the number of graduates, ended after the April 25th Revolution in 1974, when the Government abolished the courses and the category of Nursing Assistants and Auxiliary Nurse-Midwives, followed by several changes, in a path that naturally accompanied the historical, societal, and scientific evolution of recent decades.

However, while the Maternal Institute sought to solve the problems of implementing its new course, both in Porto and in Coimbra, the old courses for nurse-midwives given by the Faculties of Medicine continued to run in parallel, for candidates who, being nurses, could be admitted with the primary education exam only as qualification [1]. The discontinuance of such courses at the faculties only occurred later, first in Porto and Lisbon in the 60s and then in Coimbra in the 80s, within the scope of the nursing specialities reform.

The Maternal Institute created in 1943 was closed in 1967 [8] and simultaneously the *obstetric specialization course for nurses and nursing assistants* was created [9] with the duration of one academic year. It was a prerequisite to have the General Nursing Course for admission and it started to be taught in the Nursing School of S. João (Porto), Bissau Barreto (Coimbra) and Calouste Gulbenkian (Lisbon).

The aim of the obstetric specialization course for nurses was to prepare already qualified professionals with the general nursing course, for specialized assistance during pregnancy, childbirth, and the puerperium, whether in hospital services, public health services or the community.

According to the Study Plan of the Specialization Course in Obstetric Nursing [10] (1975), the Course was structured so that it could be attended simultaneously by Nurses and Nursing Assistants, given that there was a path towards the existence of a single type of nursing professional in Portugal. Based on the existing programmes in 1968, one single programme was created (for the year 1975/76) which remained in force in 1976/77.

As specialized course, where the students already had different professional experiences, it was structured to be flexible and adaptable to the needs of each group of students and the resources available in each school. The theoretical and practical teaching of Obstetric Nursing, as well as the coordination of the course, were now the responsibility of midwives and not doctors.

The purpose of the course was to make nurses capable of delivering midwifery care and provide specific midwifery care. Specific care was understood as: “broad and deep specialized care, differentiated from that provided by nursing professionals with basic training”. A Specialized Nurse was understood as: “the one who provided specific care in a given branch of nursing, being qualified with the legally recognized specialization course”.

After the 1976 reform of the General Nursing Course, detailed changes were introduced in 1977 [11]. The working group collected the “opinions and suggestions from professors and students of Specialization Courses in Obstetric Nursing, from nurses from various health establishments and nursing schools, and from specialists in various subjects”. Prerequisites for admission changed to having the 5th year of Lyceum, the General Nursing Course or equivalent, and 2 years of professional practice after the General Nursing Course qualification.

During the period 1940-1980, professionals with different qualifications, training and professional designations coexisted, from Qualified Midwives to

Specialist Nurse in Maternal and Obstetric Health. They were linked to the Maternal Institute or the Social Medical Services, or to the Community Houses “Casas do Povo”, or to Fisherman Houses “Casas dos Pescadores” and their practices around the period of birth took place either at home or in a community context, in the Maternal Dispensaries, Children’s Centres or at the Clinical Posts of the aforementioned institutions

In 1981, a new curriculum reform took place, as a result of the application of Decree Law 305/81 [12], applied to the nursing career, in which the Specialist Nurse ascended to level 3, which gave the Specialist, access to Head Nurse or Assistant Nurse positions. There was a new name to the course and the duration changed to 18 months. This decree established the necessary training for access to the various career degrees, determining that this training would be delivered in post-basic nursing schools, created or to be created. The number of trained midwives was far from meeting the country’s needs in terms of assistance to women and children during pregnancy, childbirth, and the puerperium. To increase the response capacity both in quantity and quality, in 1983 Post-Basic Nursing Schools were created in Lisbon, Porto and Coimbra, endowed with technical and administrative autonomy, and bringing together the existing resources.

This is how the Specialization Course in Obstetric Nursing, which had been taught at the Nursing Schools of S. João (Porto), Bissaya Barreto (Coimbra) and Calouste Gulbenkian (Lisbon), was then transferred to the Post-Basic Nursing Schools in Lisbon, Porto and Coimbra and taught among other specialties. The course was named Specialization Course in Maternal and Obstetric Health Nursing and the qualified professionals had the designation of Specialist Nurses in Maternal Health and Obstetrics.

In 1984, three extremely important Public Health laws were published, and the Specialist Nurse in Maternal Health and Obstetrics saw its scope of action expanded. They are the Law on Sexual Education and Family Planning [13], the Law that governs the regime of protection in maternity, paternity, and adoption [14], and the Law on the exclusion of illegality, in some cases, of voluntary interruption of pregnancy [15].

The protection of maternity and paternity Law, in its article 7, states that it is up to the state to increase hospital births and an Order was issued in 1986 saying that all births must be carried out in a hospital environment. The Nurse Specialist in Maternal Health and Obstetric Nursing, with the intensification of the process of hospitalization of childbirth, thus began to see her functional autonomy relativized, given that, they were no longer carrying out deliveries at home, the midwife in the hospital was subordinated to the medical authority in the team in which she worked.

It is also in this decade that, after the integration of Portugal into the EEC, the Directives of the European Parliament were transposed into Internal Law in order to regulate training in terms of theoretical and practical teaching and the

profession, allowing the mobility of these professionals between the different European countries [16].

The integration of Nursing Education into the National Educational System, more specifically at the level of Polytechnic Higher Education, would take place in 1988, with schools being responsible for organizing and delivering Higher Nursing Courses with the duration of 3 years, conferring the Bachelor's degree. The Nursing Specializations would lead to Honour Degrees and could have the duration of one or two years. From that time onwards Nursing Specialists had what was known as a two-stage Honours Degree [17].

In this context, from 1989 onwards, all nursing schools became superior nursing schools and were able to teach all specialization courses: maternal health, community health, child health, mental health, medical-surgical and rehabilitation. Instead of three post-basic schools, 11 public and three private schools started to offer the Specialization Course in Maternal and Obstetric Health Nursing. Thus, there was an exponential growth in the number of Specialist Nurses in Maternal and Obstetric Health Nursing.

In 1994, the Specialized Higher Studies Courses were created in various areas, namely Maternal Health and Obstetric Nursing [18], but ended up being defunct in 1997 due to the creation of the Nursing Degree, with a duration of 4 years and, consequently, the Postgraduate Courses. The two-stage Honours Degree ceased to exist.

The General Nursing Course becomes a Honours Degree [19] in 1999 and ensures: scientific, technical, human and cultural training for the provision and management of general nursing care throughout the life cycle, to the family, groups and community, at different levels of prevention; ensures the necessary training for participation in the management of health services, units or establishments; participation in the training of nurses and other health professionals; and the development of research practice within its scope.

It was only after the completion of the first Honours Degree in Nursing cohort in 2003 that conditions were met to start post-graduate courses in all areas, including the Specialization in Maternal and Obstetric Health Nursing, under the supervision of the Ministry of Science, Technology and Higher Education.

The Programme of the XVIIth Government established as one of the essential objectives of the policy for higher education, in the period 2005-2009, to guarantee the qualification of the Portuguese nationals in the European space, recognising the Bologna Process as a unique opportunity to encourage the attendance of higher education, improve the quality and relevance of the courses offered, promoting the mobility of Portuguese students and graduates and the internationalization of Portuguese courses [20].

With the adaptation to the aforementioned Bologna Process, in 2010, Master's courses were created in all areas of Nursing Specialization, similar to what had happened in previous years. This includes the Master's in Maternal Health and Obstetric Nursing, held at Higher Schools of Nursing, although the first master's degrees in nursing were held in universities in the 90's (e.g., Faculties of Psychology

and Educational Sciences). The process of acceptance of Nurses by Universities was not easy. It was a process that developed over time but in a certain way led the path to the Doctorate in Nursing Sciences created in 2002.

### 3. The legal status of midwifery

In Portugal Midwifery is a higher education programme, taught in nursing schools or health schools, incorporated in polytechnic institutes or universities. Midwifery education is a second cycle of studies (master's level) and requires a nursing degree (240 credits/ 4 years) as a prerequisite for admission.

The Masters in Midwifery is a 120 credits course and runs throughout two years. The curricula are oriented by the standards set by *Ordem dos Enfermeiros* (OE) (the Portuguese Nursing and Midwifery Council), and the Directive 2005/36/EC of the European Parliament, and of the Council of 7 September 2005. The latter regulates midwifery training at European level, with a view of the recognition of midwives' professional qualification throughout the member states and to facilitate freedom of movement. This directive was transposed into Portuguese national law in 2009 and last revised in 2021[21].

Midwives hold the title of "*Enfermeiro Especialista em Enfermagem de Saúde Materna e Obstétrica*" which can be translated as Specialized Nurse in Maternal Health and Obstetrics or, according to the directive, as Midwife, or Nurse-Midwife.

The programme includes theoretical, theoretical-practical, and practical lectures as well as clinical training in hospital and other health sectors. At the end of the program midwives have competencies to provide evidence-based care to pregnant women, their newborns and their family, along the sexual and reproductive life cycle, in areas such as family planning, preconception care, pregnancy, childbirth, puerperium, climacteric, sexual and gynaecology health, and newborn health.

According to the OE regulation of midwives' specific skills [22] the specific competencies profile is [22]: Care of the woman within her family and her community context:

1. in family planning and the preconception period;
2. in the antenatal period;
3. in labour;
4. in the postnatal period;
5. in the climacteric period;
6. who experiences a health/gynaecological disease process;
7. and the target group (women of childbearing age) inserted in the community.

In addition to the specialized competencies, the midwives must have common competencies assigned to all other specialization in nursing, applicable to all contexts of health care provision. These includes education of users and peers, orientation, advice, leadership, and research, with the aim to continuously improve midwifery practice.

According to the OE regulation [23] there are four domains of common competences: 1) the professional accountability which involves the development of a professional, ethical, and legal practice that respects human rights and subsequent professional responsibilities; 2) continuous quality improvement in which midwives warrant an active role in the development, support and collaboration of continuous improvement programmes and institutional strategies of clinical governance and quality of care, and where the professional ensures a therapeutic and safe care environment; 3) care management, managing the care provided, optimizing the team response and multidisciplinary team work, adapting leadership and resource management to situations and context always aiming care of quality, and 4) continuous professional development, investing in knowledge development, understanding, problem-solving and overall performance (e.g. technical skills) ensuring an updated assertive, self-aware evidence based practice.

The quality of the courses is supervised by the Science, Technology and Higher Education ministry through the Agency for Evaluation and Accreditation of Higher Education (A3ES), which mission is to ensure the quality of higher education in Portugal, through the evaluation and accreditation of higher education institutions and their study cycles, as well as in the performance of the functions inherent to the position of Portugal in the European system of quality assurance of higher education [24] and *Ordem dos Enfermeiros*.

At the end of the course, the students have an academic title of Master in Midwifery which gives them the access to the professional title of Midwife (*Especialista em Enfermagem de Saúde Materna e Obstétrica*) provide by OE and required for professional practice.

Midwives in Portugal can practice in all contexts, both in hospital and the community. At the hospital a midwife generally practices either in inpatient obstetric wards (pregnancy, intrapartum care, and post-partum), outpatient antenatal clinics, gynaecology wards and maternal-fetal medicine units, where they work collaboratively within a multidisciplinary team, and where the model of care is medical-led.

In the community they can practice in health care centres in partnership with family-doctors, who lead care, and in community care units. In the latter, midwives work with a midwifery-led model, and the aim of clinical practice is to prepare women/couples and families to childbirth, parenthood, breastfeeding, and postpartum recovery.

Keep in mind:

1. To become a midwife in Portugal first it is necessary to train as a nurse
2. Following nursing training, two years of professional practice is required to apply to a Midwifery Master's.
3. The course is full time, lasts two years, and awards 120 ECTS.
4. After accomplishing the master's degree, it is required to register with OE, who grants the title of "Enfermeiro Especialista em Enfermagem de Saúde Materna e Obstétrica" (midwife).

5. Once all the above steps are concluded one is ready to practice midwifery in Portugal, to apply to a job in hospital or in the community, or to practice independently.

If a midwife comes from an European country, and being the OE an entity of a Member State of Europe, regulated by the European Professional Qualifications Directive 2005/36/EC, the registration at OE is mandatory. Regarding this registration, the midwife should go to a Regional Section of OE, complete all required paperwork which includes personal and academic information. Midwives who are not nurses, will only be able to practice in midwifery contexts. Nurse-midwives can practice both in midwifery and nursing contexts.

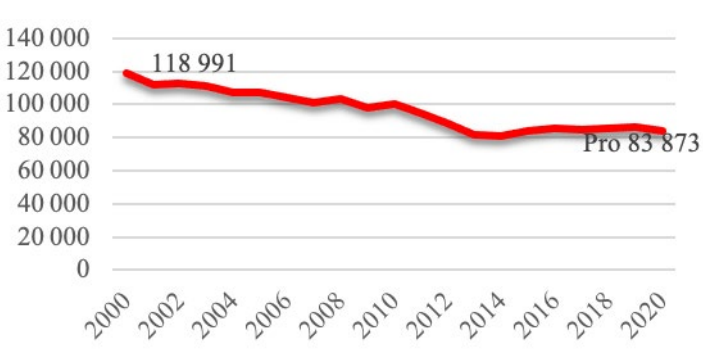
It is important to know the legislation and regulations of the profession, the Regulation of Professional Practice of Nurses (REPE), the Code of Ethics and the Statute of OE and the Standards for implementation of Proof of Linguistic Communication and Regulation of Proof of Linguistic Communication [25].

#### 4. Midwifery in numbers

In 2021 the resident population in Portugal was 10.343.066, less 2.1% than in 2011 [26]. Per sex, inhabitants were 4.920.220 male and 5.422.846 female [26].

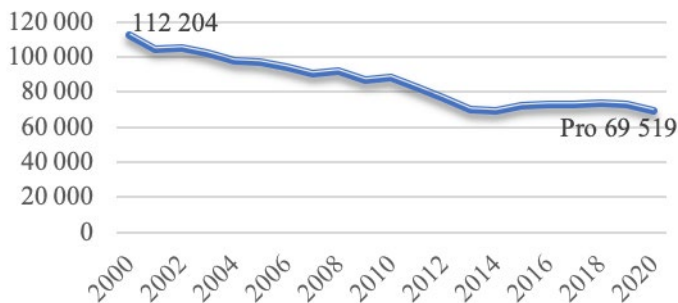
Portugal has one of lowest fecundity levels of Europe and the World, with a Synthetic Fertility Index (ISF) less than 1,4 children/women in 2020. According to *Fundação Francisco Manuel dos Santos* (FFMS) [26] the total fertility rate in 2021 was 2.1, with a gross reproduction rate of 0.65, and a crude birth rate of 7.7, the lowest of the last 20 years. The mean age of the mother at birth of first child was 30.9 years old.

Considering childbirth, in 2020 there have been 83.873 (provisional data) births in Portugal (Graphic 1). The number of births in the last 20 years has been decreasing, being in 2020 29.51% less than in the year 2000.



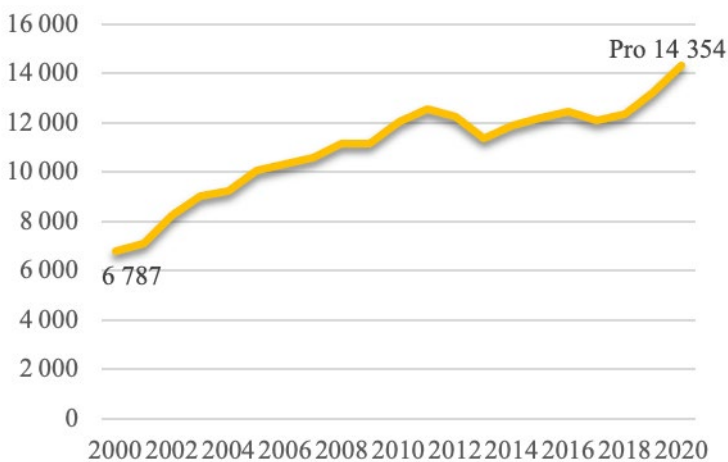
Graphic 1. Births in Portugal 2020. Source: <https://www.pordata.pt> in 23-11-2022

At the National Health Service in 2020 (Graphic 2) there were 69.519 births, less 38.04 % less than in 2000.



Graphic 2. Births in public sector. Source: <https://www.pordata.pt> a 23-11-2022

At private institutions there were 17.1% of births, a growth of 111.49% in the last 20 years (Graphic 3).



Graphic 3. Births in private sector. Source: <https://www.pordata.pt> in 23-11-2022

This increase occurred due to the expansion of the private health sector in Portugal, more inhabitants securing private insurance, and the better hospitality private hospitals offer. It also occurred due to women seeking continuity of care, a model difficult to assure in the SNS but that they can pay for, in the private sector.

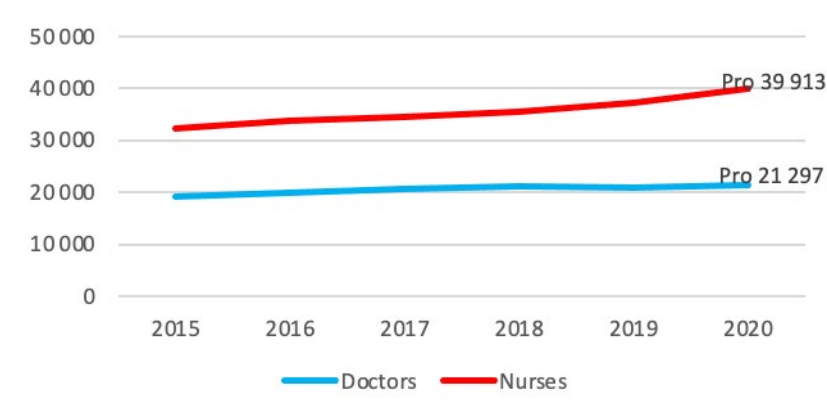
By type, 55.1% of all births were dystocic (Cesarean sections or instrumental deliveries) and 44.9% were spontaneous vaginal births. At private institutions most births (83.6%) were dystocic.

### Healthcare in Portugal

Portugal has public and private healthcare services. The National Health Service (*Serviço Nacional de Saúde*, SNS) is public. The SNS was created in 1979 to offer universal (for all the residents and expats), general (at primary and secondary levels) and tendentiously free health care. It is managed by the Ministry of Health at a national level and by Regional Health Administrations (five in the country) at a regional level. The financing of SNS comes from income tax, according to the Beveridge model. Co-payments and direct payments coexist and associated with health subsystems and private insurance, also a private financing element.

The private health sector has a complementary function and is financed by private insurances, subsystems, and direct payments.

On health human resources, Portugal has 129,1 inhabitants per nurse (including midwives) and 176,4 per doctor [27]. The National Health Services, in 2020, had 21.297 doctors and 39.913 nurses (this number includes specialized nurses such as midwives) (Graphic 4).



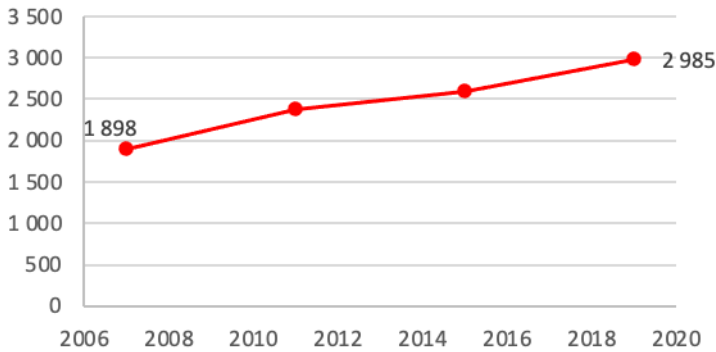
Graphic 4. Doctors and nurses working at SNS hospitals.

Source: <https://www.pordata.pt> in 23-11-2022

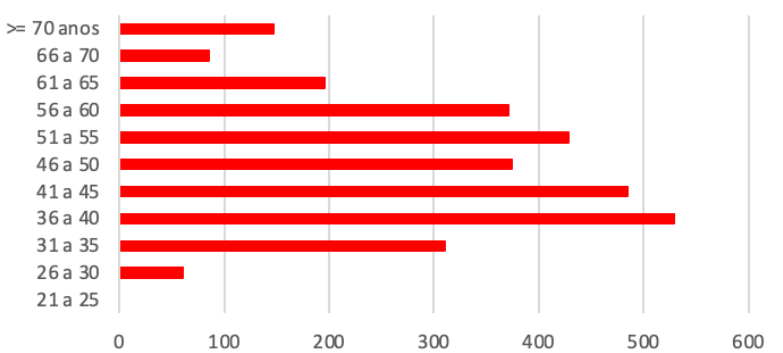
Considering midwives, the number of specialized nurses in maternal health and obstetrics (midwives), in 2019, was 2.985, 2.845 females and 140 males [28]. The number of women in this profession are greater, similarly to other EU countries.

In the last twelve years the number of midwives practising in Portugal has grown 36,4% (Graphic 5) which shows interest in the profession, although many midwives express dissatisfaction with the role they perform they perform.

Considering age, most of the midwives are between 36 and 45 years old (Graph 6). Due to education and admission requisites (four years of nursing course, two years of professional practice and two years of midwifery course), midwives are generally at least between 26 and 30 years old when they start to practice midwifery.



Graphic 5. Evolution of the number of midwives 2007-2019.  
Source: <https://www.pordata.pt> in 23-11-2022



Graphic 6. Midwives by age. Source: OE (2020). Anuário estatístico 2019

Distributed by regions, 1015 (34%) midwives work in the North, 645 (21,6%) in the Centre and 1160 (38,9%) in the South of Portugal. Considering the Islands, 91 (3%) midwives work in Madeira and 74 (2,5 %) in the Azores, which corresponds to the distribution of residents in Portugal.

The majority of the midwives work in hospital settings (63,2%, n=1886), 22,9% (n=685) in primary care units, 2,4% (n=71) in Higher Education institutions and 1,2% (n=37) of the midwives work independently [28].

## 5. Challenges and prospects

In our view, midwives in Portugal face both important challenges and opportunities.

Unfavourable institutional norms, lack of side-legislative initiatives, a strong medicalized culture of pregnancy and birth, and an unclear societal image are

major challenges that midwives encounter every day. But employability and future plans are positive aspects of the profession.

Although midwifery practice is largely within the major medical centres, public hospitals, and primary care units, midwives are now also being employed in private obstetric practices (including private hospitals) or are practicing independently as self-employed. Either way, informed women and employers are recognizing midwifery value and currently there is more demand than actual availability of midwives for private practice. In this aspect (autonomous practice) one of the challenges is that third-party reimbursement (insurance or public financing) for midwifery services is limited, for example, any screening tests prescribed by midwives (ultrasounds, blood tests) are not covered by insurance companies or have protocols with the national health service, making midwifery services financially less attractive and less accessible to the general public.

This is not an exclusive problem to private services though, similarly, if a midwife, a team of midwives or even a multidisciplinary team sets up a project to implement midwifery-led care within the *Serviço Nacional de Saúde* (National Health Service) they would find obstacles in the prescription of the recommended screening tests in the current format, since their prescriptions would not be valid, or they would not have access to information systems to do so. They depend of a doctor to prescribe ultrasounds and any kind of screening tests.

This would be easily resolved through legislative actions authorizing the convention/reimbursement to all qualified providers for the services they are licensed to provide. If both midwives and doctors are licensed to prescribe the recommended screening tests, why do they have different prices for the end consumer depending on who is the requestor?

The medicalized birthing culture, the institutional hierarchy of health professions and the predominance of the biomedical model of care are also factors that prevent midwifery thriving in Portugal. Unfortunately, this is a problem bigger than a midwifery challenge, having a direct impact on childbearing women and their families, the adequacy of the care they receive, their transition to parenthood, their overall outcomes as well as their babies, and affecting affects society as a whole.

All this contributes to the current mixed societal image of midwifery as a peripheral subordinated activity instead of an autonomous pivotal cost-effective practice.

Portugal ranks the second lowest spontaneous vaginal birth rate within comparable countries [29] and was recently highlighted as a developed nation where obstetric violence practices are still norm in many contexts [30]. This consequently impacts midwifery training. If all trainee midwives are exposed to is an interventionist approach, how will they know different? How will they acknowledge physiology?

But although we have just described a scene of obstacles there are many opportunities in midwifery practice in Portugal.

Institutional violence or lack of voice to both women and midwives is prompting women to look for control over their bodies and decisions and midwives to change their practice or cut their institutional ties and become independent autonomous practitioners.

Similarly, the low rates of normal birth and the high rates of intervention can be seen as an opportunity for investment in midwives, and it has been mentioned as a possible solution to the problem. Midwifery-led care and midwifery-led units have been discussed in the Parliament by attentive politicians who are committed to changing women's experiences of pregnancy and birth in Portugal, who want to lower the caesarean section rate and provide better equity in care access. Concurrently there are major issues with obstetric service burden. Maternities closing during days, services threatened with permanent closure for lack of medical staff and unsafe working conditions. Midwives can make a positive contribution into answering these problems.

The creation of midwifery-led units would hopefully increase the rate of spontaneous vaginal births, minimize unnecessary intervention use, as well as contribute to positive labouring and birth experiences and a smooth transition to parenthood. In addition to this, empowered midwives could revolutionize their practice contexts (such as obstetric units) into becoming women/people centred, answering their user's needs, providing options and choices, regardless of risk category, and breaking the medico-centric culture.

Another opportunity is the Portuguese midwife's strong professional conscience to provide the best possible care for women during childbirth, despite difficult working environments and low professional status. Midwifery education programmes follow international standards and often midwives attend additional training to boost their knowledge, have access to different realities, keep their skills up-to-date and gain autonomy.

The fact that Midwifery education is now at master's level is also an opportunity for Portuguese midwives, who are now better equipped to have additional visibility in research, science, and technology.

Portuguese midwives are represented in the international context sharing the principles, values and the vision of the International Council of Midwives (ICN) and the European Midwives Association as well as participating in their activities and strategy through the Portuguese Midwives Association (*Associação Portuguesa de Enfermeiros Obstetras* – APEO). Over the years APEO members fulfilled responsibilities from membership in the ICM European Regional Professional Committee to the Executive Committee of ICM Board. The next International Council of Midwives Conference in 2026 will be held in Lisbon and will be an opportunity to bring the global vision to the country and to each individual midwife.

Finally, Midwives in Portugal are increasingly aware of the importance of their role with the woman, the family, and society, aiming to walk together in the path towards excellence in sexual, reproductive, and maternity care.

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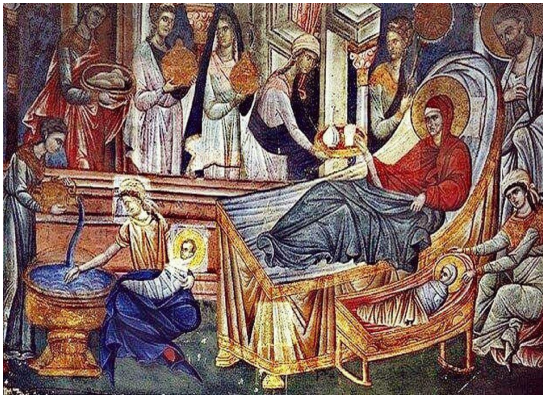
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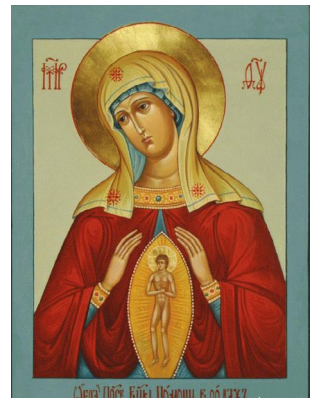
## MIDWIFERY IN SERBIA

### 1. A brief history of midwifery

Medieval art bears witness to midwifery in Serbia, numerous frescoes depict women giving birth, nursing, swaddling, and one of them is the fresco „Birth of the Virgin“ located in the King’s Church in Studenica (14th century). The fresco shows female figures with neatly tied hair, caring for a woman in labour, preparing a bath for the baby and checking the temperature of the water with the palm of her hand [1].



Picture 1. „Birth of the Virgin“ fresco



Picture 2. „Assistant in childbirth“ icon

A hundred years ago, every woman who was preparing to become a mother relied on God’s will in everything, and prayer before giving birth was mandatory. The midwife never continued to help a woman in childbirth without first praying [2].

In 1308, King Milutin founded a hospital and medical school in Constantinople, in the Prodrom Monastery. The hospital had five wards, one of which had twelve beds for gynecological cases [16]. The oldest Slavic therapeutic codex, „Hodoški codex“ (14th or 15th century), contains under serial number 32 the recipe „against rotting (bleeding) of the uterus“, and in the physiological part it has a chapter on conception [16]. Also, the Hilandar Medical Code (13th century) No. 517 devotes a lot of attention to the issues of conception, pregnancy, childbirth, maternity and newborn care [16]. At that time, the term midwife did not have its current meaning, but described the midwife as an evil being who surrounds the woman in labour

and the newborn and wants to kill them; those were childbirth demons - *babice*, *bapke*, *babile*. This led to the emergence of words that have an overtone of danger that threatens the mother and the newborn and denote the time the mother needs to spend in bed after giving birth (40 days) - *babinje*, *babine* (professional term „puerperium”).

One of the major problems of the 20th century was women giving birth at home, and the consequences were high morbidity and mortality of newborns and women in labour. In a patriarchal society, women most often gave birth in rooms isolated from the rest of the household. Mothers in labour could generally expect help during childbirth from experienced women, and much less often from trained midwives [3]. The development of Serbian medieval medicine was abruptly interrupted towards the end of the 15th century, due to the fall of Serbian lands under Turkish rule [4].

The first organized obstetric service in Belgrade dates to 1724, which was recorded in a document entitled „Decree on the Organization of Belgrade“, which also mentions midwives. In 1729, the Austrian military administration asked the Mitropolit (priest title) of Belgrade-Karlovac, Mojsije Petrović, to influence through his priests that „the harmful custom of Serbian women to hide childbirth from their husbands, even from their closest female relatives and neighbors, and to give birth alone, to be eradicated“ bushes, in forests or meadows and remote barns, which often has very bad consequences, both for the mother in labour and for the newborn child“ [4]. The Austrian city administration recorded in 1731 that the midwife Marija Nikolina was employed in Belgrade, then the only Serbian among midwives, who contributed to the development of the midwifery profession. There is no information in the document about whether she was a trained midwife, although the Austrian city administration registered her as a midwife in the public service.

It was only after the end of the Second Serbian Uprising and the partial liberation of the country, during the reign of Prince Miloš, that the first hints of the organization of military and civilian health care began to be seen in Serbia. According to the Law on the Regulation of the Health Professions and on the Protection of Public Health from 1881, municipal midwives are established by district (Article 2 of the Law). The same law established the organization scheme of the modern system of health services and institutions, and under number 3 it was written that the institution for the training of health workers, and the school for midwives.

In the „Decree on the Composition of the State Council and the Duke’s Cabinet“, based on the Constitution of Sretenje from 1835, among other things, the following was ordered: „...Establish schools for surgeons and midwives, local doctors and pharmacists.“ Determine the fees for all of these“ [4]. This is also the first mention of the need to establish midwifery and other schools in the sanitary legislation of the restored Serbia. Soon after the adoption of the new Constitution of 1838, the first laws were published that mandated city municipalities in Serbia: „... to provide and support municipal doctors and trained municipal midwives

at their own expense“ [4]. On that occasion, the Department of Quarantine and Sanitation was established, and the tasks of the department were determined by the Constitution. One of the tasks, number 5, reads: „to appoint educated doctors and midwives“. The so-called medical service The Government of the Defender of the Constitution (1838-1858) laid the foundations for the first organization of the health service in Serbia by preparing a programme to increase the number of doctors, pharmacists, medical assistants, and midwives (item no. 5); by appointing municipal doctors and midwives (item No. 7).

At the suggestion of Dr. Emmerich Lindenmeier, head of the Health Department of the Ministry of the Interior, Marija Malenović took on the responsibility of training midwives without diplomas in Serbia. With her work, she usefully served the people, so the state granted her a pension, and in her place was appointed midwife Eufemija Petković from Sremski Karlovac, who graduated from midwifery school in Pest [4]. The application for a pension of the above mentioned midwife Marija Malenović, called Sadžika, which she submitted in 1845, was used by the then chief of health, Dr. Lindenmayer, to raise the issue of the education of midwives in Serbia. Wanting to improve the health service, he presented a plan that a future graduate midwife, who would be appointed in Belgrade, should take on the responsibility of teaching midwifery skills to all other Belgrade midwives without a diploma, which would undoubtedly be of great benefit [4].

The obstetric service in the part of Vojvodina that belonged to the Military Border was significantly better organized than in the civilian part, the so-called „provincial“. The legal regulations of the second half of the 18th century mandated that only those persons who attended and obtained a diploma in midwifery courses at universities or in special midwifery schools in larger cities could engage in midwifery [6].

The first town midwife in Senta, registered in the local court protocol in 1794, was Dorotheja Gubik. In order to support the work of midwives, assistants were employed, their ability was checked, they could work based on a written proposal of the chief county doctor, but under the threat of corporal punishment, it was forbidden for anyone else to engage in midwifery [7]. City of Vršac had five midwives in 1859, nine in 1869, and 12 in 1881. The Statute of the city of Vršac from 1873 provided for two city midwives who were paid from the city treasury to attend the births of poorer women [28]. The trained midwives in Vojvodina at that time were mostly German, since among the Serbs hardly anyone knew German or Hungarian so that they could be educated in Vienna or Pest. The situation in this regard was not much better in the second half of the 19th century, so this shortcoming of the midwifery service was very well noticed by the then city doctor, Master of Obstetrics and the first head of the maternity hospital in Novi Sad, Dr. Svetozar Maksimović (born 27th of July 1879). He submitted a proposal to establish the „State Institute for the Training of Midwives and Maternity Women“ in Novi Sad. Although this initiative of his was not realized, as the first attempt to establish a midwifery school in the Serbian language in Novi Sad, it is of great importance for the history of medicine in Vojvodina, and especially

for the city of Novi Sad. All the above testifies to the familiarity of the Novi Sad doctors at the time, in modern world medical events, who, within the framework of improving the health care of the population, attached great importance to the care of women in connection with pregnancy, childbirth and midwives. Such progress could not be realized with the numerically deficient and insufficiently professionally educated midwifery staff that existed in Vojvodina at that time [6]. From then on, until the establishment of the midwifery school in Belgrade, we had to wait several more decades.

Doctor Gadeši, who was a physicist in the city of Belgrade, compiled the first „Instructions for Graduated Midwives“ in 1850, according to the then valid Austrian regulations for the regulation of midwifery. The text of this „Instruction“ on 4 pages in 19 points was adopted by the Ministry of the Interior on January 10, 1850. In Belgrade, which at that time had about 15,000 inhabitants, 5 graduated midwives were employed [4].

In 1887, in the first issue of the Serbian Archive for Comprehensive Medicine, the journal of the Serbian Medical Association, an article was published in which the establishment of the „Department for Maternity and Women’s Diseases“ was published in Belgrade. In the same article, it was pointed out that there are practically no midwives in Serbia, and no maternity hospitals, where midwives could be trained, so it posited the need to establish both a maternity hospital and a school. In 1895, the first Gynecology and Obstetrics Department in Belgrade and Serbia started working in the General Hospital in Belgrade, and Dr. Nikola Hadži Nikolić was appointed as its first head. A year later, Dr. Jovan J. Jovanović was appointed to that position. Through his efforts, in Belgrade in 1899, at the Gynecology and Obstetrics Department of the General State Hospital, the first School for Midwives in Serbia was founded, of which he was the manager, and with the help of Queen Draga Obrenović, he managed to build a new hospital building in Vračar in 1902, called the „Queen Draga Women’s Hospital“. Midwifery education in Serbia began in 1899, with the establishment of a midwifery school in Belgrade. It housed the Obstetrics and Gynecology Department of the General State Hospital and the School of Midwives [4]. From 1909, the new sanitary law provided for the establishment of schools outside of Belgrade, at regional hospitals - Zaječar, Valjevo, Niš, Čačak [16].

The beginning of the Balkan Wars of Liberation, and soon after the First World War, hit Serbia hard and stopped its economic, cultural, scientific, and medical development. Under these circumstances, the Gynecology and Obstetrics Departments in Belgrade and Niš, as well as the School for Midwives in Belgrade, ceased to operate as early as 1912. Medical personnel, including all gynecologists-obstetricians, midwives up to the age of 60 and other auxiliary medical personnel were included in the military health system. The gynecology and obstetrics departments in Belgrade and Niš started working again in 1919, and the School for Midwives in 1920 [4].

During the war years (1941–1944), due to the frequent bombings of Belgrade, by the Germans and then by the Allies, the headquarters of the gynecology-obstetrics clinic and other gynecology-obstetrics departments were moved outside of Belgrade on several occasions. A similar fate befell the Midwifery School with a boarding school. In a short time, it completely stopped working, but immediately after the liberation, in March 1945, the work of the school was re-established [4].

The first legal regulations that obliged the health authorities in Serbia to establish a midwifery school in Belgrade „when the conditions are met“ were the „Health Law on the Protection of Public Health“ from 1879 and the so-called „Vladan’s Law“ from 1881, and the first steps that were important for creating a positive public attitude regarding the need for such a school in Serbia and Belgrade were the articles of several doctors, published in the Serbian Archives at the initiative of the Editorial Board of that magazine [4].

Realizing Serbia’s great need for midwives, Dr. Jovanović wrote a „Textbook for midwives“ in 1898, and in January 1899 submitted it to the Main Health Council for evaluation and opinion. Since the textbook was favorably evaluated, Dr. Jovanović submitted a petition to the Ministry of Internal Affairs with a request to open a School for Midwives in Belgrade. On the basis of that petition by the Main Health Council, the Minister of the Interior issued a decision on July 27, 1899, and sent it to the Administration of the General State Hospital with the decision „...to try and temporarily open a school and hold a course for midwives at the Gynecology- to the midwifery department of the General State Hospital in Belgrade, which would admit up to 6 female students with the prescribed qualifications from point 2 of Art. 30 of the mentioned Law“. To begin with, the Ministry determined that the first trial course should last between 8 to 10 months, according to the plan and programme that would be determined by the maternity professor. The signatory of that ministerial act was the then Minister of the Interior, Jevrem Andonović, and that act can be considered an official document that established the first Serbian Royal School for Midwives in Belgrade. In the Decision, it is emphasized that the midwifery course in Belgrade should only be of a temporary, trial nature, but the continuity of teaching, starting in 1899, was not interrupted, so that year can be considered the year of the establishment and start of work of the School of Midwives in Belgrade. The first 6 students successfully completed the course and earned the title of graduated midwife. The first two courses lasted 10 months each, and the next three 9 months each. The students proved their readiness by taking an exam at the end of the course, in front of an examination committee consisting of the president of the Main Health Council, the physicist of the city of Belgrade and the manager of the Midwifery School.

At that time, there was also a change in the curriculum, with the introduction of new subjects (in addition to the main subject „Midwifery“, these were: Basics of human anatomy and physiology, Care of the newborn, Care of the sick, Social protection of mothers and children, Hygiene and sanitary legislation) [4].



Picture 3. Certificate from the Ministry of the Interior that Hristina Milovanović from Zaječar has been appointed as a hospital midwife of Boljevac County Hospital in 1912.

From 1920 to 1927, when the Rulebook for midwifery schools came into force, the courses lasted 10 and sometimes 11 months; later their duration was extended to 18 months [4]. In 1926, there were only three schools for midwives in the old Yugoslavia, namely in Belgrade, Zagreb and Ljubljana, which at first differed in terms of duration of education and curriculum. During 1927, the managers of the aforementioned schools created a joint curriculum, the Rulebook for schools for midwives in the Kingdom of Serbs, Croats and Slovenes (entered into force on June 29, 1927), Instructions for midwives and textbook manuscripts [16]. Students who successfully passed the exam received a diploma and took the oath prescribed by the Rulebook, which reads: „I, N.N., swear by Almighty God, that I will respond to every pregnant woman, woman in labour or midwife, even she is poor or rich, whenever she calls me, that according to the experience gained at school, I will be on her hand and that I will conscientiously perform all the duties that midwives are determined by laws, regulations and instructions. That’s how God helped me!“ [16].

To unify the work in the three then existing midwifery schools in interwar Yugoslavia, in the schools in Belgrade, Zagreb and Ljubljana, several meetings were held between the professors and managers of those schools, Dr. Milan Stajić, Dr. Franja Durst and Dr. Alojz Zalokar, at which it was determined unique material on maternity and the agreed creation of a new common midwifery textbook, which appeared only in 1932 [4].

In the years of the World War II, a generation of schoolgirls completed the midwifery course at the Belgrade Midwifery School in 1941/43. year, and in 1943 another generation enrolled, which would graduate after the liberation in 1945. For the first post-war generation, classes began on September 6, 1945 and lasted until February 28, 1947 [4].

The year 1947 brought significant changes in the midwifery education system. On July 25 of the same year, the Ministry of Public Health published new regulations for the work and status of the School of Midwives, according to which the age limit for female candidates to enroll in the School was moved from 18 to 25, and the requirement for enrollment was to complete primary school. The duration of classes was determined at two school years, the curriculum during the entire schooling consisted of as many as 24 subjects, 6 of which were general education, and the school had the status of a lower vocational school [4].

In 1948, Dr. Milan Stajić, director of the Midwifery school, in cooperation with prof. Dr. M. Ambrožić, published the first post-war midwifery textbook, entitled „Obstetrics - a textbook for midwives and students at midwifery schools“, which, with minor changes, was based on the unique Yugoslav midwifery textbook from 1932. The textbook was quickly sold out, so the authors published a second edition in 1950, printed in Latin, in Belgrade, under the title „Obstetrics - a textbook for midwives and students of midwifery schools“, and already by 1956, a third edition was supplemented, which was called „Obstetrics - a textbook for students of midwifery schools and a manual for midwives“ published by the *Medicinska knjiga Beograd - Zagreb* [4].

Until 1951, female students were enrolled in school after completing elementary school. Then the Council for Education, Science and Culture of the Government adopted the Decision on measures to increase the level of teaching in secondary, vocational secondary schools, Universities, and colleges [16]. It was expected that female students would be between the ages of 18 and 25, but in the absence of such, younger than 18-year-olds had also been accepted. The curriculum was changed to such an extent that all general education subjects were omitted and only the Serbian language subject remained. One foreign language and the subject „Home Economics“ were introduced. The school had the rank of a lower vocational school. At that time, Serbia had six midwifery schools with 230 students [16].

In accordance with the school reform, starting from the 1951/52 school year. In 1953, the School for Midwives in Belgrade was assigned the rank of a secondary medical school under the name „Three-year School for Midwives“, but already in the fall of 1953, it was restored to the status of a two-year lower school. Up until 1951, female students were admitted to the school after completing elementary school, and from the 1951/52 school year, after completing four grades of high school, i.e., at the age of eight. At that time, there were 6 midwifery schools in Serbia with 230 students.

In 1948, the School for Child Caregivers and Midwives („Lower Medical School“) was founded in Valjevo, and the education lasted for one year. In 1949, the Medical School in Valjevo established a department for future midwives, which would later grow from a two-year education to a three-year, thus this school acquires the status of a high school. After six years, this school also stopped working. On July 17, 1958, the People’s Committee of the Valjevo region decided to open the High School of Medicine in Valjevo. It started working in the 1958/59 school year. in Valjevo hospital [25]. On May 10, 1960, the NRS Council for Education and Culture decided that all medical schools, including the School of Midwives in Belgrade, admit female students with at least eight years of schooling and that the education lasts four years [4]. In 1960, at the School for Midwives in Belgrade, an „evening department“ was opened for a two-year duration for requalification, but with previously completed two grades of high school or a similar school [16].

The special engagement of the director of the School for Midwives in Belgrade, Dr. D. Mladenović, indicates that the school performed the activities of a lower and secondary school for midwives and that both are of single composition. The high school rank had not yet been officially recognized. At that time, the third grade was attended by „party leaders“ students who completed that grade on retraining. There were 100 female students in the lower school, and a total of 53 in the third grade in the high school. At that time, the school was a boarding school and out of 153 female students, 73 lived in the boarding school of the lower school, and 25 in the boarding school of the High School of Medicine. The boarding school functioned as a separate body that had its own administration, budget, and teachers (founded in 1951). This is evidenced by the special seal of the boarding school with the name „Boarding School for Midwives“. The school lost its boarding school in 1955 and shared space with the Secondary Medical School. Considering the order on confiscation of teaching premises and school offices, the quality of teaching took place under difficult conditions. The school functions with only two classrooms and two offices in the building of the Physiological Institute of the Faculty of Medicine. In 1956, first graders enrolled in the school, after passing the entrance exam, and admission to secondary vocational schools was done through a competition. That year, the Rulebook on the Admission of Students to Secondary Vocational Schools and the Rulebook on the Duration of the School Year were adopted, which stipulates that student enrollment takes place from September 1 to 3, that the academic year lasts from September 5 to June 20, and that the final year lasts until May 20. Winter vacation lasts from January 16 to February 5, summer vacation begins on July 1 and lasts until August 31, remedial exams are held from August 24 to 31. This Rulebook is almost the same as the Rulebooks that are adopted for each school year and in today’s education [16]. The year 1957 is very significant for the education system in Serbia, because in that year several ordinances were passed that regulate life and work in schools. The Rulebook on the organization and operation of vocational schools with practical training stipulates

that classes could not be larger than 35 students and that for the performance of practical classes were divided into groups of 12 to 18 or 8 to 12 students. Classes lasted 45 minutes. This year, the school continued its fight to extend education to three years. Numerous minutes from the Teachers' Council from 1962 testify to the difficulties of the School for Midwives. That year, due to lack of space, classes were shortened to 40 minutes in two shifts. It was done in two classrooms, in six classes: three classes of the first grade, two classes of the second grade and one class of the third grade. The evening department worked in the fourth shift three times a week for 6 hours. This schedule of classes lasted until moving into the building in Vojvode Milenka Street in Belgrade in 1962. Soon, in 1963, the school moved into the new building of the Gynecology Clinic, where it is still located today [16].

Until 1960, the school had the following name „School with practical training for midwives”, and the students who graduated were of the lower rank of health personnel. The reason for this was the fact that female students were educated for only two years and were only 17 to 19 years old when they finished school. The short duration of education and the youth of female students were considered for the acquisition of such complex and complex knowledge and skills. For this reason, in 1960, a decision was made to enroll female students who had completed primary school in all medical schools and that classes last four years. In June 1960, the School of Midwives became a four-year school. In this way, practical teaching was distributed to all four classes and students had more time for free time and activities. There were changes in the curriculum and the following subjects were included: Physical Education, Serbo-Croatian Language, Biology, Chemistry, History, Physics, Foreign Language, Latin Language, Hygiene, Nutrition with Dietetics, Dermatovenereology, Microbiology, Pediatrics, Pathology, Patient Care, Pharmacology, Infectious Diseases, Mental hygiene, Health education, Administration and health statistics [16].

The training of gynecology and obstetrics nurses at the Medical School in Novi Sad began in 1963, when the School Medical Center was formed. In 1977, the school became an educational institution of vocational education and secondary education and changed its name to a Nursing School „7th April” [26].

From 1966 to 1969, the School for Midwives in Belgrade organized special professional exams „for the acquisition of a higher degree in the same profession“ (3rd class midwives). In 1973, the proposal of the teacher's council of the School for Midwives was that the education should last 5 years [16]. Until 1971, the cooperation between the Nursing School for Midwives and the Nursing School for Children's Health Care, both in the territory of the municipality of Savski Venac, took place within the framework of the cooperation agreement, and then a proposal came from the Nursing School for Children's Health Care for the two schools to integrate. On the twenty-seventh of December 1972, the idea of merging these two schools was realized and their community was named „School

for Nurses and Technicians“. The merger act expresses the common desire of the schools: „... to implement a unified development policy; to unite efforts to implement the curriculum; to rationally use the existing teaching and other staff; to, thus united, rationalize the use of material and financial resources; in joint effort; to better organize the teaching-educational process; to enable easier communication between their schools; to present themselves in a unified manner before the education community and other bodies and organizations in and outside the city...“. In 1974, the integration of the third school that trained physiotherapists took place, resulting in the creation of the Education and Training Center of the Health Profession „Belgrade“ in 1980. The newly created center carried out the activity of secondary directed education according to the plans and programmes of the common basis and according to the plans and programmes for the education and training of personnel for the following professions in health care: midwifery nurse - technician; pediatric nurse - technician; nurse educator; Physiotherapy Technician; physiotherapist technician - major for the blind and partially sighted; dental nurse - technician and dental technician [4].

In 1970/71. it was precisely prescribed that upon completion of the third grade, female students had to complete professional practice at the gynecology-obstetrics departments for two weeks, and fourth grade students for four weeks, after which they were entitled to take the graduation thesis [16].

In 1985, the proposal of the professional asset of the midwifery department of the School of Midwives in Belgrade was to extend the education of midwives to the sixth degree, and then a draft was adopted to rename the professional title from midwife to gynecological-obstetric nurse technician. The purpose of renaming the title of midwife to gynecological obstetric nurse was to expand the competencies for work in gynecological and obstetric departments in health care institutions in all new areas of healthcare [16].

In 1995, the school in Belgrade received the name „Belgrade“ Nursing School, which under the same name still educates students of various educational profiles in the field of health and social care, including gynecology and obstetrics [16].

### **Professional organizations for midwives (associations, federations of associations)**

After the establishment of the School for Nurses in 1927, the Yugoslav Association of Graduated Nurses was founded with its headquarters in Belgrade, which existed until 1939 when the work was interrupted due to the war. The regulation on the work of the society defines that only one association can be registered for one profession for the whole country, that it can be divided into sections by country regions, and that membership is mandatory. The Yugoslav Society of Graduated Nurses was a member of the International Society of Nurses

(ICN) as early as 1927, and had a significant impact on the initiation and resolution of important professional issues, as well as the flow of ideas and information [27].

In the beginning, midwives were members of the Society of Health Workers of Serbia, which was founded in 1951. The association changed its name to the Association of Health Workers of Serbia in 1959. The union was part of the Socialist Union of Working People. Forms of professional work began to develop in 1964, when sections were formed (for midwives, the section for maternal and child healthcare) [10].

The Association of Nurses of Serbia was founded in 1997 on the initiative of twenty nurses and midwives [27]. In the Agency for Business Register of the Republic of Serbia, from the list of registered associations of nurses, midwives, and health workers, 43 associations have an active status. Out of that number, only 14 associations have the word „midwife“ in their name. Today, midwives can be members of unions, associations and associations of nurses and health technicians [9]. Midwives of the Republic of Serbia are not members of the European board of midwives.

### **Magazines**

In 1934, the Yugoslav Association of Nurses published its first issue of the magazine „Sestrinska riječ“, which was printed in Zagreb. In it, the texts of nurses from all provinces and republics could be published. In 1996, the first issue of the magazine „Sestrinska reč“ was published in Serbia, which is still published today. In 2011, the UINARS association launched a scientific journal of professional nursing called „Inspirum“. The magazine publishes scientific and professional articles from nursing, midwifery, medical and applied sciences, which are a source of information about the professional education of nurses and health technicians in Serbia. Today, there is no magazine in Serbia that publishes texts only about midwifery.

## **2. System of education for midwives**

The education reform of 1993 brought changes in secondary professional education in the area of Health and Social Care, which also refer to changes in the midwifery education plan. The plan for general education subjects, which is implemented in secondary vocational schools, becomes common for all educational profiles around Health and Social Protection. In this way, midwives during a four-year education, which begin after completing primary school at the age of 14 and after having previously passed the entrance exam, acquire general and professional education at the same time. The total fund of hours of general education subjects during 4 years of education is 2540 hours. The number of lessons for learning general

education subjects is reduced during education in favor of lessons for professional subjects. In the first grade, students' study 900 hours of general education subjects (74%) and 310 vocational subjects (26%). In the second grade, students' study 630 (52%) hours of general education subjects and 580 (48%) hours of professional subjects. In the third grade, the ratio changes significantly as students study 590 (49%) hours of general education subjects and 620 (51%) hours of professional subjects and in the fourth year of study 420 (38%) hours of general education subjects and 690 (62%) hours of professional subjects [30]. Of particular importance in education are the classes organized in block classes during the working week. This type of continuing education is organized in the maternity hospital in a pool of 30 hours of Midwifery with care in the third grade and 60 hours of Midwifery with care in the fourth grade. The same number of hours of the Obstetrics and Nursing teaching block remains in the teaching and learning plans from 2013. The reform of secondary professional education from 2013 did not bring major changes regarding the pool of professional medical subjects in the field of gynecology and obstetrics. The pool of professional subjects remains the same as in the 1993 reform. The education of midwives ends with the matriculation exam as a professional matriculation exam, which is passed in three parts. One part represents the passing of the native language, the second part of the matriculation exam is the passing of one elective subject that the student chooses from the field of profession or general education subjects and the third part of the matriculation exam is taken as practical work in the clinic and in direct work with patients from the fields of gynecology, obstetrics, pediatrics, and surgery [31]. This kind of matriculation and acquired general and professional education enables midwives to continue their education at all universities and colleges of their choice. The vocational school for midwives does not represent an obstacle for a midwife to continue her education at social, natural sciences, art, and other faculties. The regular education of midwives in the school system begins after completing elementary school at the age of 15. If the student, after the age of 17, expresses a desire to complete midwifery school, there is a possibility of part-time education. This type of education is organized in vocational secondary schools that implement education programmes for midwives. The difference in relation to regular education is reflected in the implementation of teaching, which is organized through special seminars in the class fund of 30% of the planned fund, both for vocational and general education subjects. The teaching of exercises is organized in health care offices and in health institutions, also in a class pool of 30% of the total class pool for one subject. The education of part-time students is realized in a shorter period compared to regular schooling, depending on whether the part-time student continuously attends seminars and takes the examinations provided for each year of education. The matriculation exam is conducted in the same way as for regular students. Today in Serbia, midwives are trained in 11 state secondary schools, and there are no private schools. The theoretical teaching of specialized subjects is carried out by doctors of certain specialties, and in the field of Health

care, teachers with previously completed higher medical school (nurse), higher health school of vocational studies (professional nurse), specializations (teaching methodology, clinical care...) or with the faculty (FASPER, Health Care, Nursing) who also teach exercises.

Higher education of midwives lasted from 1981 to 1987 at the only state school in Zemun. The curriculum raised midwifery education to the level of higher school education for a duration of two years. This highest level of midwifery education could not satisfy the needs of society, nor the profession itself, not only in terms of the number of educated staff, but also in terms of new, significantly higher standards of midwifery. We believe that then a real opportunity to start midwifery education at a high level was missed [17]. Higher education for midwives in our country has been acquired since 2007 in two state schools, there are no private schools [22]. Specialization in midwifery, master's vocational studies in the field of midwifery, as well as a faculty for midwives, do not exist. Basic vocational studies today last three years (six semesters), 180 ECTS points (3615 hours) are acquired, and the title of the qualification is professional nurse-midwife.

### **3. Legal status of midwifery**

In Serbia, the role of the midwife and her activity are defined in the Regulations on the organization and systematization of the work of health institutions and the Regulations for the performance of health activities in health institutions and other forms of health services.

A health center can be established and perform health activities if, in terms of staff in the field of women's health care, there is one nurse - technician with a secondary/higher/high school education for every 6,500 women over 15 years of age. A health center that includes an inpatient and a maternity ward should have seven gynecological-obstetrical nurses [12]. In terms of personnel, there should be 70 nurses - technicians with secondary/higher/high school education for 100 hospital beds of basic and semi-intensive treatment level in a general hospital (50 in patient care and 20 in operating rooms, clinics, offices, etc.). As for private practice, at least one nurse-technician with a secondary/higher/high school education is required [24]. There is no professional regulation for Midwives in Serbia. In the Catalogue of professions in healthcare institutions, it is defined that a midwife and a nurse-technician can work in the same workplace. Data on midwives are presented in the job group together with nurses, not separately [11]. In primary health care, at health centers and in outpatient maternity hospitals, it is defined that the work is performed by a senior nurse - technician/midwife, with a higher education at the first level of professional studies or at basic studies lasting at least two years, that they have passed a professional exam and obtained a work license. A midwife can work in an out-of-hospital maternity ward if she has a four-year secondary

education, a professional exam, and a work license. The same level of education and educational profiles listed above are prescribed for work in secondary and tertiary health care institutions and in institutions at multiple levels of health care.

All the activities of the midwife are related exclusively to the health institution and nowhere is her possible role in childbirth in home conditions mentioned [13]. We do not have a family nurse/midwife in Serbia.

The Chamber of Nurses and Health Technicians of Serbia (KMSZTS) is a professional organization of nurses and health technicians in health institutions and private practice. There is no word „midwife“ in the name of the chamber?! Membership in the Chamber is mandatory for all midwives who are employed, and in accordance with the law, they are registered in the Directory of Chamber Members after completing secondary, or higher education in the health profession and passing the professional exam for health workers. Then they get an identification number and a license. A license is a public document that proves the professional competence for independent performance of healthcare activities in the Republic of Serbia and is issued for a period of seven years. A midwife's license can be renewed if, during the period of validity of the license, in the process of continuing education, she has acquired 140 points through the content of accredited continuing education programmes, related to the professional activity she performs, and for which the license is issued or renewed, while the number of points collected in one year of the license cannot be less than ten [14]. The trade union of nurses and technicians, to which midwives also belong, was founded in 2006, and to this day, the trade union of midwives has not been established as a separate organization.

#### **4. Midwifery in numbers**

The total number of health institutions in public ownership according to the Decree on the Plan of the Network of Health Institutions in 2021 in the Republic of Serbia was 335 (without institutions from the territory of the Autonomous province of Kosovo and Metohija and Military Health Institutions). This number includes health centers and general hospitals located within health centers [18]. In 2021, there were a total of 56,946 healthcare workers with higher and secondary education in healthcare institutions, of which 43,164 (76%) were nurse technicians [18]. In 2021, a total of 5,399 healthcare workers with higher and 22,164 with secondary education worked in inpatient institutions in the Republic of Serbia [18]. According to statistical data, the number of nurses and midwives per 10,000 inhabitants is 60.86, according to which our country ranks 55th in the world out of 194. According to the data of the Chamber of Nurses and Health Technicians of Serbia (KMSZTS) from the register of members for the year 2020, 85,347 were registered. There is no separate data for midwives in this register, which according to some estimates indicates that it is an „invisible“ profession in our country. By

graduating, midwives acquire the professional title of professional nurse - midwife (higher vocational education) and gynecological-obstetrical nurse (secondary vocational education), which is an unrecognized profession in the world (either a medical/gynecological obstetric nurse or a midwife) [23].

## **5. Challenges and prospects**

The profession of a midwife in Serbia requires a completed four-year secondary medical school - gynecology-obstetrics major or a vocational college - study section professional nurse - midwife and who has a license to practice that work.

In the countries of the European Union, a midwife is a person who has completed a midwifery education programme that is based on ICM's essential competencies and the framework of ICM's global midwifery education standards, which is pre-university or higher vocational education. There is a need for harmonization of standards in the education of midwives and accreditation of study programmes of professional master's studies for midwives within the educational system of Serbia, and in the context of the new paradigm of health care, which implies a personalized approach and the concept of self-protection [21]. „One out of every 145 European citizens is a nurse or a midwife“. In Serbia, there is no official data on the age of nurses and midwives because no one has dealt with this analysis, which, in addition to education, should be key in bringing about reform changes in nursing and midwifery in Serbia [19].

As already emphasized, there is no Nursing Development Strategy in Serbia, which should include the real needs for personnel as well as the education plan for nurses and midwives.

When hiring in healthcare institutions, there are criteria for selecting candidates, but nurses and midwives do not have a direct influence on defining these criteria, which is expected from the Nursing Chamber. It is also very important to emphasize that in Serbia there is no Competition, criteria and mandate for the selection of head nurses at all levels, which is defined by very precise rules and regulated in Europe [19].

Higher educational institutions have accredited the educational programmes of specialist studies, but after the realization of the studies, in most cases, midwives are not able to get their rights in terms of recognition of the education by the health institution. After completing specialist studies, midwives acquire the title of specialist vocational nurse-midwife. Why midwifery education is a weakness can be explained in two ways. Primarily, Serbia has an insufficient number of highly educated midwives on the one hand, and on the other, those with completed faculties and specializations do not have an adequate position in health institutions, because the health system „does not recognize“ them. There is no faculty for midwives in Serbia [19].

The scope of work of midwives has not been defined and adopted at the national level.

Protocols of procedures, standards of interventions and guides of good practice in primary and secondary health care are necessary and necessary for the quality and professional work of midwives in Serbia. For member countries, there is a handbook „European Union Standards for Nursing and Midwifery Professions: Information for countries in the accession process“ (World Health Organization 2009).

Health care documentation is not complete, harmonized, unique and applicable in all health care institutions in Serbia, because it is evident that extensive health care documentation is kept in some institutions, while others do not comply fully. Nursing terminology is not aligned with the International Standardized Language of Health Care (ASENDIO ICN). The health care process as a modern work method is not harmonized and adopted at the national level and is done sporadically from institution to institution with modified documentation. Health care documentation written by nurses is legally not an integral part of medical documentation [19].

The participation of midwives in the decision-making process at the levels of health institutions is not adequate to their engagement in the work process as highly educated professionals who participate in the prevention and treatment of the population of all population groups and at all levels of health care [19].

In 1948, the Rulebook on trainee service and professional exams... and mandatory professional development of health professionals was adopted, where Article No. 54 prescribes that: „All doctors, specialist doctors, nurses, midwives... in the health service must undergo mandatory professional training every 5 years. This training was carried out in courses that lasted at least two months [16]. Today this does not exist.

The Health Council of Serbia has 15 members (of which only one member is a nurse, and there are no midwives among the members), and it is elected by the Assembly of the Republic of Serbia on the proposal of the Chambers and educational institutions. Widespread and growing problems call for effective reforms in midwifery.

Suggestions for improving and ensuring autonomy in midwifery can be achieved through the following:

- by introducing the Law on Midwifery and the Law on Health Care,
- Education of midwives at a high level - professional, specialist, master's and PhD studies
- Harmonization of vocational, specialist, master's and PhD education
- by establishing a unique midwifery association at the state level
- Forming a Department in the Ministry of Health of Serbia that would be managed by a midwife
- defining the competition procedure and introducing clear criteria for the selection of the head midwife of the department/clinic at all levels of health care
- continuous monitoring of modern achievements in midwifery

- Define the competencies, responsibilities, and methods of controlling the work of midwives
- By standardizing midwifery services, developing protocols in health care as well as good practice guides
- By adopting unique documentation in health care,
- ensuring the safety of patients and midwives at work,
- conducting research in midwifery
- Dangers and threats to the midwifery profession are:
- Education,
- Institutions of the system (Ministry of Health, Education, KMSZTS, RZZO, health institutions)
- Disunity of midwives - many different associations
- Organized work trip abroad
- Retraining of all existing occupations

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## MIDWIFERY IN SLOVAKIA

### 1. Brief history of midwifery

The role of a midwife in the territory of Central Europe has changed over the centuries depending on the social, cultural, and material conditions of the society. Midwives played an important role in providing health care to women in labour, puerperas, and newborns. Their education included passing on practical professional experience and skills from generation to generation through more experienced colleagues directly in practise. Gradually, it acquired the character of an organized and institutionalized training, supported by the involvement and participation of physicians, who later on took over guarantees for the professional performance. The role of midwives in the then Austrian Empire, which comprised most of Central Europe including present-day Slovakia, was defined by the order of *Ordopolitiae*, issued by Ferdinand I of Habsburg, Holy Roman Emperor, in 1552 [1, 2].

Significant progress was made in 1799 when the first legal order for the provision of health care *Taxa Pharmaceutica* came into force in our territory. This order defined the duties of midwives and the conditions of their practise, which could only be exercised by those who had been trained and tested by medical doctors. Separate official authorisation was required to implement the practise. Midwives were strictly prohibited from performing other healing activities and abortion procedures [1]. Article XIV of the Act of 1876 on the organisation of public health tightened the qualification requirements for midwives. The condition of performance was the diploma obtained by passing a regular course at the university or a special school for midwives. This functional system was taken over by the First Czechoslovak Republic in 1918 [2].

After World War II in 1948, the education of midwives was incorporated into a uniform system of education in vocational schools as higher health schools. In 1965, the study was adapted to 2-year postgraduate qualifications, where applicants of at least 18 years of age with completed secondary education (a school leaving qualification) were admitted. Since 1993, to bring the system closer to the European Union countries, the number of midwifery lessons has increased and the study has been modified to a higher degree study lasting 3 years. Graduates end up as diploma midwives [3].

As part of the European Union integration process, a new requirement for university higher education of midwives was introduced and started in Slovakia in 2003 in the bachelor study programme and in 2011 also in the master study programme.

## 2. System of education for midwives

### *Bachelor's degree university study in Midwifery*

Today, midwifery is a regulated profession, which is due to mandatory criteria laid down in the legal norms (*in the Slovak Republic, Act No. 578/2004 Coll.*), which must be fulfilled by the applicant [4]. These norms define the minimum requirements for study programmes aimed at obtaining the professional qualification of a general nurse. The bachelor study lasts 3 years, the total number of hours is 4600 and the practical part of the education should comprise at least 2300 hours. The Act further specifies the subjects that should be included in undergraduate university education. The theoretical part of education includes all subjects that form the basis for providing general care in midwifery.

The programme, similar to other study programmes provided in the European Union, is based on the European Credit System. This system enables high learning flexibility and can prevent deficit and low effectivity due to non-standard teaching.

Practical training is carried out in primary health care facilities and in clinical settings that meet the given standards. Their compliance is guaranteed by contracts with the University. Practical training is provided according to the schedule of practical lessons under the guidance of the midwife teacher. The duration of professional practise at each workplace is determined by the curriculum, which precisely defines all circumstances to achieve 2300 hours of practical instruction. Practical training also includes a compulsory continuing professional practise that lasts at least 720 hours. Each subject is evaluated with a certain number of credits in the curriculum accordingly with a level of demands related to the subject. The total number of credits for full-time study comprises 180 credits for the bachelor level.

The bachelor study curriculum includes biomedical subjects, midwifery practise, and continuous vocational practise. The study is divided into three stages:

The first phase (1st - 2nd semester, 60 credits) - teaching of essential biomedical subjects and the first stage of teaching of specialised subjects including historical development of midwifery, theory, and models with their specifics in midwifery.

The second phase (3rd - 4th semester, 60 credits) - core of teaching of special subjects in midwifery, practical application of gained knowledge in clinical settings and community facilities focused on physiological pregnancy, birth and puerperium.

The third stage (5th and 6th semester, 60 credits) – further teaching of clinical subjects and practical exercise focused on pathological conditions during pregnancy labour and puerpera. Students also develop and elaborate their final bachelor thesis.

After fulfilling all the obligations defined in the curriculum, that is, successful completion of all subjects and obtaining the required number of credits, a student might take a state examination in midwifery as well as defend the bachelor thesis in

order to complete the study programme successfully. Upon successful completion of the state examination, he/she receives a Bachelor's Degree Diploma. The graduate also receives a Diploma Supplement to provide the necessary information on the study discipline to promote international transparency and to ensure acceptable recognition of further academic and professional qualifications.

#### *Master's degree university study in Midwifery*

In Midwifery in Slovakia, there was no follow-up master programme until 2010. A midwife who received a bachelor's degree in midwifery continued her studies in a master's degree programme in nursing.

The study focusses on gaining theoretical knowledge based on the current state of scientific knowledge and its practical implementation, as well as development of creativity. Currently (2022), a master's degree programme in midwifery is provided in Slovakia at the only university meeting the legislative criteria (accreditation) as a follow-up two-year programme to previous bachelor study. The master's degree programme is provided both in full-time and part-time form of study. Since students already work as midwives, most of them employ the part-time form, which means they study simultaneously with their professional practise. During this programme, students should receive 120 credits.

The Master's degree is characterised by further development of the knowledge and skills gained during the bachelor's study. The content of the study programme is focused on community care and prevention as a response to the Conception of State Health Policy in the Slovak Republic approved in 2008 as the Governmental Resolution (UV 11/2008). The study provides knowledge and skills needed for independent, coordinated, and interdisciplinary work in the given health care system. In addition, students learn to work with scholar literature, both domestic and international. They are also acquainted with the basic principles of scientific work in the field, leading to design, arrange, and implement an uncomplicated research and interpret its results. Great emphasis is placed on the students' ability to synthesise gained knowledge, to interpret it, and to formulate conclusions.

The master's degree graduate should be able to manage midwifery services at various levels of health care, to work as a teacher of midwifery disciplines in various types of school facilities, to participate in dealing with various research tasks, and to apply the gained knowledge and skills in practise to improve the quality of the provided health care.

In curriculum development, utmost importance is placed on the continuation of the preceding study, i.e. its content should not overlap with the bachelor's degree programme.

The master's degree study programme includes both biomedical subjects and continuous vocational practise. The total number of contact hours is 3500. Within them, practical education includes 2560 hours, i.e. 73.1% of total education.

During practical training students deepen their knowledge and practical skills in providing midwifery-led care for clients/patients in healthcare facilities. The community care module includes lessons on pedagogical practise, in which students acquire skills in community facilities (asylum homes for pregnant women and mothers, home care agencies, community maternity centres, and licenced midwives working in the field). The second area of the curriculum is focused on research in midwifery and the research-related issues. Students develop and elaborate their diploma theses. As in all bachelor theses, these include empirical data and their interpretation gained via own research. The topics of diploma theses are usually based on the needs of the practise as well as research activities of the respective teachers. Students retrieve and subsequently evaluate information resources to develop the selected thesis. Furthermore, they assess the methodology aspects of the given research, collect empirical data, and interpret results in the light of findings of other studies, as well as of the theoretical concepts. The master's degree study is completed by the final state examination and the defence of the diploma thesis.

The gradual modification of post-secondary education up to the university level has brought several undisputed advantages from the perspective of the midwives themselves. Theoretical knowledge has deepened significantly, allowing graduates to better penetrate into the essence of the profession. A qualitative change has also been made in practical lessons that have become more focused on supporting midwifery skills and abilities as opposed to the preference for medical knowledge in the past. Compared to the past, experienced midwives are much more involved in the education of midwives than physicians-obstetricians. Graduates with university education have even more prerequisites for establishing their own independent practice, thus creating space for the support of autonomy of midwifery in Slovakia [5].

### **3. The legal status of midwifery**

Midwifery as a scientific discipline and regulated profession is guided by several legal regulations of the Slovak Republic at the level of the Parliament and the Government of the Slovak Republic (laws, government regulations), as well as at the level of the Ministry of Health of the Slovak Republic and the Ministry of Education of the Slovak Republic in the field of nurse education (decrees, professional guidelines, concepts of disciplines, etc.). In midwifery matters, midwives are represented by the self-governing professional organisation, the Slovak Chamber of Nurses and Midwives, which operates throughout the territory of the Slovak Republic. The Chamber was established by Act No 311/2002 Coll. on the profession of nurse, on the profession of midwife, on the Slovak Chamber of Nurses and Midwives of 16 May 2002. It is currently regulated by Act No. 578/2004 Coll. [4]. On health care providers, healthcare

workers, professional organisations in the health sector, and amendments to certain laws.

In Slovakia, we have two basic laws that regulate health care, in general. The aforementioned Act No. 578/2004 Coll. [4]. On health care providers, healthcare workers, professional organisations in the health sector and amendments to certain laws defines concepts such as the scope of practise of midwifery, licences for nurses and midwives. The second important law Act No. 576/2004 Coll. [6] on health care and on services related to health care defines basic concepts such as midwifery, midwifery care, and midwifery practice, it also defines the obligation to keep documentation in midwifery [4, 6]. It should be noted that prior to 2004, these terms were not defined separately in Slovak law. An important document for midwifery that has promoted the autonomy of midwifery in Slovakia is also the Concept of the department of Midwifery No. 10973/2006-OO issued by the Ministry of Health of the Slovak Republic, which deals with the scope of care in the field, the development of care, and the education of midwifery workers [7].

Slovakia joined the EU on 1 May 2004, which was preceded by a ten-year accession process that included significant adjustments to the study and practise of midwifery. The Decree of the Ministry of Health of the Slovak Republic No. 364/2005 Coll. defining the scope of midwifery practise provided by the midwife independently and in collaboration with the physician stipulated that a midwife may only perform physiological childbirth on the basis of a written mandate from a physician. This was unacceptable from the EU point of view, so very quickly The Decree of the Ministry of Health of the Slovak Republic No. 470/2006 Coll was issued, which abolished the restriction of the midwife's competences [8]. Currently, both decrees are replaced by a new document, the Decree of the Ministry of Health of the Slovak Republic No. 95/2018 Coll., which defines the scope of nursing practise provided by the nurse independently, independently based on the indication of the physician, and in collaboration with the physician, and the scope of the practice of midwifery provided by the midwife independently, independently based on the indication of the physician and in collaboration with the physician [9]. This Decree sets out in detail the competencies of the midwife and also establishes four categories of midwife based on education and length of experience. The interventions carried out by midwives are divided into six categories: 1) general interventions, 2) antenatal care of the woman, 3) care of the woman during childbirth, 4) postnatal care of the woman (interventions 1. - 4. Interventions performed by the midwife independently and independently of the physician), 5) interventions carried out by the midwife independently but on the basis of the physician's indication, 6) interventions that are performed in collaboration with the physician and mostly involve assistance in medical and diagnostic interventions.

1. Scope of midwifery practise provided by the midwife independently (general interventions):

- Assesses the midwifery care needs of the woman, family or community, makes nursing diagnoses, plans, arranges for or implements the meeting of reproductive health, gynaecological and obstetric needs, and evaluates the meeting of identified needs,
- ensuring that the woman's safe environment is maintained and that intimacy is protected in the provision of midwifery care;
- arranges and performs activities within the scope of practise of midwifery related to admission, discharge, transfer, dying, and death of a person,
- collaborates with other health professionals on the basis of the midwifery care plan,
- educates the woman, family, and community about prevention, healthy lifestyle, and regimen measures related to midwifery care with emphasis on the person's self-sufficiency,
- recommends the use of over-the-counter medicines, medical devices, and dietetic foods in connection with the provision of midwifery care,
- contributes to the protection, promotion, and development of public health,
- coordinate the work of health care assistants and orderlies and delegate to them the activities arising from their professional competence;
- carry out administrative and documentation activities, issue certificates and reports related to the provision of midwifery care,
- use available personal health records, including electronic records, to implement and document midwifery care,
- assesses the health status or change in health status of the woman and the newborn, measuring the assessment or change in health status using assessment tools and measurement instruments,
- participates in the assessment of the woman's condition by means of a follow-up record or questionnaire in relation to the disease or clinical condition concerned and informs the physician of any deviations detected,
- measures, monitors and interprets numerical data and clinical data on the vital signs of the woman and the newborn and on the physiological functions of the woman and the newborn to the extent necessary for the provision of health care,
- ensures the provision of continuous midwifery care to the woman and the newborn on discharge from an institutional health care facility to the natural social environment;
- manages the hygiene of the environment, including the disinfection and sterilisation of medical devices, appliances, instruments, and equipment used in the provision of midwifery care, and participates in disinfection and sterilisation according to the degree of difficulty,
- recommends further health care within the scope of midwifery care,
- decides on and implements activities related to the provision of midwifery care according to the identified needs of the woman, the family, and the community;

- provides counseling in premenopause, menopause, and postmenopause, recommends alternative treatment in the menopausal period,
- provides mobilisation and nursing rehabilitation for women and participates in the prevention of immobility disorders,
- assesses and treats disorders of skin and mucous membrane integrity,
- ensuring the application of wraps and compresses,
- suction of secretions from the upper respiratory tract and ensuring its patency, suctioning secretions from a person with a blocked lower respiratory tract,
- treats sites of insertion of invasive inputs such as drains, peripheral and central venous cannulas, epidural catheters, ensures and checks their functionality;
- treats all types of stomas,
- indicates bladder catheterisation, performs bladder catheterisation and inserts a permanent urinary catheter in a woman, ensures the functionality of the permanent urinary catheter, inserts a rectal tube,
- examine blood using simple diagnostic equipment,
- administers oxygen therapy, inhalation therapy, enteral nutrition, enemas, and medicated baths,
- monitors and assesses fluid balance,
- performs resuscitation of the person, including the use of an automated external defibrillator and rescue breathing with an anaesthetic mask in emergency care,
- implement preventive measures for women with chronic diseases, physical or mental disabilities to reduce the risk of destabilising health conditions;
- cooperates in practical teaching of students of health professions.

## 2. The midwife in the course of antenatal care independently:

- carries out preventive examinations of women with physiological pregnancy, provides advice on examinations necessary for early diagnosis of a risky pregnancy, and recommends medical care,
- performs examinations using available and appropriate clinical resources, performs pelvic pelvimeter examinations, performs external palpation, stethoscope, and electronic foetal monitor examinations,
- provides information on early diagnosis of pregnancy,
- monitors the progress of physiological pregnancy, identifies risk factors in pregnancy,
- monitors weight, physiological functions, and indicates standard laboratory tests for each week of pregnancy,
- makes and evaluates the cardiotocographic record, informs the physician in case of pathological values and changes,
- performs psychophysical preparation of the pregnant woman for childbirth and supports the pregnant woman and her family in the choice of place and method of delivery;
- carries out educational programmes aimed at preparing for parenthood,
- educates on the proper breastfeeding technique and prevention of complications in breastfeeding,

- educates about the benefits of breastfeeding for mother and baby, identifies at-risk groups of pregnant women who need specific assistance in breastfeeding support,
- informs the pregnant woman about the possibilities and risks of breast milk substitutes.

### 3. The midwife provides care during labour independently:

- Psychologically supports the mother and the accompanying persons,
- monitors the health of the mother and assesses the progress and progress of labour by checking contractions and vaginal examination;
- monitors and assesses the foetal health using a cardiotocograph and stethoscope, foetal doppler or electronic foetal monitor, makes and evaluates the cardiotocographic record, informs the physician of pathological values and changes,
- identifies deviations from the normal course of labour and provides follow-up medical care,
- recommends to the parent the choice of nonpharmacological methods to relieve and manage labour pains and alternative positions used in the management of labour;
- performs physiological labour, including labour requiring episiotomy,
- assess the extent of birth injuries and treat simple birth injuries, except those requiring medical intervention,
- performs the first treatment of the physiological newborn, assesses its state of health, and provides care during the immediate postnatal period,
- ensuring the timely attachment of the newborn to the mother's breast,
- monitor the psychological state and physical condition of the woman in the immediate postnatal period and provide immediate medical care as necessary.

### 4. Midwife in the course of postpartum care independently:

- assesses the health status of the hexuplets and the newborn,
- supports the six-week-old in breastfeeding,
- assesses breastfeeding technique, assesses and records the effectiveness of breastfeeding,
- identifies breastfeeding problems and provides assistance, provides breastfeeding assistance for specific conditions in the newborn,
- assist the woman and educates the woman on newborn hygiene care,
- implements preventive measures for the healthy development of the newborn,
- makes visits to the families of six-week-olds,
- assesses the social environment of the six-week-old and the newborn and suggests interventions.

5. The midwife independently, but on the basis of the physician's indication, performs the following:

- prepares the woman for diagnostic and therapeutic procedures, provides and ensures midwifery care during and after procedures,

- collects biological material such as capillary blood, peripheral venous blood, central venous catheter blood, urine, stool, sputum, scrapings from skin, mucous membranes, body cavities, and wounds,
- dresses and treats wounds,
- removes sutures from a primarily healed wound,
- inserts gastric probes and duodenal probes in cooperating persons, ensures their functionality, administers enteral nutrition, cancels gastric and duodenal probes,
- inserts peripheral vein cannula, withdraws peripheral vein cannula,
- administers parenteral nutrition,
- administers drugs sublingually, orally, rectally, inhalation, topically to the skin and mucous membranes, vaginally, epidurally, intracutaneously, subcutaneously, intramuscularly, intravenously, with the exception of transfusion of blood, blood derivatives as well as contrast media,
- ensuring the management of administrative activities related to the implementation of examinations.

Four categories of midwives.

**Midwife** - has acquired professional competence to perform professional activities in midwifery and performs all activities within the scope of the interventions listed 1 - 6.

**Midwife specialist** - has acquired professional competence to perform midwifery and professional competence to perform special activities. Midwife specialist performs all activities in the range of interventions 1 - 6 and the following interventions:

- Indicates and performs peripheral vein cannula exchange and cancelation,
- administers medical therapy within the dosage range and pharmacological composition based on the physician's indication and after assessing the person's need and evaluating the effectiveness of the treatment.

**Advanced practise midwife** is a midwife who has obtained a first degree in a bachelor's degree programme in midwifery and a second degree in a master's degree programme in midwifery and a specialisation in the relevant field of specialisation and who has acquired at least five years' professional experience in the relevant field of specialisation. Or a midwife who has completed a first-level diploma in a bachelor's degree programme in midwifery and a second-level diploma in a master's degree programme in midwifery or in nursing and who has acquired at least eight years of professional experience. He or she may carry out all activities within the scope of interventions 1 to 6 above, as well as midwife specialist activities and other activities related to the management of the work of the midwifery team, the control of the activities carried out, and other activities such as the indication of the collection of biological material and the training of midwifery students or students of other disciplines.

**Midwife in midwifery practise management**- completed university education in master's degree, speciality in the relevant speciality field, and has

professional experience [10]. She can perform all as in the previous categories, but her work is mainly orientated toward the management of planning, organisation, and control of the implementation of strategic and operational objectives in the field of midwifery [9].

Competence has also been extended to midwives by the Decree of the Ministry of Health of the Slovak Republic No. 89/2018 issuing a list of medical devices that the nurse or midwife is entitled to prescribe. Midwives in Slovakia cannot independently prescribe any medication, but can prescribe some medical devices. The list of devices given in the decree is more orientated toward nurses, but some devices are also necessary for the work of midwives, such as devices for wound care, devices for ensuring a hygienic-epidemiological regime, devices for incontinence of women, etc. [11].

The legal norms in the Slovak Republic allow midwives a relatively broad framework of independent activities; the problem is the inconsistency between the set norms and their application in practise. Many of them are not implemented by midwives in practise at all [12]. The categorisation of midwives allows for better professional and personal development in practise, as well as better and fairer remuneration of the work, further legalises the activities that midwives performed in practise but did not have them included among the legal interventions (cancellation of a cannula, prescription of set medications by a physician, prescription of medical devices, etc.), reducing the large gap between theory and practise [13].

#### 4. Midwifery in numbers

Women have long been the predominant group among health workers in Slovakia, with no significant changes from year to year. The proportion of women in the health professions is 81.3%, in the nursing profession the stable level of women is 98%, and in the midwifery profession it is up to 99.8% of women. The number of health workers in 2020 was 85,626, nurses are the largest group of them (36.9%), then doctors (23.4%) and midwives are only 1.7% of the total number of health workers [14]. The number of midwives in 2020 was 1773, and an overview of the numbers from 2010 to 2021. It is evident from the data that the numbers do not change significantly from year to year, but demand continues to increase as new roles are created where midwives are in demand. The current age distribution for midwives for 2022 is shown in Table 1.

Tab. 1. Age structure of midwives in Slovakia in 2020 [14].

Total	age group									
	22-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
1773	65	165	121	159	165	229	298	315	185	71

There are 0.33 midwives for every 1000 people in the country and 1.3 midwives for every 1000 women of reproductive age [14]. Based on current data from the Slovak Chamber of Nurses and Midwives (SChNM), the actual number of midwives in 2022 with active registration is only 1601, their average age is 52.0 years. Only 131 midwives are licenced to practise independently and 26 midwives work abroad. In 2015, most midwives work in the 50+ age group, a trend that is unlikely to improve, as the retirement of midwives and nurses has long outweighed the entry of graduates into the workforce.

According to the SChNM registry, 44% of midwives have a first or second-degree university degree, 40% have achieved full secondary education and 16% have achieved higher vocational education [15]. About 47% of midwives work in government facilities (hospitals, outpatient clinics) and 53% work in non-government facilities [14].

## 5. Challenges and prospects

However, the Slovak Republic still lacks the third level of structured study in midwifery to be in accordance with the Bologna Declaration (Ministerial Conference in Bologna, 1999; [16,17,18]. To date, midwives have been studying a postgraduate programme in nursing so that they can teach in universities and carry out scientific research in their field, as in most European countries. However, to be a full-fledged field [19] midwifery must have its own third level of university education. In Slovakia, the PhD study system at Jessenius Faculty of Medicine in Martin, Comenius University in Bratislava is currently being created and the proposed study programme is undergoing an accreditation process. This faculty, as the only one in Slovakia, has the prerequisites for accrediting the programme from the teaching and scientific-research base points of view. Successful accreditation of all three levels of education is also associated with the possibility of performing the postdoctoral teaching qualification (habilitation) procedure and the appointment procedure of professors, as well as providing high quality continuous postgraduate education [20]. This would make Slovakia the leader in countries of midwifery education in Central Europe and an inspiring example for other transforming countries in this region.

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## **MIDWIFERY IN SLOVENIA**

### **1. Brief history of midwifery**

Help during pregnancy, childbirth and puerperium was, before the formal organization of midwifery, based on help of older women with their own experience of childbirth. This woman who was usually a senior member of the community was called by lay people »bab'ca« in the Slovenian language. In order to practice midwifery, midwives had to be less than 45 years old, have children of their own, they had to submit a reference of their moral god-fearing character and they needed to know how to read and write [1].

Midwives were respected due to their help with childbirth, but sometimes they were also despised, due to fact that usually midwifery was usually practised by poor women. Since they had a lot of knowledge on how to prevent pregnancies or even terminate it, they were often condemned for witchcraft and persecuted in the middle ages [2]. The first formal regulation of midwifery in Slovenia (in 15th century) was initiated by the church that allowed midwives to baptize babies in cases, where the child might die during the labour. Midwives were also allowed to mediate the couple when entering marriage. The benefit of being a midwife was that they were excused of paying taxes and their husbands were excused to serve a feudal lord [1].

Professional exams were not in use until the 17th century. Until then, midwives were poorly educated. They learnt from senior colleagues. During an apprenticeship the knowledge was passed to younger generations, but also false beliefs and superstitions. There was no formal regulation of their knowledge nor activity [3]; there was no unified tariff for their services. Midwives were usually paid with goods, and they were invited as a guest at the baptism of a child [1].

Midwives worked within the home of their labouring women, therefore they had to be physically strong and capable to walk many kilometres (including in snow) to come in time for the labour. In a case of normal pregnancy, birth and postpartum, they were completely autonomous. Doctors were included only in the case of abnormalities. Midwives were the one who visited woman also during the pregnancy; usually they were quite skilled in correct estimation of the due date. Their major task during birth was to support the labouring woman and to control the contractions in order to estimate the progress of the labour [2].

Members of the occupation had different competencies as nowadays. For example, they were not allowed to perform vaginal examinations (only rectal examinations and Leopold's palpation), but on the other hand they had great jurisdiction in the case of emergency complications (like for example manual removal of the retained placenta). They used different herbal treatments in case of birth dystocia and sometimes even did an amniotomy, however they had to perform it just at the right time to avoid so called "dry birth". Since they were not allowed to use any medical equipment, they did it with their nails. To ease labour pain, they used herbal oil treatments that worked anaesthetically and massaged women with them. Another method was also use of the warm pads, filled with hot oat grains or sand. They most often practised birth on a birthing chair, rarely in a laying position (in this case they always protected the perineum during the expulsion of the baby – nowadays we would say that they practiced hands-on technique). If needed, they also performed an episiotomy (usually medial). After the birth they sutured the perineal injury with bee-waxed hemp thread; stiches were removed after 7 days on one of their regular postpartum visits that were also done exclusively by a midwife. A midwife had an assistant (usually a younger midwife who was still learning). Assistants had less responsibilities and worked under the supervision of the senior older colleague. Her task was helping the midwife during the birth and to perform newborn care. Every midwife was obliged to train two assistants during their career [1].

In 18th century the first formal regulations and instructions for midwifery work that had the nature of laws were created. Austria was the first state in Europe that developed health law and also included midwives into it. The authors were medical doctors. These rules defined midwifery scope of practice and how the professional title could be obtained (more about that is described under the subheading regarding history of midwifery education). The new rule was that midwives who worked in the community had to do a theoretical exam, that was performed by a local obstetrician. If they passed it, they had to take a Midwifery Oath, swearing that they would practice in accordance to ethical standards and in benefit/health of women and babies [1].

With the establishment of a formal school for midwives (from 1753), there was a tendency that this would become the only career path to midwifery. Midwives who graduated from this school, were employed in the maternity hospitals that began to be established at the same time. Midwives who gathered knowledge via apprenticeship were not allowed to work anymore; from 1812 also, local obstetricians lost the right to question them and award them the professional title [4]. From this point community midwives were stamped with a bad reputation; they were derogatively named "*mazačke*". With this designation, medical society wanted to raise doubt at their competencies, despite that they were still highly valued by the communities they served. This path to a midwifery profession slowly died out. The midwives who practised for generations in the community did not pass their knowledge and skills on to anyone, therefore a lot of midwifery tricks and traditions were forgotten. Midwives in the midwifery school were taught by

obstetricians and the maternity hospitals were led by medicine. Despite the benefit of an academization of midwifery, midwifery slowly lost its autonomy. Midwives who worked in schools were named by obstetricians and took care of practical training in maternity hospital. With the disappearance of midwives who worked in the countryside, home births also disappeared for a long time.

The decline of home births was especially obvious after World War II. In 1920 only 3,2% of women gave birth in the maternity hospital, in 1950 the rate was 38%, in 1960 80% and in 1969 almost all women (99,7%). In correlation with these proportions also number of terrain midwives was lowering; from 472 in 1952 (from altogether 564), the number dropped to 52 (from altogether 567) in 1969 [5]. The birth as a social event when performed at home, had become in 19th and 20th century more and more controlled and medicalized; with this the role of the midwife in hospitals, that were led by medicine, was more and more subordinated. The good aspect however was that their role spread also to preventive measures; they started with active health education of mothers to preserve the health of the families.

In 1920 midwives established a professional association whose main aim was the development and professionalization of the midwifery occupation. The main action to foster new knowledge among members was the establishment of a professional journal in 1929 that was regularly issued until 1968. The Midwifery association joined with Nursing chambers in 1976, but midwives were still preserved as their own professional section. In 1999 the midwifery section, under the umbrella of the Nursing chamber, joined International Confederation of Midwives (ICM) and in 2000 European Midwifery Association (EMA) [6]. A working group from the Midwifery section was also the author of a Midwifery code of ethics that was issued in 2011.

## **2. System of education for midwives**

### *Historical overview of education for midwives*

The Faculty of Health Sciences is part of the University of Ljubljana and the youngest faculty of the University of Ljubljana. Health education has a long tradition in Slovenia. Higher education began in 1954 with the establishment of three colleges: Nursing College of Ljubljana merged with the College of Physiotherapy and the College of Radiology to form the College of Health Professions, which became part of the University of Ljubljana in 1976. In 1993, the College of Health Professionals was transformed into the University College of Health Care and in 2009 into the Faculty of Health Sciences. In 1996, higher education for midwives began in the following field of study: nursing - gynaecology and obstetrics. Midwifery education has a long history in Slovenia, and one can speak of a true midwifery profession - midwifery - only when midwifery schools were established, as this was the only way to train candidates. Midwifery schools were established

in the Slovenian provinces during the reign of Empress Maria Theresa (1717-1780), who invited the Dutch physician Gerhard van Swieten (1700-1772) to Vienna in 1745 to improve the outdated health care system in Austria. Gerhard van Swieten founded four midwifery schools in the Slovenian provinces: The first midwifery schools were founded in Ljubljana and Klagenfurt in 1753, in Graz in 1759, and finally in Trieste in 1827. The midwifery school in Ljubljana was an important cultural and political event for Slovenes and represented an important step in the acquisition of expertise and the professionalisation of the midwifery profession, while at the same time it laid the foundation for the development of obstetrics and gynaecology in Slovenia. After 1924, the Midwifery School in Ljubljana remained the only Slovenian midwifery school that trained midwives for a relatively large area in what was then Slovenia [3]. Due to the need in health care, the Secondary Medical School in Maribor introduced training of nurses in obstetrics and gynaecology in 1962, which ended with the 1981/82 school year [7].

The School of Midwifery has the longest tradition in medical education in Europe, having been in continuous operation for 228 years. It was abolished with the passage of the New School Reform and Guided Education Act in 1981. The last generation of nurses and midwives, who entered the four-year secondary school in 1980/81, graduated in June 1984. The school, which had always taught in Slovenian and which, with its trained staff - the midwives - watched over the lives of Slovenian mothers and children and thus influenced national consciousness, ceased to exist [8]. In 1991/92 and 1992/93, the Higher School for Health Professionals (now the Faculty of Health Sciences) offered specialisation training for nurses, who received the professional title of Senior Nurse, Specialist in Obstetric Nursing. The School of Midwifery was important not only for the training of the midwifery profession, but also for the preservation and strengthening of the Slovenian language. At that time, the most important study materials were textbooks written by obstetricians in Slovenian, and it was also the first organised medical school in Slovenia to offer education in Slovenian [9] in 1996/97, after midwifery education had been discontinued in Slovenia for fifteen years, midwifery education was reintroduced at the Faculty of Health Sciences in Ljubljana with the introduction of a new course of study degree programme for higher professions in the following field of Nursing - Gynaecology and Obstetrics, which was the first midwifery education in Slovenia at the university level.

In the period of accession to the European Union (EU), midwifery in Slovenia has received special public recognition. In Europe, midwifery is one of the regulated professions protected by special laws, and member states joining the EU have committed to include midwives in the health care system as independent professionals for normal pregnancy, childbirth and postpartum. With Slovenia's accession to the EU, midwifery education was radically transformed, separating from nursing and becoming an independent discipline. Another important step was taken in March 2009, when the University of Health Sciences was transformed into a Faculty of Health Sciences (Figure 1).



Figure 1. Different levels of midwifery education in Slovenia

### *Higher professional study programme field Nursing-Obstetrics and Gynaecology, 1995/96*

First-cycle professional higher education study programme Midwifery in Slovenia was introduced in the academic year 1995/1996 at the Faculty of Health Sciences of the University of Ljubljana. The study programme was based on principles consistent with the World Health Organisation definition of the role of the registered midwife.

Enrolment conditions: Anyone who has passed the final exam in any four-year secondary school, vocational mature or general mature may enrol in the professional higher education study programme Midwifery [9, 10].

Duration of studies: The undergraduate degree programme in midwifery lasts three years.

Study Programme: The study programme included 2,250 hours: 1,047 hours of lectures, 998 hours of tutorials (clinical, seminar, laboratory and practical) and 205 hours of seminars. The curriculum included 24 subjects. In the first year, the emphasis was on the basic subjects (anatomy, physiology, pathology, microbiology with parasitology, etc.), which formed the basis for understanding the clinical subjects. Emphasis was placed on the following subjects: nursing, obstetrics, gynaecology, neonatology, nursing home nursing, and home pharmacy nursing. Supervision and introduction to personal development were included in the third year. This was followed by a one-year internship for graduates.

Completion of studies: the final examination consisted of a practical part, a written examination and an oral defence before a committee. Upon graduation, students were required to participate take part in an apprenticeship programme and take a professional examination before the Ministry of Health.

Professional title: upon graduation, the graduate is awarded the professional title *diplomirana babica* (VS) or *diplomirani babičar* (VS) (professional degree), abbreviation: dipl. bab. (VS). The professional title is in accordance with the Professional and Scientific Titles Act (Official Gazette of the Republic of Slovenia, No. 47/98; 3349), published in the Official Gazette of the Republic of Slovenia, No. 22/99; 2441.

### *European Higher Professional Degree Programme in Midwifery, 2004/2005*

Midwifery education in the European Union is related to what the EU has defined as “mutual recognition of professional qualifications in health care.” Due to the requirements of the European Union for the renewal of curricula, we

have assessed the state of midwifery in Slovenia with the help of EU experts for the recognition of the professional activity of qualified midwives and made some suggestions and comments on education, the professional association of midwives and the general situation of midwifery in Slovenia. The European Higher Professional Degree Programme in Midwifery was approved by the Council for Higher Education of the Republic of Slovenia on December 5, 2003.

Enrolment conditions: Anyone who has passed the final examination of a four-year secondary school, vocational mature or mature may enrol in the professional higher education study programme Midwifery.

Duration of studies: The first cycle professional higher education study programme Midwifery lasts 3 years (6 semesters) and comprises a total of 180 ECTS credits.

Study programme: the main change compared to the previous programme is the increase in the number of hours from 2,250 to 4,600 over the three years of the programme (mainly the increase in the number of internship hours) and the consequent elimination of internships. It includes 1,290 hours of lectures, 265 hours of seminars, 695 hours of tutorials, and 2,350 hours of clinical practise. The curriculum includes 16 modules (with 39 subjects).

Completion of studies: the requirements for graduation are a practical diploma examination (in the delivery room) and a final thesis, which the student prepares in the form of a written paper under the supervision of a mentor. Upon completion of formal education, which culminates in a diploma, students also receive a licence to practise medicine - a first for the programme - and are entered into the Register of Midwifery Professionals of the Chamber of Health and Midwifery.

Professional title: upon graduation, the graduate is awarded the professional title *diplomirana babica* (VS) or *diplomirani babičar* (VS) (professional degree), abbreviation: dipl. bab. (VS). The professional title is in accordance with the Professional and Scientific Titles Act (Official Gazette of the Republic of Slovenia, No. 47/98; 3349), published in the Official Gazette of the Republic of Slovenia, No. 22/99; 2441.

*Current education for midwives in Slovenia - undergraduate system of education (Bologna Higher Professional Degree Programme in Midwifery, 2009/2010)*

Before the introduction of the Bologna system, European degree programmes varied in content and structure, making them difficult to compare. The creation of a uniform structure for higher education in Europe has significantly increased transparency and comparability. This also makes it easier to compare and recognise qualifications, both for further study in another European country and for finding a job in the European labour market. The Bologna Higher Professional Diploma in Midwifery was first introduced in 2009/2010. In redesigning the curriculum, the programme developers opted for a 3+2 model, as is common in some European midwifery programmes [11]. The degree programme includes courses and measures

prescribed by the European Union's sectoral directives. The internship component of the degree programme replaces the abolished practicum. The study programme at the bachelor's level follows the Directive of the European Parliament and of the Council (2005/36/ EC) and Directive (2013/55/EU).

Enrolment conditions: Anyone who has passed the final examination of a four-year secondary school, vocational mature or general mature may enrol in the professional higher education study programme Midwifery.

Duration of studies: The first cycle professional higher education study programme Midwifery lasts 3 years (6 semesters) and comprises a total of 180 ECTS credits.

Completion of studies: in order to complete the studies, the student must fulfil all obligations related to all compulsory and elective subjects and acquire 180 credit points.

The Diploma Thesis subject, which includes the practical diploma examination (in the delivery room) and the preparation of the final thesis (under the supervision of mentor), is the last subject of the programme. Upon completion of formal training, which culminates in a diploma, students also receive professional licensure and are entered into the Register of Midwifery Professions at the Chamber of Health and Midwifery. Graduates receive the title of "registered midwife" when they receive the registration certificate from the Slovenian Nursing and Midwifery Association.

Professional title: upon completion of the programme, the graduate is awarded the professional title *diplomirana babica* (VS) or *diplomirani babičar* (VS) (professional degree), abbreviation: dipl. bab. (VS). The professional title is in accordance with the Professional and Scientific Titles Act (Official Gazette of the Republic of Slovenia, No. 47/98; 3349), published in the Official Gazette of the Republic of Slovenia, No. 22/99; 2441.

#### *Bologna Higher Professional Degree Programme in Midwifery in the process of renewal (2018)*

The University of Ljubljana is the largest and oldest higher education and research institution in Slovenia. It is a comprehensive university with 23 faculties and 3 art academies. The first degree programme in Slovenia (regardless of the field of study) lasts 3 years (6 semesters) and includes a total of 180 credit points according to the ECTS system (European Credit Transfer System).

At the Faculty of Health in Ljubljana, the only first-cycle degree programme for midwifery in higher professional education in Slovenia is established. After completing the first cycle of midwifery studies, students can continue their education in other relevant master's programmes, but also in programmes of related disciplines after passing differentiation exams. Currently, there is no master's degree programme in midwifery in Slovenia.

The first cycle of the midwifery degree programme in Slovenia is currently undergoing a major overhaul and will be transformed into a four-year university degree programme for midwives. An important innovation of the new, renewed

university programme is the division into theoretical and practical semesters, which will give students more time for in-depth study and continuous practical training in various obstetric clinics in Slovenia.

*Vision for the development of the postgraduate course for midwives*

The global goal of midwifery education is to develop and implement high quality midwifery education (at levels 1 (midwifery higher education), level 2 (midwifery master's degree), and level 3 (midwifery doctoral degree) that is designed to meet the needs of women and their families and to provide continuous, holistic midwifery care. In midwifery, we desire highly qualified personnel who will ensure the scientific and ethical principles of beneficence and autonomy in prenatal, perinatal, and postnatal health care. In response to employer needs and the increasingly expressed desire of graduates to expand their knowledge and skills (including those directly related to their profession), a working group of faculty and midwifery faculty members has begun preparing a stand-alone Master of Midwifery degree in the 2020/21 academic year, consistent with the Bologna system.

### **3. The legal status of midwifery**

Midwifery is an important component of Slovenian health care system which is accessible to all and is based on universality, solidarity, equality, fair financing, and safety of healthcare. According to assessments by the World Health Organisation (WHO) and Organisation for Economic Cooperation and Development (OECD), the healthcare system in Slovenia is among the best functioning systems in Europe [12].

The legislative and regulatory framework for the health care system in Slovenia has begun with the Constitution of the Republic of Slovenia in 1991 which defines fundamental rights related to health: the right to health care, freedom of choice in family planning and the right to a healthy living environment. The legislation is harmonized with that of the EU and applies nationally. The Slovene health care system is organized across the national and local (municipal) levels of government (Figure 2) [13].

Slovenian healthcare consists of the primary, secondary, and tertiary level. Midwives can work at all three levels. On the primary level they work in primary healthcare centres, on the secondary level they can work within the specialist ambulatory outpatient and hospital inpatient care, and the tertiary level at clinics, clinical institutes, or clinical departments and other authorised healthcare institutions [12].

In Slovenia statutory social health insurance provides universal coverage for a broad benefits package. With a single public insurer, it provides almost universal coverage for a broad benefits package. In tandem, high levels of co-insurance have resulted in extensive uptake of complementary, voluntary health insurance [13].

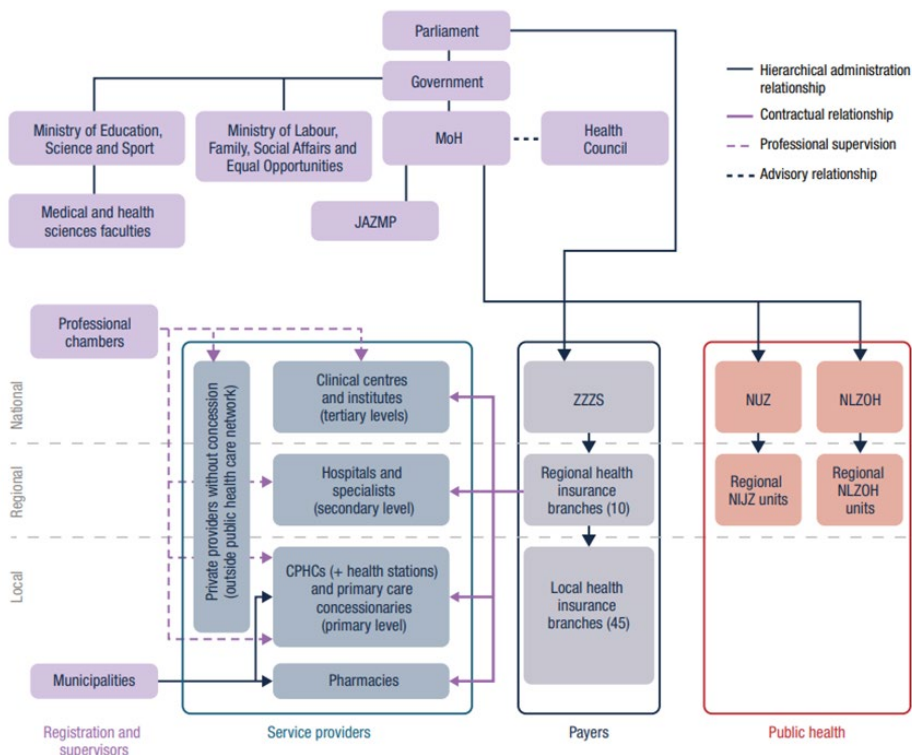


Figure 2. Organization of the Slovene health care system

The insured persons can implement their rights deriving from compulsory health insurance at institutions or surgeries that operate within the framework of the public health care service [14]. Therefore, all midwifery medical needs offered in public healthcare system are covered by statutory social health insurance and voluntary health insurance.

Health care providers are categorized as individual (e.g., midwives) or institutional providers (e.g., hospitals and rehabilitative centres). The scope of practice of a registered midwife in Slovenia is defined in Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013 amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) [15].

The conditions for qualification for the independent work of graduated midwives are laid down in Health Activity Act [16]. They can work independently (in public or private sector), if they completed an appropriate first-level study programme of at least three years' duration and may be additionally expressed with equivalent ECTS credits and comprising at least 4,600 hours of theoretical and clinical education or training, where the duration of theoretical education

represents at least one third and the duration of clinical training at least half of the minimum duration of training. This is described in detail in the chapter System of education for midwives.

The professional competences defined in the list of health professionals for a graduated midwife are consistent competences defined in Directive 2013/55/EU and broadly summaries the definition of competences according to the International Confederation of Midwives. In Slovenia midwives can 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.

A graduated midwife may also carry out the activities referred to in the preceding paragraph at the patient's home under conditions which are determined by the Minister of Health [17].

The competences and professional activities in midwifery for Slovenian midwives are based on International Confederation of Midwives Essential Competencies for Midwifery Practice which outline the minimum set of knowledge, skills and professional behaviours required by an individual to use the designation of midwife but with specific highlights and adjustments for Slovenia [18].

Individual health care providers are regulated by professional chambers. According to the regulations in force, all midwives in Slovenia must be entered into the record and hold a valid license to practice independently. This is specified

in a document titled Order on the list of health professionals who must be entered in the register and have a valid license [19]. The Nurses and Midwives Association of Slovenia has national regulatory authority for the field of nursing and midwifery over the registration and licensing of nurses, midwives, health care technicians, and caregivers. Their role is to maintain the national register and at the same time they are responsible for granting, renewing and revoking licenses to nurses and midwives. They also carry out professional supervision in the field of midwifery, namely supervision of professionalism, quality and safety at work and plan specializations and specialist exams for midwives and, in agreement with the Minister of Health, adopt regulations [20].

The medical and midwifery profession advise against giving birth at home, as they believe childbirth at home is less safe than childbirth in the maternity hospital for both the mother and the newborn.

However, there is a small number of midwives who have the authorization of the Ministry of Health to carry out medical activities in the field of midwifery care in patients' home. They are suggested to follow the Professional Guidelines for Planned Homebirth. The document Professional Guidelines for Planned Homebirth was prepared by the Working Group of The Nurses and Midwives Association of Slovenia in cooperation with the Association for Perinatal Medicine in spring 2017. The document thus prepared served as the basis for the work of the Working Party on the preparation of the proposal for the legal and organizational regulation of homebirth, appointed by the Ministry of Health of the Republic of Slovenia [21]. This independent home birth midwives who are working in private practice are unfortunately not contracted with The Health Insurance Institute of Slovenia. Nevertheless, for the past few years they are struggling to change and update the current system of concessions to be reimbursed for their services.

Midwives are joined together with nurses in the extended professional college for nursing care and midwifery which is the highest professional body in an field of nursing and midwifery. The professional college coordinates the proposals of clinics, professional associations and chambers, higher education institutions, medical institutions, and individual experts [16].

We would like to highlight a weakness in the legal status of midwifery in Slovenia, as well as the lack of influence on health care culture and politics, midwives in Slovenia still lack national midwifery legislation to define their scope of practice [22].

#### **4. Midwifery in numbers**

Slovenia aims to maintain and strengthen public health, within which health care providers seek to act in the public interest for the benefit of its 2,081,000 residents in a non-profit way. Here are some important data for Slovenia when you put the country on the map of the European Union and the worldwide: GDP is

\$44,000 in 2021 (\$47,000 in OECD) [25]; health spending 2,060 euros per capita; human development index is 0.918, ranking Slovenia 23rd out of 191 countries [25]; Gini index<sup>1</sup> is 24.3 (2019) [26].

Table 1. Key indicators in 2019 (European Perinatal Health Report 2015-2019) [27].

Country	Total births	Stillbirth per 1000 total births		Neonatal mortality per 1000 live births		Preterm birth	Caesarean section
	N	>=24 weeks	>=28 weeks	>=22 weeks	>=24 weeks	% of live births	% of total births
Austria	84 429	2.7	2.2	1.7	1.3	7.4	30.0
Belgium	117 663	4.4	3.2	2.6	2.1	8.1	21.5
Croatia	36 635	4.0	3.2	3.0	2.2	6.5	26.2
Cyprus	9 799	4.7	3.2	2.0	1.7	11.3	53.1
Czech Republic	112 633	3.2	2.7	1.6	1.3	6.9	24.5
Denmark	60 779	2.2	1.9	1.6	1.1	5.9	20.3
Estonia	13 900	1.8	1.7	0.9	0.8	5.7	19.4
Finland	45 866	2.4	2.0	1.4	1.2	5.3	17.9
France	714 335	3.6	2.8	--	--	6.9	20.9
Germany	763 946	3.4	2.7	--	--	8.1	31.8
Hungary	89 573	4.3	3.7	2.2	2.0	8.3	41.5
Iceland	4 452	3.2	2.5	0.5	0.5	6.6	16.6
Ireland	59 592	4.0	2.9	2.3	--	6.8	34.8
Italy	422 184	2.7	2.2	1.7	--	7.5	33.0
Latvia	18 703	3.7	3.2	2.3	1.8	5.6	22.5
Lithuania	24 796	4.0	3.3	2.4	2.1	5.3	20.9
Luxembourg	7 208	3.2	2.0	--	--	7.0	30.4
Malta	4 455	3.2	2.5	4.3	3.8	7.4	31.9
Netherlands	164 291	3.1	2.3	3.0	2.1	6.5	17.4
Norway	55 214	2.5	2.0	1.2	1.1	6.1	16.4
Poland	374 978	2.9	2.3	2.7	2.2	7.2	44.4
Portugal	87 319	2.9	2.3	--	--	8.0	--
Slovakia	57 401	4.2	3.5	--	--	7.2	30.1
Slovenia	19 256	2.0	1.4	0.7	0.6	7.2	21.9
Spain	361 749	3.0	2.5	2.1	--	7.1	25.7
Sweden	116 082	3.0	2.5	1.3	1.0	5.4	18.2
Switzerland	86 368	2.8	2.3	2.4	1.4	6.8	--
UK: MBRACE	717 654	3.3	2.5	2.2	1.7	7.8	--
UK: England and Wales <sup>1</sup>	641 808	3.5	2.6	2.7	1.4	7.8	--
UK: Northern Ireland <sup>1</sup>	22 641	3.5	2.7	3.3	2.8	7.5	32.7
UK: Scotland <sup>1</sup>	48 876	3.3	2.7	1.7	1.4	8.6	35.5
UK: Wales <sup>1</sup>	28 994	4.2	3.1	--	--	8.0	28.3
Median		3.2	2.5	2.1	1.5	6.9	26.0
Interquartile range		2.8-3.8	2.2-2.9	1.5-2.4	1.1-2.1	6.4-7.4	20.7-32.1
Range		1.8-4.7	1.4-3.7	0.5-4.3	0.5-3.8	5.3-11.3	16.4-53.1

<sup>1</sup> The Gini index measures the area between the Lorenz curve and a hypothetical line of absolute equality, expressed as a percentage of the maximum area under the line. Thus, a Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality.

The main data on midwives, midwifery, and the contribution of midwifery to women's health in Slovenia are based on national (Nurses and Midwives Association of Slovenia (NMA), Ministry of Health) and international sources. In the 32 countries that provided data for the European Perinatal Health Report 2015-2019, some important key indicators were presented (Table 1). In Slovenia, a total of 19 256 births were recorded in 2019, with 1.4 stillbirths ( $\geq 28$  weeks) per 1 000 total births, which is the lowest rate among all EU countries, and a neonatal mortality rate of 0.6 ( $\geq 24$  weeks) per 1 000 live births, ranking Slovenia second after Iceland (0.5 per 1 000 live births). The caesarean section rate was 21.9% in 2019 (range, 16.4% to 53.1%). The rate of spontaneous vaginal births was 75.3% and the rate of vaginal operative births was 2.8%.

The NMA document *Analysis of the labour market and the proposal for policies and measures of the health resources strategy in the nursing and midwifery* was prepared in June 2021 at the invitation of the Ministry of Health, which asked for data and proposals to prepare an analysis of the labour market situation for the development of a human resources strategy in the health sector. Although health care providers (employers) identify the shortage of nurses and midwives as one of the most important health care issues that will be more urgent in the future due to the changing health care needs of the population, the retirement of nurses, the migration of Slovenian nurses and other professionals abroad, and the introduction of a long-term care system, we do not consider this problem solved yet. NMA's suggestions and comments on the Recovery and Resilience Plan were not taken into consideration and the plan was adopted by the Government of the Republic of Slovenia on January 28, 2021. The government should immediately start preparing a national analysis of labour market activities in nursing and midwifery, which must involve all key stakeholders and is the last opportunity to develop a strategy and a systemic approach to ensure an adequate number of nursing and midwifery care providers [28]. For the strategy to be successful, it is not enough to increase the number of nursing and midwifery caregivers in secondary education programmes and universities, but it is also necessary to improve working conditions in nursing and midwifery, reduce the burden on staff, invest in human resources, ensure adequate pay, and accept appropriate policies and strategies to implement them.

The neglect of initiatives to increase enrolment is already evident in educational planning, as the number of enrolment spaces does not meet the health care needs of women and families. In Slovenia there is still only one university that can provide tertiary and EU regulated education for midwives. Data on the number of graduates in midwifery higher professional degree study programme (Table 2) for 2017, 2018, 2019, and 2020 show a decline in already very low graduation rates. Midwives not only work in hospitals and university clinics, but also perform health screenings during pregnancy under the Public Health Act [29].

Table 2. Number of graduates in midwifery higher professional degree study programme (Tertiary education at the bachelor's level) [28].

Year of graduation	Public study programme	Number of graduates
2014	Midwifery	6
2014	Midwifery	20
2015	Midwifery	5
2015	Midwifery	16
2016	Midwifery	6
2016	Midwifery	26
2017	Midwifery	38
2018	Midwifery	37
2019	Midwifery	33
2020	Midwifery	32

In addition, midwives are part of the gynaecological team for prevention programmes, for the protection of reproductive health at the primary and secondary levels and are members of the neonatal team. According to the midwifery competencies [18] they will continue to actively participate in the implementation of midwifery care in the postnatal period and provide family and newborn care in the first 4 weeks.

The NMA is the national regulatory body for nursing and midwifery, responsible also for the registration and licencing of nurses, midwives, health care assistant and nurse practitioners. As of 12/1/2022, there were 1008 midwives (999 female, 9 male) on the national registry (Table 3). The data show the generational gap that occurred between 1984 and 2000, when there was no training for midwifery as a profession. The largest generation of midwives with secondary education will retire in the next three years. There will be a huge shortage of midwives in all areas of health care.

Table 3. Number of midwives in Slovenia [28]

Age	Midwives (secondary school)	Graduated midwives (male and female)
20 - 30	0	191
31 - 40	0	234
41 - 50	2	153
More than 50	427	1
<i>Total</i>	429	579

Globally, nurses and midwives represent the most numerous categories of health care workers in almost all OECD countries. The key role they play in providing care in hospitals, long-term care facilities, maternity services, and the community was again underscored during the COVID 19 pandemic. In 2019, there

was an average of nearly nine nurses per 1 000 population in OECD member countries (Figure 3). Between 2000 and 2019, the number of nurses per capita increased in almost all OECD countries, and the average increased from 7.0 per 1 000 population in 2000 to 8.8 per 1 000 population in 2019. The number of nurses includes both those who provide services directly to patients (“practicing” nurses) and those who, in some cases, work as managers, educators, or researchers. In countries where nurses may have different skill levels or functions, the data include both professional nurses who have higher levels of education and perform more complex or skilled tasks, and associate professional nurses who have lower levels of education but are still recognised as nurses. Health care assistants (or nursing aides) who are not recognised as nurses are excluded. Midwives are excluded except in some countries where they are recognised as specialised nurses or for other reasons (Australia, Ireland, and Spain) [30].

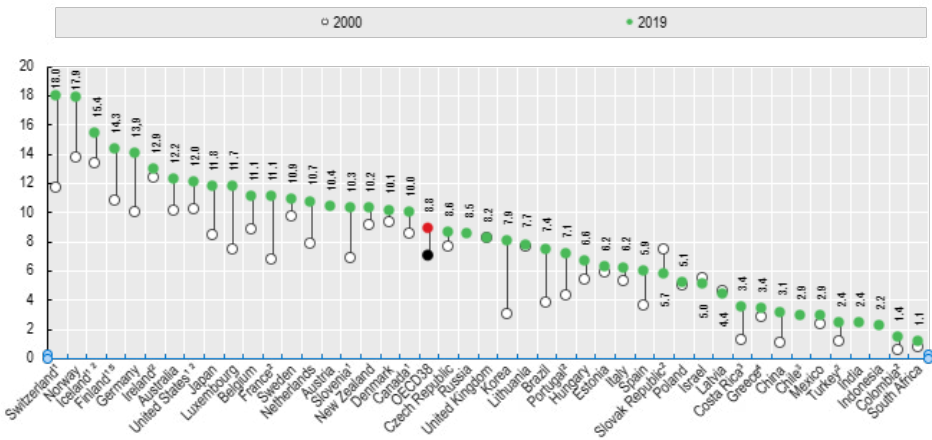


Figure 3. Practicing nurses per 1 000 population, 2000 and 2019[31].

According to the OECD indicator definition, nurses are all “practicing” nurses who provide direct health care services to patients, including self-employed nurses. This indicator is measured per 1 000 population. However, for some countries (France, Ireland, Italy, the Netherlands, Portugal, Slovakia, Turkey, and the United States), in the absence of comparable data, the data correspond to “professional” nurses, including nurses working in the health sector as managers, educators,

<sup>2)</sup> Associate professional nurses with a lower level of qualifications make up about two thirds of nurses in Slovenia; about one third in Switzerland, Iceland, Finland and Canada; and about 18% in the United States. In Switzerland, most of the growth since 2000 has been in this category. Data include nurses working in the health sector as managers, educators, researchers and similar. Data include all nurses licensed to practise. Data only refer to nurses employed in hospitals (OECD Health Statistics 2021).

researchers, etc. Some countries, such as Slovenia, include midwives because they are considered specialized nurses. Accordingly, there are 10.5 nurses/midwives per 1,000 inhabitants in Slovenia [32].

According to OECD Economy Surveys (2022) [33] COVID-19 has led to a sharp increase in health spending, but health worker shortages persist. Prior to the pandemic, health spending averaged over \$4,000 per person in OECD countries and reached nearly \$11,000 in the United States. Inpatient and outpatient services accounted for the majority of health expenditures, typically accounting for 60% of total health expenditures. With the onset of COVID 19, there was a sharp increase in health care spending in many countries, particularly in Europe. Combined with a decline in economic activity, the average ratio of healthcare spending to GDP increased from 8.8% in 2019 to 9.7% in 2020. Countries that were hit hard by the pandemic reported unprecedented increases in the share of GDP spent on healthcare. The United Kingdom, for example, projected an increase from 10.2% in 2019 to 12.8% in 2020, while Slovenia expected its share of healthcare spending to rise from 8.5% to more than 10%.

In summary, Slovenia will receive European structural funds of EUR 5.1 billion (6.4% of GDP in 2021) in the 2021-2027 programming period. The health and social sectors account for 15 % of the resources of the Recovery and Resilience Facility [33]. The focus is on actions to support the digital transformation of the health system, improve the skills of health professionals, and ensure quality of care. We strongly believe that investments in future nurses and midwives, the most important healthcare providers in Slovenia, will not be forgotten or ignored.

## **5. Challenges and prospects**

In recent years, there have been many improvements in midwifery education and practise in Slovenia. The undergraduate midwifery programme accepts new students every year and provides them with evidence-based knowledge. The midwifery profession is growing in terms of providing high level care to all women, babies, and their families. Midwives provide compassionate care as health professionals, while the position of birthing women in Slovenia is evolving from passive observers to active participants who are involved in their decision-making process.

The latter sounds optimistic, but there are still certain areas where midwifery in Slovenia faces challenges. As noted in a study by Mivšek et al. [22], midwifery in Slovenia is not (yet) an autonomous profession. Therefore, midwives are struggling to gain recognition. This is clearly evident in some areas of midwifery care, such as antenatal care and postpartum care in the community, where other health professionals provide care to women. However, in order to gradually acquire the professional autonomy, midwives have to become more proactive by continually

expanding their knowledge and skills through lifelong learning and actively advocating for midwifery through national organisations as well as in their local maternity hospitals.

The existing health care system in Slovenia presents some challenges affecting midwifery care. However, midwives have to strive to provide midwifery-led care, which has been shown to have many benefits [24]. Another model of care that should be implemented in maternity hospitals is continuous midwifery care. In addition, the current labour market shows that there is a shortage of midwives in practice. This is a potential threat to optimal care for women, babies, and their families. According to Mivšek et al. [22], national midwifery legislation needs to be created in the near future to determine the scope of practice of midwives.

Midwives must also strive to provide evidence-based midwifery care, which is only possible through evidence-based education. Current formal education for midwives is at the undergraduate level (1st cycle) and lasts three years. With the establishment of a new 1st degree programme, which is under the process of accreditation, we aim to extend undergraduate education to four years. In doing so, we hope to allow students more flexibility in their studies, especially in the organisation of clinical internship blocks. As midwifery is a regulated profession in Slovenia [23], we are obliged to meet the criteria for education, which includes many hours of clinical placement. The clinical placement is of utmost importance, but students can deepen their knowledge and enhance their skills through new pedagogical approaches. The vision for future midwifery education is also to provide high-quality simulation training in well-equipped facilities, along with the use of virtual reality methods. Finally, our goal is to improve midwifery education at the postgraduate level (2nd cycle and possibly 3rd cycle).

We believe that the establishment of postgraduate education will have a broader positive impact on the increasing professionalisation of midwifery. Midwives need to become fully competent practitioners in all aspects of midwifery care, including normal pregnancy, labour and birth, postpartum period and newborn care. In addition, the provision of midwifery care needs to be re-established in all areas of midwifery care.

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## **MIDWIFERY IN TURKEY**

### **1. Brief history of midwifery**

Midwifery is one of the oldest professions in the world. Throughout history, information specifically related to midwifery has been found in various sources that carry written history to the present day, such as hieroglyphs, papyri, tools, figures, bone remains and pictures [1-3]. From these sources, it is clear that the task of midwifery is performed by midwives for the continuation of humanity in all cultures [2]. Midwives have gone through many different stages in the course of professionalization in the world and in Turkey and have reached their present position.

If we look at the sources from the past, we find that midwives have been highly valued in Turkish culture at every stage of history. If we look at the current definitions of such a well established profession, the Turkish Language Institute defines the word midwife as “the woman who delivers a baby”, while the Ministry of Health defines it as “the person who provides sexual and reproductive health services, plans and conducts the necessary education, follow-up and examinations during pregnancy, childbirth and postpartum, who works in maternal and infant health services, who applies appropriate measures in obstetric emergencies according to the protocols established by the Ministry, who follows up and vaccinates children in the age group 0-6 years, who educates the society about hygiene rules, first aid, protection against infectious diseases and family planning, and who collects statistical data on deaths-births” [4,5]. The definition of midwife as a profession has reached its current definition thanks to its change in the historical process. The development of Turkish midwives in this process can be studied from two points of view: before and after the Republic of Turkey.

#### *Midwifery Before the Republic*

Childbirth occupies an important place in Turkish culture. Under these circumstances, midwives have an important position [6]. Among the Central Asian Turks, childbirth was considered an important phenomenon and women were delivered by midwives whom they trusted. In Central Asia, midwives made various talismans for pregnant women, babies and children during ceremonies related to childbirth so that they would be healthy and maintain their health, and midwives who performed births were considered goddesses [7].

In the Ottoman period, despite various ethnic, religious or class differences in society, midwifery was a profession acquired through experience and passed down from woman to woman [8]. Midwives fulfilled the needs of society in health

issues such as pregnancy, childbirth, postpartum and reproductive health. During this period, midwives were classified as “Saray Ebeleri, Kibar Ebeleri and Halk Ebeleri”. “Saray Ebeleri” were in charge of the palace and delivered to the members of the sultanate and checked the health status of the girls admitted to the hareem [9]. Since “Saray Ebeleri” served the members of the sultanate, they had a good life, mansions and assistants. “Kibar ebeleri”, on the other hand, would deliver respected families and built close relationships with them. These midwives were experienced and elegant and they had handmaidens and maids in their households [10]. “*Halk Ebeleri*”, on the other hand, delivered in villages and towns. After the birth, “halk ebeleri” helped and provided training on postpartum and infant care. These midwives were also called by different names such as “Ev Ebesi” (home midwife) and “Mahalle Ebesi” (Neighborhood Midwife). In general, the warm-blooded, good-natured and gentle women were preferred among the old women whose experience and skills were trusted [9]. The value of midwives increased in proportion to the importance and skill they attached to courtesy and cleanliness. During this period, midwives possessed licenced staffs that represented their power and prestige [10]. When the midwives had to go out late at night to deliver, the soldiers at the police stations in the streets they passed recognised the midwives by the sacred wand in their hands. Thanks to this wand, they gave the midwives the help they needed and provided every kind of convenience [2, 11]. Midwives in this period often used four-legged birthing chairs called “öreke” with bars on the top (Figure 1). The seat of the “öreke” was in the shape of a half moon and they were specially produced for childbirth [12].

During the Ottoman period, midwives took an active role in the care and interventions that women and newborns required throughout pregnancy, childbirth and the puerperium. In addition to their entrepreneurial role in these processes, midwives’ obstetric and reproductive activities included issues such as newborn preparation, breastfeeding, breast problems, the treatment of infertility, abortion and birth control. Apart from these activities, they also performed some rituals that could be called spiritual or folkloric, such as “tuzlama” that means bathing the baby with salt water or rubbing the baby’s entire body with salt and “kırklama” that means taking a special bath on the day the newborn is forty days old. In addition to these tasks, midwives also acted as mediators or a kind of expert witness between the state and society in cases of sexual crimes such as rape. They were an important part of the networks of relationships between women, as they looked after women’s privy parts. This showed that the midwives’ tasks were not limited to deliver but had a meaning and function that went beyond that [8,13].

In the Islamic world and Turkish culture, it was not appropriate for men to be present at birth, so women intervened in childbirth. In fact, the profession of midwifery was long passed down from generation to generation among women through the master-apprentice relationship [14,15]. However, in the 18th century, doctors began to take over this role and the understanding of modern medicine began

to develop. Men assisted in childbirth mostly working with an instrument called “lavta”, which is used to extract the child from the womb during difficult births [10]. It can be said that the Industrial Revolution influenced both the medicalisation of births and the participation of men in childbirth during the same period.



Figure 1. Birthing Chair [56]

In the 19th century, Ottoman statesmen decided to issue some regulations because midwives without training could harm the mother or the child without even realising it [13,16]. In this century, certain regulations such as licencing midwives to practise midwifery were made and attempts were made to control them by the state. The first concrete data can be found in the newspaper *Ceride-i Havadis* of 11 April 1841 [13, 16]. In this newspaper article it is mentioned that there will be some changes related to midwifery, that childbirth is a difficult and dangerous process and how important it is for midwives to master their work in order to overcome this process. Another point mentioned in this newspaper article was that midwifery should be learnt from books like medicine [8]. After this news, two foreign midwives named “Madam Ventura” from Paris and “Madam Roberts” from Belgium were brought into the country [17]. From 1842, midwives in the neighbourhoods were subjected to strict control. A two-year course programme was established for the education of midwives, one hour per day, two days per week. Later, the course programme began to be organised every week on Thursdays. This programme was the first course programme prepared in the country for midwives [17]. Those who successfully passed the examination at the end of the course received a diploma. This diploma entitled them to practise midwifery within the borders of the country [13].

When Besim Ömer Pasha returned from Paris in 1890, he found that puerperal fever was widespread in the country and prepared a report which he submitted to the “Tıbbiye-i Mülkiye and Sıhhiye-i Umumiye”. Based on this report, the Medical University and the Sıhhiye-i Umumiye announced in 1891 that all midwives working in Istanbul would be subject to strict records regarding asepsis-antisepsis [13]. Following this announcement, conferences on asepsis-antisepsis were held by Dr Besim Ömer [18]. In 1892, Dr Besim Ömer opened the first maternity hospital in Turkey where midwives could receive practical training. In this maternity hospital, both doctors and midwives had the opportunity to practise their theoretical childbirth classes [19]. We can say that with the establishment of the maternity hospital, which was the first in the Ottoman Empire, pregnancy and childbirth were medicalised and turned into formal education.

In 1895, Dr. Besim Ömer started teaching at the midwifery school. At that time, in order to attend the school, women had to fulfil conditions such as being younger than 30 years old, being able to read and understand Turkish and be able to write in their own language [20]. The “Tıbbiye-i Mülkiye (Civil Medicine)” in Istanbul’s Kadırğa district was moved to the building in Haydarpaşa in 1909 and both medical institutions (military and civil) were merged under the name “Istanbul Darulfunun Medical Faculty”. When the building in Kadırğa was empty, a school of pharmacy, dentistry, midwifery and a second maternity clinic were established, affiliated the faculty. Dr Besim Ömer was appointed head of all these institutions. When a new midwifery school was established in Kadırğa, a curriculum was developed and practical teaching was emphasised [13]. In the following years, Besim Ömer was awarded the title “Midwife of Midwives” for his works in the field of midwifery. The focus of Besim Ömer’s work was contemporary obstetrics and maternal and child health. Being aware of the influence of midwives on mother and infant health, he wrote the books “My Advice to Midwife Ladies”, “Midwifery” and “After Delivery” in the field of midwifery. These books are the first books written in our country in the field of midwifery [21]. It took a long time for the attempts made for midwifery education to reflect on daily life and in the field. While all these regulations ensured that midwifery education was based on scientific principles, but they unfortunately led to a reduction in the autonomy of midwives over their work and, since women did not have the opportunity to receive medical training until 1922, to a shift in autonomy mainly towards male doctors. [8].

The midwifery school continued its teaching during the First World War. Between 1920-1922, which corresponds to the period of national struggle, three courses were held in the midwifery school of Kadırğa, Erzurum and Trabzon. In general, the expected and desired participation in the courses could not be achieved. Unfortunately, all these attempts were not enough to meet the need for midwives in the rural areas [22-24]. As a result, the profession of midwifery, which had been learned in a master-apprentice relationship in the Ottoman Empire since the mid-19th century, was put on a more scientific footing by giving midwives formal

education, enacting legal regulations, issuing licences and opening schools and courses. As a result of all these initiatives and changes, the profession of midwifery was professionalised and brought to its present position.

#### *Midwifery from the Republic to the present day*

As a country coming out of war in the early years of the Republic, the priority was to heal the wounds of war and create legislation as an infrastructure of legal regulation. During this period, special importance was given to preventive health services due to the high prevalence of epidemic diseases [25]. To support all this, it was important to solve the problems related to the quantity, quality and distribution of healthy labour. In 1923, the number of midwives under the Ministry of Health, Special Provincial Administrations and Municipalities was determined as 136. As expected, this number of midwives unfortunately could not meet the number of midwives the country needed [13]. As a result of the meetings held to increase the number of qualified midwives, it was decided to open Numune hospitals throughout the country and provide midwifery education in these hospitals. The plan was that midwifery education in these institutions would focus on pregnancy, childbirth and childcare, and that would be able to meet the public's need. At the same time, the intention was that midwives would take an active role in reducing infant mortality due to poor care conditions, superstition and other reasons, and guide society in the provision of primary health care and preventive health services [13]. To achieve this goal, theoretical and practical courses for midwives have been held quarterly at Numune hospitals since 1925. For example, the first of these courses was organised at Sivas Numune Hospital on 15 September 1925 for a period of 3 months [13].

After the midwives graduated from the Midwifery School in Kadırga, which was established in the Ottoman period, had their diplomas approved, they were employed for 3 years in places where the government deemed it necessary and where midwifery vacant positions were available [13]. The "Midwives' Student Dormitory" was opened in 1924 to provide accommodation for the midwives who came for education to meet the demand [26]. In 1925, houses for child care and assistance were established to improve mother and infant health services and reduce the infant mortality rate [2]. Midwives who completed their education in these institutions had duties such as free deliveries, making home visits in the postpartum period, and meeting the health needs of mothers and infants [2].

In 1928, the role and duties of midwives were defined by the "Law on the Mode of Execution of Medicine and Medical Sciences", and midwives without diplomas were forbidden to assist in delivery [27]. Under the same law, only graduates of midwifery schools and those who obtained certificates of competence from the hospitals where they practised could become midwives. In this law, midwives were forbidden to use any aids and to write prescriptions, and it was emphasised that a doctor should be called in case of complications related to delivery [27,28].

The Midwifery School, affiliated to Istanbul University, was the only institution in our country offering midwifery education until 1936. Since the midwives trained at this school could not meet the country's needs and wanted to work in the cities, the villages were left without midwives. According to the 1936 regulation, village midwives were also included in the village health organisation. With this regulation, village midwifery schools began to be opened. The first of these schools was opened in Balıkesir in 1937. In the following years, village midwifery schools were opened in many cities [26]. In order to determine the duties and employment conditions of village midwives, the "Instruction on the Duties and Employment of Village Midwives", consisting of 19 articles, was drafted. The curricula of the village midwifery schools were divided into 3 parts, in the first part preparatory lessons, in the second part of lessons on midwifery and its practice, and in the last part lessons on childcare and pregnancy diseases were taught. To be admitted to the village midwifery schools, students had to live in the province where the school was located or in nearby provinces. In these schools, where the education period was 1 year, the basic needs of the students such as food and clothing were provided by the school. The students also received a monthly financial allowance. After graduation, students who were boarders of the state were obliged to work for four years in their own village or in nearby villages with a population of no more than 4,000. Midwives were obliged to visit pregnant women in the area for which they were responsible at least once a month from the period of six months of pregnancy, to keep track of the time of birth, to make the necessary preparations for the birth, to follow up the puerperium, and to contact the government doctor in the nearest vicinity if a possible negative situation for the health of mother and infant was detected. It was stipulated that precautions should be taken as recommended by the doctor [13]. The "Village Health Girl" programme was developed because the number of midwives deployed in the periphery was insufficient to protect maternal and child health and provide fertility services. Village girls who graduated from primary school began working in the villages after receiving one year of theoretical and practical training in state hospitals [27]. In 1942, midwives were trained under the name "Village Midwifery School" with a 9-month education. The duration of education in village midwifery schools was later increased to 1.5 years. Midwifery programmes were opened in village institutes in 1943 [2].

From 1961, midwifery programmes were transformed into three-year health schools [2,27]. In 1975, midwifery and nursing schools were merged and schools were opened to train "midwife-nurses". The village schools for midwives were closed in 1978. In 1978-1979, the "Health Colleges" were transformed into "Health Vocational High Schools". From the academic year 1985-1986, midwifery programmes affiliated to the Health Vocational High Schools started to provide education at the Associate Degree level [1,2, 13,18,27,28]. With the decision of the Health Council in 1995, the education would be 4 years and was transferred to the Higher Education Institution (YÖK). In the academic year 1997-1998,

health colleges were established and undergraduate midwifery education started. The established colleges became faculties over time [29]. Midwifery education was updated in line with the process of adaptation to the European Union. It was decreed by the Council for Higher Education with the “Regulation on Determining the Minimum Conditions for Doctoral, Nursing, Midwifery, Dental and Veterinary Studies”, published in the Official Journal of 2 February 2008 under number 26775. In accordance with the criteria of ICM, YÖK, and the Ministry of Health that a midwife must meet after 4 years of education, studies on the “Midwifery National Core Education Programme (EUÇEP/2016)” were conducted and national qualifications for midwives were established. However, in midwifery, a master’s degree programme was introduced in 2001 and a doctoral degree programme in 2013 [29]. And this is how the current education system came into being.

The Ministry of Health started admitting students to the health vocational high schools in 2001 and transferred the vocational high schools to the Ministry of National Education in 2004. From 2014, it was decided to stop admitting students due to the oversupply of midwife nurses and to train nurses and midwife assistants in schools. Since 2014, midwife assistants have been trained in accordance with some articles of the decree-law published in official paper No. 28886 of 18 January 2014. The first midwife assistants graduated in 2018 [29].

#### *Midwifery Associations in Turkey*

Associations play an important role in the development, professionalisation and legal establishment of a profession. To this end, the Turkish Midwives Association was established in 1954 under the leadership of midwife Sekine Arcan within the Faculty of Medicine at Istanbul Cerrahpaşa University to meet the country’s need for qualified midwives. The association still exists today [30,31].

In the 2000s, as midwifery education had reached master’s and doctoral level, midwives were more aware of the benefit forming associations, they had a voice in legal regulations, and the profession of midwifery was able to evolve from its then current position to a better place, the Midwives and Nurses Association was established in 2007, The Midwifery Education and Research Development Association in 2014, the Anatolian Midwives Association in 2018 and the Midwifery Education Programmes Evaluation and Accreditation Association was established in 2021 (Table 1).

Table 1. Midwives’ associations in Turkey

<b>Year of Foundation</b>	<b>Association name</b>	<b>Association link</b>
1954	Midwives Association	<a href="https://www.turkebelerdernegi.org">https://www.turkebelerdernegi.org</a>
2007	Midwives and Nurses Association	<a href="https://www.ehemder.org.tr">https://www.ehemder.org.tr</a>
2014	Midwifery Education, Research and Development Association	<a href="http://www.ebearge.org.tr/">http://www.ebearge.org.tr/</a>
2018	Anatolian Midwives Association	<a href="https://anadoluebelerdernegi.org">https://anadoluebelerdernegi.org</a>
2021	Midwifery Education Programmes Evaluation and Accreditation Association	<a href="https://epdak.org">https://epdak.org</a>

## 2. System of education for midwives

Midwifery education in Turkey takes place at three levels: Undergraduate, Graduate and Doctoral. The boundaries of these education programmes have been established on a legal basis.

Table 2. Practices for Students in Midwifery Education.

<ul style="list-style-type: none"><li>— Counselling of pregnant women, including at least 100 antenatal examinations,</li><li>— Follow-up and care for at least 40 pregnant women,</li><li>— Performing at least 40 births themselves (If this number cannot be achieved due to lack of women giving birth, this number can be reduced to 30 on condition that the student assists in 20 more births),</li><li>— Active participation in a breech delivery (If a breech delivery is not possible, a simulation should be performed),</li><li>— Making an episiotomy and starting suturing (This includes theoretical information and clinical practice. Suturing practice includes suturing after episiotomy or simple perianal fissure. If necessary, this can be done in the form of a simulation),</li><li>— Supervision and care of 40 high-risk patients during pregnancy, labour or postpartum,</li><li>— Supervision and care of at least 100 puerperant and healthy newborns (including examination),</li><li>— Observation and care of newborn babies, including premature babies, postpartum babies, low birth weight babies or sick babies who need special care,</li><li>— Care of women with gynaecological and obstetric disorders,</li><li>— Be involved in medical and surgical care (this should include theoretical training and clinical practice).</li></ul>
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### *Undergraduate midwifery education in Turkey*

Undergraduate education in midwifery in Turkey is regulated by the “Regulation on Determining the Minimum Educational Requirements for Doctoral, Nursing, Midwifery, Dentistry, Veterinary, Pharmacy and Architecture Education Programmes”, published in the Official Journal on 2 February 2008 under number 26775 [32]. This section contains the sections relating to the regulation of midwifery education in the aforementioned Regulation. The fifth article of the Regulation deals with midwifery education, and its subsections state that admission to midwifery education requires at least a high school diploma and a minimum of 4 years of full-time theoretical and practical training. Students who successfully complete midwifery education should have gained sufficient clinical experience in approved institutions under the supervision and control of qualified staff, particularly in obstetrics and gynaecology, the sciences on which midwifery is based, professional ethics and the legal provisions relating to the profession, midwifery and obstetrics. Furthermore, in order to ensure the minimum requirements for the training, it is necessary to take the courses for applied and theoretical training and to carry out the practical and clinical training under appropriate supervision and control (Table 2, Table 3) [32]. In addition to all these trainings, students are also supported with some additional courses so that they can follow the current literature during their

education. After successful completion of the faculty or high school offering basic training, students can register their diplomas with the Ministry of Health of the Republic of Turkey and receive the title “Midwife”.

Another issue in midwifery education is the Bologna Process. This process was initiated by European countries to create a common higher education area, of which Turkey is a part. The main purpose of the Bologna Process is to create diplomas and degrees in a simple and understandable way between member countries in educational programmes, including Bachelor’s, Master’s and Doctoral programmes, to introduce the “European Credit Transfer and Accumulation System (ECTS)”, to ensure and disseminate student and faculty mobility, implement and spread the network of quality assurance systems in higher education and to develop the European dimension in higher education. Under the Bologna Process, students must complete 240 ECTS in the course of their 4-year education [33,34].

Table 3. Theoretical topics to be taught in the midwifery programme.

<b>Theoretical and technical training (General Topics)</b>	<b>Special topics related to midwifery</b>
<ul style="list-style-type: none"> <li>-Basic Anatomy and Physiology</li> <li>-Basic Pathology</li> <li>-Basic Bacteriology, Virology and Parasitology</li> <li>- Basic Biophysics, Biochemistry and Radiology</li> <li>-Newborn Infant Intensive Pediatrics</li> <li>- Hygiene, Health Education, Preventive Medicine and Early Diagnosis of Disease</li> <li>- Nutrition and Dietetics for Women, Newborns and Infants</li> <li>-Basic Sociology and Socio-Medical Issues</li> <li>-Basic Pharmacology</li> <li>-Psychology</li> <li>-Teaching Principles and Methods</li> <li>-Health and Social Legislation and Health Organization</li> <li>-Professional Ethics and Legislation</li> <li>-Sex Education and Family Planning</li> <li>-Legal Protection of Mother and Infant</li> </ul>	<ul style="list-style-type: none"> <li>- Anatomy and Physiology</li> <li>- Embryology and Development of the Fetus</li> <li>- Pregnancy, Birth and Puerperium</li> <li>- Gynaecological and Obstetric Pathology</li> <li>- Preparation for Birth and Parenthood, Including Psychological Issues</li> <li>-Preparation for Birth (including knowledge and use of technical equipment during childbirth)</li> <li>-Analgesia, Anesthesia and Resuscitation</li> <li>-Physiology and pathology of the newborn baby</li> <li>-Care and follow-up of the newborn baby</li> <li>-Psychological and Social factors</li> </ul>

### *Postgraduate Education in Midwifery in Turkey*

In Turkey, there are master’s and doctoral programmes in midwifery or different departments (such as gynaecology, nursing, public health) that accept midwifery graduates. Postgraduate education in midwifery in Turkey is organised according to the “Graduate Education and Training Regulations” published in the Official Journal of 20.04.2016 under number 29690. In this section, the sections related to postgraduate education in midwifery are listed in the above-mentioned regulation.

The total score shall be determined from the percentages obtained on the Academic Personnel and Postgraduate Education Entrance Exam (ALES), foreign language exam, graduation degree, as determined by YÖK and left to the discretion of the University, during the calculation of the application score of undergraduate midwives during their application to graduate programmes. Depending on the opened quota for doctoral or postgraduate students, the candidates applying for this semester will be admitted into the programme according to the number of quotas among the applicants by ranking the students who exceed the base point according to the quota for doctoral or postgraduate students who can be taken [35].

### *Master's Programme*

The aim of the Master's programme is to enable bachelors to have advanced knowledge, develop solutions to professional problems, access accurate information, evaluate and interpret information, update their knowledge and apply evidence-based practises to the profession. In addition to these goals, it also serves to train future researchers and faculty members.

#### a. Application and admission

According to the postgraduate education and training regulations, a minimum score of 55 from ALES is required for application and admission to master's degree programmes. However, the basic score of ALES can also be set by the university senates if desired. A master's degree programme with thesis consists of at least seven courses (the total number of credits of these courses should not be less than twenty-one credits), a seminar course and the thesis. A master's degree programme with thesis consists of a total of at least 120 ECTS credits, including at least eight courses, including the seminar course, provided that there are not less than 60 ECTS credits in an academic semester. The first two semesters are for the course phase and the last two semesters are for the final thesis. The programme must be completed in a maximum of 6 semesters [35].

#### b. Appointment of a supervisor for the thesis

For each student in the Master's programme with a thesis, a thesis supervisor must be appointed by the head of the department/ art major of the Institute no later than the end of the first semester. The student should propose the topic of the thesis to the Institute by the end of the second semester at the latest, which he/she has determined together with his/her supervisor. The supervisor and the topic of the thesis are determined with the approval of the Head of the Institute [35].

#### c. Completion of the Master's thesis

The student defends orally before the jury by reporting the results obtained in relation to the Master's thesis topic, which he/she has defined together with his/her supervisor. Before the defence of the Master's thesis, the student presents the finished thesis to the supervisor. If corrections have been made in the thesis, the student should send the final version of the thesis with the corrections to the supervisor. If the supervisor is of the opinion that the thesis is defensible on the basis of his/her examinations, he/she will submit the thesis to the Institute with his/

her opinion. The jury for the Master's thesis is appointed on the proposal of the supervisor of the thesis and the responsible department/art major of the Institute and with the approval of the Institute's Board of Directors. One of the juries consists of the thesis supervisor and three or five faculty members, provided that at least one of them is from outside their faculty. Upon completion of the thesis, the student delivers the required number of copies of the thesis to the thesis supervisor. After the supervisor has made the necessary checks, he or she sends it to the institute. Subsequently, the student must take the examination of his/her thesis within one month. The examination consists of the presentation of the thesis followed by the question and answer section. After completion of the examination, the jury decides by absolute majority whether to accept, reject or correct the thesis. The student who fails the thesis is dismissed from the university. At the request of this student, he/she may be issued a Master's diploma without a thesis, provided that he/she fulfils the requirements of the Master's programme without a thesis. The student who receives corrections to the thesis must complete the corrections within three months at the latest and defend his/her thesis again before the same jury [35].

### *PhD Programme*

The aim of PhD programmes is to provide students with the ability to conduct independent research, to investigate and interpret scientific events, to analyse them and to determine the necessary steps to reach new results. The doctoral programme is a four-year post-graduate education process. Usually, two years of this education are lectures and two years are doctoral work [35].

Students with a Master's degree with thesis and a Bachelor's degree can be admitted to the doctoral programme. If admitted with a Master's degree with thesis, students must take courses totalling 21 credits and not less than 60 ECTS in one semester. By the time of graduation, he/she must complete at least 240 ECTS credits, including at least seven courses, seminars, qualifying exam, thesis proposal and thesis. For students accepted with a Bachelor's degree, this consists of at least 300 ECTS credits, including 14 courses of at least 42 credits, seminars, qualifying exam, thesis proposal and thesis [35-37].

#### a. Application and admission

To apply for the doctoral programme, candidates must hold a Master's degree with thesis and score at least 55 points from ALES in the point type of the programme for which they are applying. However, this score may be increased by a corresponding Senate decision. A further condition for applying for this degree programme is that students achieve at least 55 points in the central foreign language examinations recognised by the University Council in a language other than their mother tongue or in the international foreign language examinations recognised as equivalent by the Student Selection and Placement Center (ÖSYM). It is compulsory to achieve a result equivalent to this score. This minimum score may be raised by the University Senate depending on the characteristics of the degree programme applied for by the applicant [35].

For those admitted to doctoral studies with a Master's degree, the duration of study is eight semesters and the maximum duration of the degree is twelve semesters. For those admitted with a Bachelor's degree, it is ten semesters and the maximum duration of the degree is fourteen semesters [35].

b. Qualifying exam

The qualifying examination measures whether the student who has completed the courses and seminar has the depth of scholarly research related to the basic topics and concepts of the field and the doctoral studies. A student takes the qualifying examination no more than twice a year. When the student takes the qualifying examination is determined by the regulations adopted by the Senate. However, the student admitted with a Master's degree must take the qualifying examination no later than the end of the fifth semester, and the student admitted with a Bachelor's degree no later than the end of the seventh semester [35].

The qualifying examinations are organised and conducted by a five-member Qualifying Examination Board approved by the Institute's Board of Directors. The qualifying examination jury consists of five faculty members, two from another higher education institution, one supervisor and two from the higher education institution to which it is affiliated. The qualifying examination is conducted in two stages. First, the written examination is held and the successful student is admitted to the oral examination. The calculation of the examinations is done according to the regulations of the higher education institution. The jury will assess the student's success in the written and oral examinations as successful or unsuccessful and notify the Institute [35].

c. Appointment of the thesis supervisor

The Board of the Department of the Institute shall appoint a faculty member from among its members of the University to be the thesis supervisor for each student. The topic of the thesis shall be determined jointly by the advisor and the student, and they shall propose the title of the thesis to the institute to which they belong. The advisor and the thesis proposal are finalised by the decision of the Board of the Institute. When the thesis advisors are appointed is determined by the regulations set by the Senate. However, it is mandatory that they be appointed by the end of the second semester [35].

d. Thesis monitoring committee

After the student has passed the qualifying examination, a thesis monitoring committee shall be formed within one month. The thesis monitoring committee consists of three faculty members. In addition to the thesis supervisor, the committee includes one member from within and outside the faculty of the Institute [35].

e. Thesis defense

The student who has successfully completed the doctoral qualifying examination shall defend his/her thesis proposal, which shall include the purpose, method and study plan of the research to be conducted, before the thesis monitoring committee within six months at the latest. The thesis proposal submitted to the thesis monitoring committee may be accepted, corrected or rejected. A simple

majority is required for this decision. In cases where a correction is made, one month is allowed for the correction. After this period, the positive or negative decision should be reported to the Institute within three days [35].

If the student's thesis proposal is rejected, he/she has the right to choose a new supervisor and/or thesis topic. In this case, a new thesis monitoring committee may be appointed. For students whose thesis proposal has been accepted, the thesis monitoring committee meets at least twice a year, once between January and June and once in July and December. Before the meetings, the student plans and presents the current status of the study he or she has done during that period, namely the thesis, and which part of the thesis he or she intends to study on in the next semester. The student thus presents his/her study plan. The thesis work of the student is determined as successful or unsuccessful by the committee [35].

#### f. Completion of the doctoral thesis

The student shall report on the data obtained from the research in accordance with the rules for writing thesis and defend it before the thesis jury [35]. In order for the student to complete his or her thesis, the student must participate in at least three thesis monitoring committee at specified intervals before the five-member thesis monitoring committee appointed with the approval of the Institute's Board of Directors. Students whose thesis is accepted are considered successful. This decision shall be communicated to the Institute concerned by the Head of the Department of the Institute. The student whose thesis is found unsuccessful and rejected shall be dismissed from the university. Such students shall, on their application, be awarded a Master's degree without thesis [35].

### **3. Legal Status of midwives**

The scope of practice of midwives in Turkey is regulated by the relevant articles of the laws, regulations and circulars listed in Table 4 [38-51]. The duties, authorities and responsibilities of midwives are specified in the laws, regulations and circulars listed in Table 4. When discussing in broad terms the duties, authorities and responsibilities of midwives established on a statutory basis, midwives participate

- In sexual and reproductive health care,
- In the preparation and execution of antenatal classes and parenthood preparation programmes in the pre-conceptual phase,
- In the preparation and implementation of birth preparation programmes,
- In monitoring the reproductive health of women of reproductive age,
- Diagnosis of pregnancy, normal antenatal check-ups and necessary examinations of pregnant women,
- Early detection of risk situations, taking necessary precautions and referral,
- In the care of the birth process and delivery,

- In the recognition of risk situations during delivery, in the management of the birth process in cooperation with the doctor,
- In the care of the mother and the newborn in the postpartum period and in the necessary training of the mother in this process,
- In the administration of medicines as determined in accordance with the protocols for obstetric emergencies issued by the Ministry,
- Providing the necessary training and counselling services to protect and improve the health of mothers and infants during pregnancy, childbirth and the postpartum period,
- Family planning, reproductive health services,
- Screening programmes for women and newborns (hearing, vision, etc.),
- the care of children aged 0-6 years (vaccination, etc.) and developmental monitoring,
- communicable disease control programmes and immunisation.

Table 4

Law	Regulation	Circular
Law No. 1219 on the mode of execution of medicine and medical sciences (11.04.1928),	Regulation for Implementation of Family Practice	Pregnancy School, Pregnancy Information Course, Childbirth Preparation and Counselling Centres Working Procedures and Principles - 2-10-2018-99910406-799
Law on Family Practice No. 5258 (24.11.2004)	Regulation on Payments to Personnel Employed by the Ministry of Health and Contract Procedures and Principles in the Scope of Family Practice	Circular on the Opening and Operation of Health Cabinets. 25.03.1997-3- 6091
Public health law in Turkey no. 1593 (24.4.1930),	Ministry of Health Regulation on the Operation of Inpatient Treatment Facilities	
Law No. 2827 on Population Planning (24.5.1983)	Establishment of Minimum Education Requirements for	
Health Services Fundamental Law No. 3359 (7/5/1987),	Doctoral, Nursing, Midwifery, Dentistry, Veterinary Medicine, Pharmacy and Architecture	
Civil Servants Law No. 657	Education Programmes 2.2.2008/26775	

#### 4. Midwifery in numbers

According to the Health Statistics Yearbook for 2020, there are 55,505 midwives working in the Ministry of Health, 901 midwives working in university hospitals, 2,634 midwives working in private health institutions and a total of 59,040

midwives [52]. Currently, there are midwifery departments in 91 universities in Turkey [52]. About 30 to 100 students are admitted to these universities. In addition to undergraduate education, the assistant midwife department is also actively carried out in medical vocational high schools [37].

## 5. Challenges and prospects

When examining the difficulties related to the midwifery profession in our country, one finds that many different components play a role. These factors include midwives themselves, other health professionals, patients, inadequate health policies, budgets allocated for research and development for midwives, hospital management and budgets, and general working conditions.

Although the profession of midwifery, which in the past held a very rooted and respected position in our country, has generally changed from the past to the present, a change to the expected level has unfortunately not been achieved. It is obvious that we still have a long way to go to give the profession the status it deserves. However, the increasing number of midwives' associations in recent years, the more moderate attitude of midwives towards the unification process and the fact that they have come a long way in terms of science and research make us hopeful for the development of the midwifery profession in our country.

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## **MIDWIFERY IN THE UNITED KINGDOM**

### **1. Brief history of midwifery**

Midwifery in the UK has a long history, though as is the case for other ‘women’s roles’, its development was hampered by the difficulty of accessing knowledge and education, and by the social position of women. In Middle English, the word midwife is accepted as meaning ‘with woman’, and midwifery has traditionally been women’s work. Early accounts of midwives range from descriptions of ill-educated poor women providing a basic level of care, to more mystical ‘*wyse*’ women, knowledgeable in the use of herbs and potions. Throughout history midwives were considered to have special knowledge of women’s business, of the workings of women’s bodies, fertility, birth and care of babies. Midwives were often involved in providing fertility advice, and in matters of the religious and social aspects of birth. This included being present at the birth to confirm no substitution of babies had taken place; to confirm that if the child died, it was not caused by the mother; responsibility for christening any stillborn babies, or babies considered at risk of dying; and ensuring the correct and safe burial of stillborn babies, in order that the body not be used in witchcraft.

Midwives might also be asked to examine unmarried women in cases of suspected rape, and also in confirming pregnancy in situations in which the woman was condemned to death for a crime [1].

Other more celebratory roles for the midwife included leading some of the post birth rituals such as carrying the baby to church for christening, and having a special place at the celebratory feast that followed. The midwife was often also part of the group of ‘gossips’. This term was used usually for the woman’s friends and female family members, and these gossips arrived to support the woman, enable nourishment, and also had a role in witnessing and confirming the birth event in a slightly official way [2, 3].

In the seventeenth century, a different practitioner emerged from barber surgeons – the male midwife [1], and this led to what has always been considered to be a battle between the two very different professions. Barber surgeons were able to perform procedures including bloodletting, amputation and removal of teeth. The Company of Barber-Surgeons, initially a trade guild established in 1540, later became two separate organisations and then the Royal College of Surgeons [4].

The involvement of male midwives, later to be called obstetricians, was often seen as a ‘last resort’ for the childbearing woman, and called in when there was a need to save the mother’s life, often using instruments to deliver the baby. At this

time, childbirth was a risky business, many babies did not survive, and maternal mortality, and indeed morbidity rates were high, though often unrecorded.

## 2. System of education for midwives

Midwifery education in the UK prior to the 1902 Midwives Act [5] was built upon an information apprenticeship process – often referred to as ‘sitting by Nellie’, in which a woman, usually mature, and often a mother herself, would work alongside a more experienced midwife. What sort of women were midwives in the early centuries? Many worked in rural areas, attending women, and also performing other roles such as caring for the sick, and laying out the dead. Increasingly there is evidence being discovered about early midwives that suggests that some midwives, especially those in towns, were in demand and commanded more lucrative reward, and even respectable pensions [6, 1].

Prior to the advent of printing in the 16th Century, and the availability of midwifery texts, midwives would have gleaned their knowledge and skills from more experienced midwives, passed by word of mouth, and observation. The practice would have been variable, and this was largely due to lack of access to scientific information and education. Midwives were however, highly valued as members of the community, and some texts describe the midwife as an honoured guest at a christening procession [7]. As previously described, the midwife was an important person in terms of determining premature birth in a situation; confirming the birth of the baby to a particular woman to prevent substitution; and also to address illegitimacy.

This required that midwives were of good character, approved by the Church. Midwifery licensure was first arranged by law in 1512, and midwives had to seek a reference from the local vicar, and gain the support of six ‘honest matrons’ to support their applications, along with the swearing of an extensive oath [6]. Examples of these oaths demonstrate the commitment of these early midwives to the health and well-being of the woman, balanced with an expressed commitment to preventing the use of witchcraft and sorcery [8]. This form of licensure meant that midwives’ practice was to a certain degree overseen by the church and by the local community [9]. This contributed to good standards of practice according to the time, and midwives were deemed the experts in matters related to fertility, pregnancy and childbirth.

Jane Sharp was one of the first midwives to write a textbook for midwives, and was concerned about the women in the hands of ‘unskilful Midwives’ [10]. For those midwives who had been educated and able to read, this textbook contained the knowledge of the time, which included the anatomy of ‘*the parts of Men and Women*’; recognising the signs of pregnancy; sets of practice information governing knowing when the woman was in labour; and the range of cures and care available.

This included postnatal care, and how care of the mother and child should be governed. Even with today’s eyes, the commitment for midwifery, and the love she had for the women in her care, shines through.

There were continuing efforts to improve the safety and care of women through pregnancy and childbirth, and there were different efforts to licence and educate those who provided midwifery care. There was public concern about midwives. The writer Charles Dickens, described ‘Mrs Gamp’, who made a living as a nurse and midwife, and laying out the dead, with an unfortunate personal habit of liking strong alcohol [11]. There was also pressure from the rising power of the male accoucheurs, who were actually in direct competition with midwives. Interestingly, the mortality rate for accoucheurs tended to be higher than those for midwives.

The 1902 Midwives Act enabled standardisation of training and practice, as in Table 1.

Table 1. The Development of midwifery education in the United Kingdom, [12]

Table 5.1 Development of midwifery education courses in the UK (Macdonald, 2023)					
Year	Awarding Body	Length of Course	Examination	Award (Level)	Comments
Late 19th century	London Obstetrical Society	3 months	None formal	Certificate of proficiency	Small number of students led to negligible impact on practice
1902–1915	Central Midwives Board (CMB)	3 months	3-hour written examination 15-minute viva voce conducted by an obstetrician	Certificate	Focus on labour and postnatal care
1916	CMB	6 months (2-month exemption for nurses)		Certificate	
1926	CMB	1 year for non-nurses			
1938	CMB	Part 1: 12 months for non-nurses (hospital based); 6 months for nurses Part 2: 6 months for all (district and community experience)	Practical assessment and submission of set number of case histories	Certificate	Midwifery and obstetric theory and hospital-based practice clinical experience based in community and some lectures from the local Medical Officer of Health

Table 5.1 Development of midwifery education courses in the UK (Macdonald, 2023)

Year	Awarding Body	Length of Course	Examination	Award (Level)	Comments
1968	CMB	1 year for nurses 2 years for direct entrants	Two 3-hour written examinations Viva voce	Certificate	Normal midwifery and complicated obstetrics and neonatal care
1980	CMB	18 months for nurses 3 years for direct entrants Education based in schools/ maternity unit	Two 3-hour written examinations Viva voce	Certificate	Normal midwifery and complicated obstetrics and neonatal care + new technologies (i.e. Cardiotocographs (CTGs), inductions, etc.) – some doctors' lectures
1990s	United Kingdom Central Council for Nursing and Midwifery (UKCC) National Boards – registration Colleges/ universities – academic qualification	18 months for nurses 3 years for direct entrants. Education based in colleges	Development of continuous assessment processes and devolvement of assessment	Diploma of Higher Education (DipHE) degrees in midwifery	Increased focus on psychology, sociology, physiology and social policy
2000s	Nursing and Midwifery Council (NMC) – registration Universities – academic qualification	18 months for nurses 3 years for direct entrants. Some variation in programmes (i.e. 20 months for nurses and 4 years for degree) Based in university	Continuous assessment theory and practice. Use of mentors as assessors in the clinical area, midwifery lecturers' moderation	All programmes at university degree level – BSc/BA (Hons)	Most programmes in modular form. Academic credit accumulation and transfer possible Minimum 50% practice. Grading of clinical practice Increased emphasis on importance of knowledge and skills in normal practice

Table 5.1 Development of midwifery education courses in the UK (Macdonald, 2023)

Year	Awarding Body	Length of Course	Examination	Award (Level)	Comments
2020 and beyond	Nursing and Midwifery Council (NMC) – registration Universities – academic qualification – Minimum BSc or Masters	18 months for nurses – may be increased to 2 years 3 years for direct entrants Some variation in programmes (i.e. 20 months for nurses and 4 years for degree) based in university	Continuous assessment theory and practice. Use of practice supervisors as role models and allocated practice and academic assessors in the clinical area Midwifery lecturers’ moderation	All programmes at university degree level – BSc/BA (Hons) MA or MSc – maybe include leadership or research stream	Now underpinned by the NMC <i>Standards of proficiency for midwives</i> (NMC, 2019); Informed by the ICM Global standards (ICM, 2019/2021)

Source: Macdonald 2023 by kind permission of Elsevier.

### 3. The legal status of midwifery

The public concerns regarding midwives resulted in the Midwives Bill 1813 [13], and work continued. In the late 19th Century a small group of educated and middle class midwives, including Dame Rosalind Paget, worked with a group of wealthy and influential women, one of whom was Louisa Hubbard, to set up the Matrons Aid Society, which became the Midwives Institute, later to become the Royal College of Midwives (see Figure 1).

The society developed a journal and a library for midwives and began to work towards improvements in midwifery practice and a reduction in maternal mortality. This group worked with sympathetic medical colleagues, and applied pressure on the politicians of the day – a challenge at a time when women in the UK did not have a right to vote. The concern about the falling birth rate and poor health amongst the soldiers engaged in the Boer war, enabled the first Midwives Act to be passed in 1902. This set the process for standardised education and practice of midwives and official registration to commence [5].

The Central Midwives Board (CMB) was set up to regulate the roll of certified midwives and their practice. At this time medical practitioners were heavily in control of the regulation, and the Board itself was comprised of, and controlled by, the medical profession. Initially, many of the midwives entering the roll, did not have certification of their competence, but were given a period of time to achieve this.



Figure 1. Photograph of Rosalind Paget, Honorary Treasurer of the Royal College of Midwives, Mary Stephens, first midwife to appear on the Midwives Roll of the Central Midwives Board and Paulina Fynes-Clinton, Secretary of the RCM with other unidentified but presumably prominent midwives who also campaigned for the registration and education of midwives. (Courtesy of the Royal College of Midwives)

Initially also, practice requirements about dress, equipment and record keeping were stipulated by the rules, and midwives were expected to strictly adhere to these. Midwives could also be removed from the roll for what was deemed misconduct, even in their private lives.

With the passing of this law, the midwife had ‘protection of title’ – meaning that it was, and still is, a criminal offence for a person to call themselves a midwife without being so qualified and certified.

In 1983 the CMB ceased to exist as nursing, midwifery and health visiting regulation was amalgamated into the United Kingdom Central Council for Nurses, Midwives and Health Visiting (UKCC). The UKCC included 4 national boards for each of the UK nations: England, Scotland, Northern Ireland and Wales, held a role of overseeing education and training. Each board also had a midwifery committee to oversee all matters pertaining to midwives and midwifery education and practice. The UKCC then took responsibility for overseeing the regulation, training and education of all practitioners.

In 2002, after the passing of the Nursing and Midwifery Order 2001, the functions of the UKCC were placed into the new Nursing and Midwifery Council (NMC), which maintained and regulated the register of nurses, midwives and specialist community public health nurses [14]. The NMC is now the statutory

regulator for nurses and midwives in the UK, with a role to safeguard the public, and therefore deals with any complaints or allegations of misconduct, or lack of fitness to practice due to health issues.

Midwives complete their requisite education and training – a minimum of eighteen months for a person already qualified as a nurse, or three years for a ‘direct entrant’. The education and training is provided at university degree level in partnership with the National Health Service (NHS), which takes responsibility for providing the supervised clinical practice placements for students. The student is required to be deemed competent in terms of academic achievement, and practice [11]. Programmes are designed in line with the International Confederation of Midwives (ICM) competencies, and the requirements of the European Union Midwives Directives [15; 16]. The NMC determined a set of principles to guide practice in *The Code*, which requires UK nurses, midwives and nursing associates to prioritise people, practise effectively, preserve safety and promote professionalism and trust [17].

In 2019, after an extensive review and analysis of the needs of women, babies and families, alongside professional views, the NMC published the new *Standards of proficiency for midwives* [18]. These drive education programmes, including pre qualification and continuing professional education programmes which students, and existing practitioners are required to achieve.

Under Article 15(1):

These standards of proficiency are in alignment with the International Confederation of Midwives’ definition of the midwife: ‘A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery [18]

The proficiencies are divided into six domains

1. Being an accountable, autonomous, professional midwife
2. Safe and effective midwifery care: promoting and providing continuity of care and carer
3. Universal care for all women and newborn infants
4. Additional care for women and newborn infants with complications
5. Promoting excellence: the midwife as colleague, scholar and leader
6. The midwife as skilled practitioner [18]

The proficiencies were drawn up reflecting extensive evidence based material as presented in the *Lancet Midwifery* series, which integrated all of these competency frameworks, alongside the Framework for Quality Maternal and Newborn Health

[19, 20]. This model highlights the unique contribution of midwives to the health and well being of women, babies and the wider community.

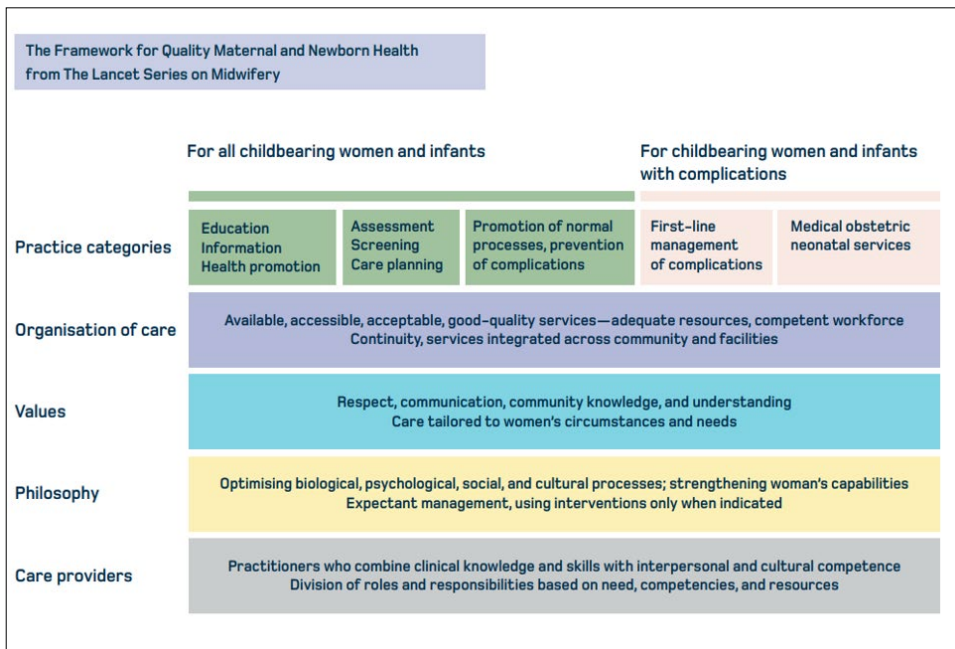


Figure 2. The Framework for Quality Maternal and Newborn Health [20].

### Sphere of practice

*‘Every woman needs a midwife and some need a doctor too... [21]*

Midwives in the UK provide care to women from early pregnancy through the pregnancy, labour and birth and care for the new mother and baby/ies for up to 28 days. This care is centred around the normal physiological processes, and midwives refer a woman to an obstetrician, and the baby to a neonatologist should there be a deviation from the normal. Women with complex medical issues, would be under joint care of the physician, obstetrician and midwife. There is a commitment to multi-disciplinary working, to ensure that the care is integrated and ‘joined up’ – and this is enhanced if the woman is being provided care within a continuity of care model.

It is normal practice for women to either refer themselves, or be referred by the General Practitioner (family doctor) to the midwife during the early weeks of pregnancy.

The majority of midwives are employed by the National Health Service (NHS), providing maternity and newborn services, free at the point of care. Care is provided within the acute sector of the hospital, primary care and also within the woman's home, with midwives employed by the maternity services, some of whom are based totally in a hospital setting; others totally in the community and some moving between hospital, birth centre and community, being wherever the woman and baby are. In some areas, women and their babies attend post natal clinics rather than being visited in their homes by the midwife.

In the 1970s, birth in the UK was increasingly moved from women's homes and community into taking place within hospital maternity units, persuaded by the Health Departments Advisory Committee chaired by Sir John Peel, who advocated 100% hospital delivery, supported by the consultant-led 'obstetric team' (to include general practitioners and midwives) as a way of addressing perinatal mortality [22]. This was further strengthened by a the 1980 Commons' Social Services Committee (the Short Committee) [23]. This move from community to acute/hospital services has since been challenged, as impacting adversely on women's choice, and leading to an increase in intervention and pathologising of birth without a commensurate reduction in morbidity and mortality [24]. It certainly led to midwives working within a hospital setting, often in one sphere of practice – for example, being allocated to work in the antenatal clinic for months or even years. Many midwives identified that this led to them being deskilled and certainly this affected confidence in other areas of practice.

Increasingly now, informed by evidence and research [25] (Birthplace in England Collaborative Group, Brocklehurst P, Hardy P, Hollowell J, et al) as well as government policy [26-32], different choices for place of birth are available and offered to women and their families, including home, birth centres (alongside maternity units or standalone) and also consultant obstetric units (CU). As highlighted in the Lancet Midwifery framework model, all women need the care of a midwife, and some will require the additional care of an obstetrician or a neonatologist, therefore multi-professional team working is an essential part of the midwife's function [20].

### **The way midwives work**

The majority of midwives are employed by the NHS, and the way they work and where, will vary between maternity services.

Countries of the UK have all developed landmark maternity strategies which support the development of service that focusses care on the woman and baby, enhancing a model of continuity of care, and improving choice and control of the woman on her pregnancy and childbirth journey. These include in England: *Maternity Matters: Choice Access and Continuity of Care* [29]; *Better Births: improving outcomes of maternity services in England* [30] and the *NHS*

*England Maternity Transformation programme* [33]; in Wales, *Maternity Care in Wales: A Five Year Vision for the Future (2019-2024)* [34] in Scotland *The best start: five-year plan for maternity and neonatal care* [35], and in Northern Ireland, *A Strategy for Maternity Care in Northern Ireland* [36]. At the heart of these strategies are the concepts of personalised care, better choice and continuity of care and carer.

Models of care include caseload models in which midwives hold a caseload, and work in small teams of 6-8 practitioners, often geographically based, enabling the whole pathway of care, from pregnancy, labour and postnatal period to be supported by a small group of known midwives. This model of care has been shown to improve satisfaction and quality of care for women, babies and families, and for increasing job satisfaction and team working by midwives [37-41].

The process of moving towards more personalised, continuity of care models has been overseen by the Departments of Health, and many services planned to roll out these models. This requires that staffing levels are sufficient to enable the models of care to succeed, that midwives and the wider maternity team are well prepared, and that student midwives are included within the workforce plan [33-36].

Clearly, progress on strategies and models of care though these initiatives has been hampered by the COVID-19 pandemic, as some staff had to be redeployed, and many services had to be provided through virtual and limited contact means. However, services are returning to something near normal, though at present (July 2023), they are being impacted by staff shortages [42].

### **Midwives career possibilities**

Midwives have much choice regarding careers. Many midwives will choose to focus on clinical practice either within a group practice model of care, or in a maternity unit based role – including working within neonatal care. Roles can include clinical leadership – being responsible for an area, or for leading the practice in the labour ward as a labour ward co-ordinator or team leader. There is also the role of matron in which the midwife has a defined responsibility for an area of practice. Consultant midwives may have a role that includes clinical leadership, expertise, research and teaching. Midwives may also select a role in management, including leading maternity services, with possibilities of elevation to the role of chief executive, leading an NHS service. Midwives may also choose to become educators, working within universities as well as the clinical area. The career pathway the practitioner chooses may require further education and training – for example a midwife wishing to work as an educator will need to complete a course in educational knowledge and skills, and/or complete research through a PhD or Masters in Philosophy [43, 11].

## 4. Midwifery in numbers

Currently there are approximately 41,000 midwives, which equates to around 22,391 whole time equivalent midwives in the NHS in England. There are also around 6655 dual qualified practitioners – i.e. those who are both midwives and nurses.

Regionally and nationally, the shortage of midwives and an ‘ageing midwife population’ are a problem in all areas of midwifery practice [42, 44-46] and in each of the four countries of the UK. In the UK, it is estimated that an additional 3500 midwives were needed [44, 45], with 2500 needed in England alone [46] and recent statistics indicate a continuing reduction in the number of midwives in the UK [42, 44-46, 48]. This also has led to midwives working over their contracted hours; additional stress and feelings of burnout [46]. Recent anecdotal reports suggest that applications to midwifery programmes have also reduced by between 8% to 28% across the four countries of the UK [50, 51]. This might reflect the socio-political situation current at this time, and must be a matter of concern, as previously midwifery has been a popular career choice and recruitment to midwifery programmes has always been extremely healthy.

It is not just a national shortage, but worldwide with a global shortfall of approximately 900,000 midwives (United Nations Population Fund (UNFPA), World Health Organization (WHO) and International Confederation of Midwives (ICM), (UNFPA,WHO and ICM) [52]. Addressing this effectively through quality midwifery education, would positively impact on outcomes for women, childbearing people, babies, and families globally [53]. But also there is a critical need to place explicit value on midwives, and address their working environment, and their models of care, enabling better autonomy and control over their working life [54]. Long term strategic planning is needed to attract and educate people into the profession, ensure they are supported in their transition and journey as midwives and more importantly improve retention and working environments.

### **Payscales**

Midwives working within the NHS are paid according to a framework called ‘Agenda for Change’ which has been in place since 2004, based on competencies and role function [55]. This pay system covers all NHS staff except doctors, dentists and very senior managers. Each of the nine pay bands has a number of pay points. Staff normally progress to the next pay point annually until they reach the top of the pay band. In addition to basic pay, there is also extra pay for staff who work in high cost areas such as major cities like London (See Table 2) [56].

Table 2. Agenda for Change pay bandings

<b>Some of the lower bands 1-4 cover staff including</b> domestic support worker, housekeeping assistant, driver, nursery assistant, domestic team leader, security officer, secretary/typist and healthcare assistant. emergency care assistant, trainee clinical coder, estates officer and occupational therapy support worker	
<b>Band 5 – usually newly qualified midwives</b>	
<2 years' experience	£27,055
2-4 years	£29,180
4+ years	£32,934
<b>Band 6 – Once full competencies and preceptorship has been completed</b>	
<2 years' experience	£33,706
2-5 years	£35,572
5+ years	£40,588
<b>Band 7 Midwife at higher level – often Team manager of area co-ordinator or research midwife</b>	
<2 years' experience	£41,659
2-5 years	£43,806
5+ years	£47,672
<b>Band 8a</b> Examples of roles at band 8a - consultant prosthetist/orthotist, dental laboratory manager, project and programme management, modern matron (nursing) and nurse consultant (mental health nursing).	
< 5 years' experience	£48,526
5+ years	£54,619
<b>Band 8b Consultant Midwife</b> Examples of roles at band 8b - strategic management, head of education and training, clinical physiology service manager and head orthoptist.	
< 5 years' experience	£56,164
5+ years	£65,262
<b>Band 8c Higher level Consultant Midwife</b> Examples of roles at band 8c - head of human resources, consultant clinical scientist (molecular genetics/cytogenetics) and consultant paramedic.	
<5 years' experience	£67,064
5+ years	£77,274
<b>Band 8d</b> Examples of roles at band 8d include consultant psychologist (8c-8d), estates manager, chief nurse and chief finance manager.	
<5 years' experience	£79,592
5+ years	£91,787
<b>Band 9</b> Examples of roles at band 9 include podiatric consultant (surgery), chief finance manager and director of estates and facilities.	
<5 years' experience	£95,135
5+ years	£109,475
<b>High cost area supplements</b>	
Area	
Level (1 April 2022)	

Inner London

20% of basic salary, subject to a minimum payment of £4,888 and a maximum payment of £7,377

Outer London

15% of basic salary, subject to a minimum payment of £4,108 and a maximum payment of £5,177

Fringe

5% of basic salary, subject to a minimum payment of £1,136 and a maximum payment of £1,915

[55, 56]

## 5. Challenges and prospects

Over the past ten years there has been a gradual increase in student midwife recruitment. However, the UK government removed student nurse and student midwife bursaries between 2017-2020, in a bid to reduce NHS costs. This adversely affected recruitment, as many students come into midwifery as a second career, often have dependents, and therefore financial hardship can be a major hurdle to coming into a midwifery programme [57]. A non means tested maintenance grant for students has now been reinstated.

There is an expressed government commitment to increase student numbers, however, one of the difficulties is that student numbers must be synchronised with the number of qualified midwives providing supervision and mentorship, and also alongside the available clinical experience.

There is also growing concern that there are insufficient midwifery educators, as pay and conditions in the education sector have fallen behind those in the NHS.

Emerging from the global COVID-19 pandemic, the challenges for the maternity services and in particular for midwives have been emphasised. There are challenges within the UK NHS, which has had limited increases in funding over the last decade and, because of the pandemic, are dealing with high waiting lists and ‘catching up’ care that was not possible during 2020-2023 [ 58]. The effects of the COVID-19 pandemic have been exacerbated by the UK leaving the European Union (‘Brexit’), the war in Ukraine and the rising cost of living. This has impacted on the NHS, and thus on the maternity services, in different ways, adding to a staffing crisis and stress, and resulting in some practitioners leaving the profession, or choosing to work elsewhere. This is reflected in other parts of the world [50].

A creative, concerted and ongoing strategic national approach to recruiting new students into the profession, and importantly improving retention and staff well-being is required.

There are many challenges in the care of women, their babies and families. In the UK, many women postpone starting their family until they are established in their career, so may face difficulties with reduced fertility, as well as more complex health needs. The shape of the family in the UK is also changing.

The COVID-19 Pandemic highlighted the impact of socio-economic disparity and how this can affect maternal and perinatal morbidity and mortality. The rise of interventions including induction of labour and caesarean section rates, also impact on midwifery practice, and midwives need to be alert and up to date with research and evidence, in order that they can provide women and families with the evidence on which to make an informed decision.

One major intervention – identified by the Lancet series, and by several UK government reports, is continuity of care and carer. Evidence consistently shows this, especially provided by a midwife, significantly improve health outcomes, patient safety and patient and practitioner satisfaction. Initiatives included in the 4 countries [30, 34-36] slowed by the pandemic will begin to be returned to, but are dependent on good staffing numbers [59].

The changing landscape of health and care demands that midwives are educated to a high level, in order that they can provide the best possible care, with kindness and compassion. This will ensure that women, their babies and families are informed, supported and nurtured through their pregnancy and childbearing experience, deviations from the normal are swiftly identified and managed.

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## **MIDWIFERY IN VIETNAM**

### **1. Brief history of midwifery**

In Vietnam, midwifery was formed and developed from the early years of resistance against the French. On 15/11/1945, six midwives who were read by Mr. Ho Dac Di – Director of the University of Medicine and Pharmacy completed the exam to receive the Vietnamese Midwife degree.

It was followed up to 1947 that midwives were trained only in Hanoi.

In central Vietnam, the first class of midwives graduated in 1960.

To understand the history of midwifery, we should learn through the 3 stages of formation and development of midwifery training schools in southern Vietnam.

#### *National midwifery school period (1947 – 1975)*

On 29/5/1947, Vietnam National School of Midwives was established, located at 284 Cong Quynh, District 1, Saigon, under Saigon Medical University.

On 18/9/1958, the National School of Midwives was managed by the Ministry of Health, the address remained at 284 Cong Quynh, District 1, Saigon.

The head of the School at this time was Professor Georges Cartoux (1947-1954).

He was followed by Professor Tran Dinh Vi, who served as superintendent from 1954 to 1964. Dr. Nguyen Van Hong then served as the school's director from 1964 to 1975. In 1960, the first midwife graduated in Hue, central Vietnam.

In light of the tight working relationship between the National Midwifery School and the hospital at this time, the school's director would assume the duties of the hospital's deputy director and vice versa. There is a boarding section at the school that is strictly supervised by teachers in terms of class time. The school has trained many midwives who are not only skilled but also have a very kind heart that contributes to the care of women, mothers and their children at that time. Currently, among the students from the first courses in all parts of the country and abroad, there is still a tradition of meeting every year on the first Sunday of December 12. That meetings had many useful activities, reiterated the traditions of the profession, and awarded scholarships to poor students studying Midwifery.

#### *Midwifery period (1975 – 1998) [1].*

The leaders followed in turn by:

- Mrs. Thu Ba, Mrs. Nguyen Thi Suong 1975 -1977
- Dr. Nguyen Thi Thuong 1977-1978
- Dr. Ngo Thi Huê 1978 -1980

- Dr. Ngo Huynh Mai 1980 -1984
- Dr. To Thi Ngan Ha 1984 -1989
- Dr. Nguyen Hoang Le 1989 -2006

After 30/4/1975, the National School of Midwives became the Midwife Branch of the Medical Technical High School, under the Military Administration Committee of Saigon - Gia Dinh City.

Six months later the school was renamed as Central Medical Technical High School 3- Midwifery Secondary School, under the management of the Ministry of Health.

The location remains the same but the other street name is 191 Nguyen Thi Minh Khai, District 1, Ho Chi Minh City.

Following the National School of Midwives, midwives trained midwives for all provinces and cities in the country. The sector leaders at that time had the head of the department and 2 management departments: the professional department with the ministry and the teachers; The administrative department consists of the head of the department, the kitchen and the management of the women's boarding house.

In midwifery at this time, there was a dormitory dedicated to midwifery students, which later became a women's dormitory for all other branches of the School.

The teaching activity of the period was also the Midwifery Division of midwifery. Teachers of the Midwifery Department, which is very close to the practice hospital, especially Tu Du Maternity Hospital. Each faculty who participates on duty at the Delivery Room usually assumes the responsibility of being the shift leader or deputy.

Midwives trained from the school spread across the country to bring skill knowledge and a love of the profession to serve the people. The prestige of the school was built by midwives with their own work. Senior midwife classes are always the pride of junior classes.

#### *Midwifery period (2006 – 2017)*

The departmental leadership of this period was:

- Mrs. Trieu Thi Ngoc Thu 2006 -2012
- Mrs. Do Thi Huong 2013 to present

Since 1998 when the 3rd Central School of Medical Engineering merged into the University of Medicine and Pharmacy of Ho Chi Minh City to become the Faculty of Nursing and Medical Technology, the Department of Midwifery became the Department of Midwifery. [2]

A big turning point worth remembering is that midwives in Vietnam today have been trained through many ranks from intermediate to college, university and postgraduate. Since 2017, the Government has stopped intermediate training.

Midwives today are qualified to participate in management in the leadership as well as key officials in public and private health facilities. In addition to caring for the sick, midwives today also participate in scientific research, always learn creatively in their work to help improve the quality of care, especially exchanges

with other countries around the world through projects to exchange specialized contents between countries, to learn from their advances.

The Vietnam Association of Midwives (VAM) was established on 09/12/1995 under Decision No. 657/TTG by the Prime Minister of the Socialist Republic of Vietnam, which was formally approved on 16/10/1995. It is supported by the Ministry of Health, the Vietnam General Medical Association, Ms. Chieko Nohno, a member of the National Assembly of Japan, and a number of central agencies. The Association formally affiliated with the Vietnam Medical Association and became an associate member of that organization as soon as it was founded. In 1996, VAM formally ascended to the position of important member of the International Conference Midwifery with the assistance of the United Nations Children's Fund (UNICEF) [3].

Ho Chi Minh City Midwives Association established on 15/5/2015. It is a professional social organization of people doing scientific research or professional expertise in midwifery, voluntarily established for the purpose of gathering, uniting, protecting rights, interests, supporting and mobilizing scientific and technical staff specialized in Midwifery in all fields of activity and of all economic sectors; strive for study and work, participate in the development of science and technology specialized in Midwifery; help each other constantly improve their professional capacity, practice their profession in accordance with standards of duty and ethics, actively contribute to the cause of protecting and promoting the health of mothers and babies on an advanced medical platform [4].

Midwives also have an organization founded under the present legislation called „Vietnamese Midwife Family,” which is attended by the majority of retired midwives. This organization has rules for organizing activities, and is strictly regulated. The inaugural meeting, which took place on February 12, 2001, and took into account the members' ages, was presided over by Ms. Nguyen Thi Thuy Hien, with a class 17 student. Numerous sisters attended, and the Representative Board and activities produced a lot of beneficial work. This organization attracts many midwives to many courses, many provinces and cities including girls and sisters from outside Hue to connect with each other through many meaningful activities such as: meeting every year for 1 day on the first Sunday of December. Meeting to bond with cordiality, to summarize the quiet work of the Representative Board during the year such as supporting midwives with special difficulties, visiting families of sisters with hospitalized people, reviewing the list of scholarships for midwifery students, especially the work of finding and persuading donors to contribute money to help the „Vietnamese Midwife Family” get meaningful expenses. They meet to prepare and to plan the direction of the next year's work. The annual reunion day is great fun and brings back unforgettable memories of school and work. The girls travel from distant provinces with a youthful and enthusiastic spirit that always created a happy and intimate atmosphere for the meeting. As of today, after 20 years of operation, there are girls who no longer come, due to health reasons, because of geographical

obstacles such as being in distant provinces, or being abroad, so they cannot attend meetings. Vietnamese midwives, when young, devote their energy enthusiastically to taking care of the women and their children, when they retire, they spend their energy taking care of each other.

## **2. System of education for midwives**

### *Undergraduate Education*

The midwifery education system has gone through many different stages, with different types of training to adapt to historical circumstances.

Right after the announcement of the establishment of the Democratic Republic of Vietnam, the training of medical human resources was also very focused. As evidenced by the first opening of the School of Medicine and Pharmacy in the North of Vietnam, with six Midwifery students admitted. Even during the war, the training of medical staff mainly focused on doctors and nurses to serve the military. However, there were still some schools that offered some form of midwifery training.

In the 1930s of the twentieth century, an Indochina Midwifery school (Saigon) trained midwives at the secondary level in the South of Vietnam.

Since 1975, the secondary midwifery training level has gradually been established in universities and colleges. The study period is 2 years for students who have graduated from high school. After graduation, midwives can work in hospitals, birth centers, clinics, community health centers, other specialized medical units or agencies, and administrative and non-business units. They serve as caregivers and assistants to doctors in specialized techniques.

Since 2010, national standards for the accreditation of the three-year, Bachelor of Midwifery programme have been developed. Nationally, 63 schools offered midwifery training at the secondary level, and some schools offered midwifery training at the college level by 2013 [5-8].

The current midwifery education system offers a 4-year bachelor's in midwifery as well as 3- and 4-year college bachelor's degrees. Both public and private schools, including secondary vocational schools, colleges, and universities, offer midwifery training [9-11]. High school graduates must meet admission requirements. Some schools may make their decision to admit a student on their high school academic records or on their performance on the results of the national high school exam.

Midwives must possess at least a college degree in order to get the title of Class IV Midwife, as stated in the Ministry of Health's joint circular on regulations on norms and requirements for professional titles [12]. As a result, in order to satisfy the established standards, it becomes necessary to refresh knowledge, information, and qualifications. The scope of education for intermediate midwives is getting smaller.

Universities around the nation currently train university midwives using a credit system, with a minimum of 120 credits and including general, basic, specialized, and elective studies [13].

The programme's objective is to educate professional midwives in reproductive health at the university level. After graduation, midwives offer population and family planning services in public, private, and community health facilities as well as care for mothers and children. Attention is also paid to the moral aspects of the exercise of the profession and to the possibility of continuing education to graduate at home and abroad to advance credentials.

#### *Post Graduate Education*

There is no training for a master's degree in midwifery in the country. Some private schools offer application-oriented postgraduate midwifery training called Specialized Midwifery I. However, students have the opportunity to raise their degree of learning after graduation: Master of Midwifery, Doctor of Philosophy in Midwifery in Asia or other parts of the world.

### **3. The legal status of midwifery**

In recent years, midwives were a strictly autonomous profession, the terms "midwife" and "practice of midwifery" are defined in the laws of Vietnam. The aim of such definitions is to delimit the scope of a midwife's practice and thus to prevent her from performing, in connection with child-birth, acts pertaining to the medical profession. The laws also stipulate that the practices defined may be performed by qualified midwives only and so reserve the practice of midwifery to such persons.

In Vietnam, the practice of midwifery is restricted to persons of Vietnamese nationality (or to nationals of a country in which Vietnamese midwives may practice) who hold a diploma or degree in midwifery, are registered with the Vietnamese Ministry of Health, and hold the license for midwifery practice. Rural midwives may, however, practice in villages in which there are no qualified midwives.

The scopes of midwifery practice were clearly determined in circulars 12/2011/TT-BYT issued on March 15th, 2011 provision of professional standards of midwife. In these circulars, the scope of midwifery practice for each midwifery education level is also described very clearly from primary midwife to bachelor midwife [14]. In addition, the decision 342/QĐ-BYT issued on January 24th, 2014 from Vietnamese Ministry of health approved the document about basic competency of Vietnamese midwife. Based on this decision, the curriculum and programme learning outcomes for midwifery were also revised and updated. There are seven competencies that a midwife should have in order to practice

as a midwife [15]. The joint circular number 26/2015/TTLT-BYT-BNV issued on October 7th, 2015 provisions on code number, standards for midwifery professional. In this circular, the midwifery professional is divided into three class. The lowest class is midwife class IV with code number V.08.06.16 and the highest class is midwife class II with code number V.08.06.14. The tasks, standards of training, and professional competencies of each midwife class also described in the circular clearly [16].

#### 4. Midwifery in numbers

An estimate of the national population is about 97.6 million in 2020, an increase of nearly 4 million people compared with 2019. Life expectancy at birth in Vietnam grew slightly year on year but is still lower than other countries in Southeast Asia (Table 1) [17, 18].

Table 1. Demographic and socioeconomic context in Vietnam

Name of Indicators	Implemented target 2018	Implemented target 2019	Implemented target 2020	Target to 2020	Target to 2025
1. Population ('000000)	94.7	93.7	97.6	98	
2. Life expectancy at birth (year)	73.5	73.6	73.7	75	74.5
3. Population Growth Rate (%)	1.06	1.06	1.15	1	
4. n Sex ratio at birth	114.8	112,1	112.06	115	109
5. Percentage of the population participating in health insurance	86,8	89.10	90.85	>80	95
6. Doctors per 10000 persons	8,97	9.06	9.81	9	10
7. Percentage of TYT having midwife or Pediatric (%)	94,5	96.1	94.5	>95	
8. Maternal mortality ratio (per 100000 live births)	46	46*	46*	52	
9. Infant mortality rate – IMR (%)	14.2	14.4	13.9	11	12.5
10. Decrease of birth rate (%)	0.1	0.1	0.1	0.1	

##### *Health care system*

The health care system of Vietnam is organized into four levels. At the national level is the Ministry of Health, which is responsible for care and protection of the people's health and supervising health sectors. Administration of public

services in these fields is within the scope of state management carried out by the Ministry of Health [19]. At the provincial level, there are 58 provincial health bureaus, including provincial hospitals, centers for preventive medicine, and medical secondary schools. These all follow policies of the Ministry of Health but are organic parts of the provincial governments under the Provincial People’s Committees. The district health centres are responsible for providing primary health care services and implementing national programmes at the community level. Commune health centers provided a range of basic services, such as: mother and child health care, family planning, treatment for acute respiratory infections, immunization and treatment of common ailments [20,21].

*Maternal and infant statistics*

Based on data collected in 2015, 93.6% of births were delivered in health facilities, with 89.7% in public sector facilities and 3.9% in private sector facilities; only 5.6% of births took place at home and this proportion was highest in the poorest wealth quintile (26.5%) and ethnic minority groups (30.7%) [22]. The maternal mortality rate was 46 per 100,000 live births in 2020 (Table 1). Neonatal mortality was estimated at 12 per 1,000 live births. The infant mortality rate was 14.2% live births in 2018, lower than the rate in 2015 which was 16% and under-five mortality rate amounted to nearly 21.4% for the same period. This indicates that nearly 67% of under-five deaths were infants in Vietnam [17, 22].

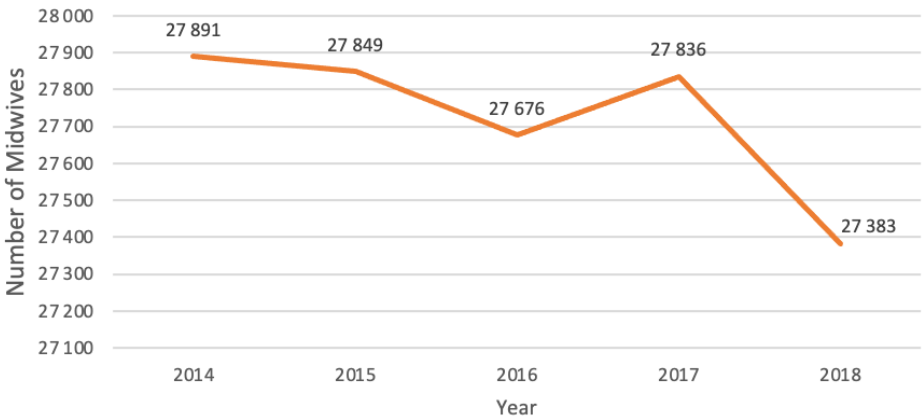
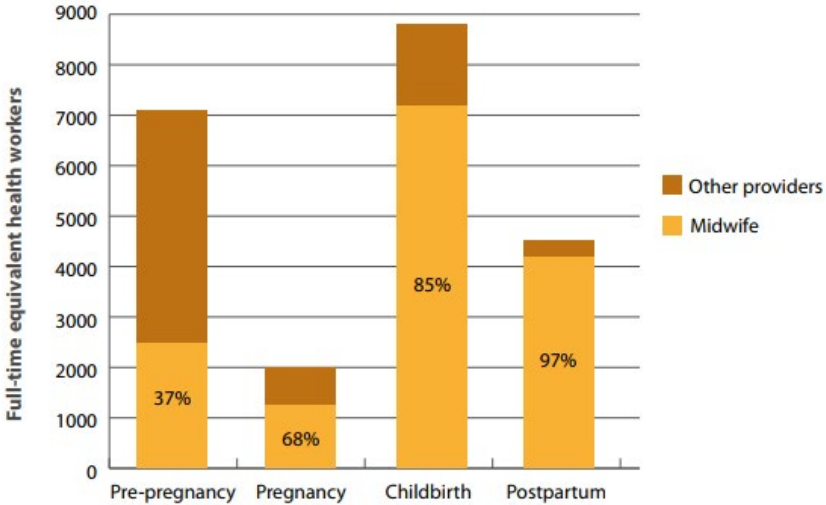


Chart 1. Number of midwives

*Midwifery information*

About midwifery education, university consists of a 4-year obstetric nursing programme, while college consists of 3-year midwifery training, and secondary consists of 2 years. Figure 1 shows the lower number of practicing midwives

compared to 1000 population [23]. The number of midwives does not seem to change from 2014 to 2018 (Chart 1) and midwives mainly take part in maternal and neonatal care activities at birth and postpartum. However, the number of midwives involved in antenatal care is only about 35% (Figure 1).



Source: Estimates based on SoWMy methodology. See Annex 3 for detailed assumptions.

Figure 1. The relative share of midwives to overall workforce required to meet four groups of essential midwifery service needs in Vietnam, 2015

Nearly half of the public midwives are located at the commune level including the commune health stations, although these health workers are not working exclusively providing midwifery services because they are often involved in other tasks such as implementing the expanded programme on immunizations. About 32% of the midwifery workforce is working in district level. The remaining 28% work in reproductive health centers at the provincial level (Figure 2) [17].

There is also an internal overlap because other health workers are also involved in maternal and child health care (Figure 3). There is a substantial overlap, but also independence, among different types of health professionals providing midwifery services in Viet Nam. Each one of the cadres has their own unique contribution to give, including village birth attendants who often have intimate knowledge of cultural practices that are important to the women and their families. It can be seen that the 3-year midwifery training builds on the 2-year midwifery training and this training will result in skills and knowledge that are unique to the midwife, just as the skills and knowledge of obstetric and gynecologic physicians, general practitioners and nurses are unique to their professions [24].

## Midwifery distribution

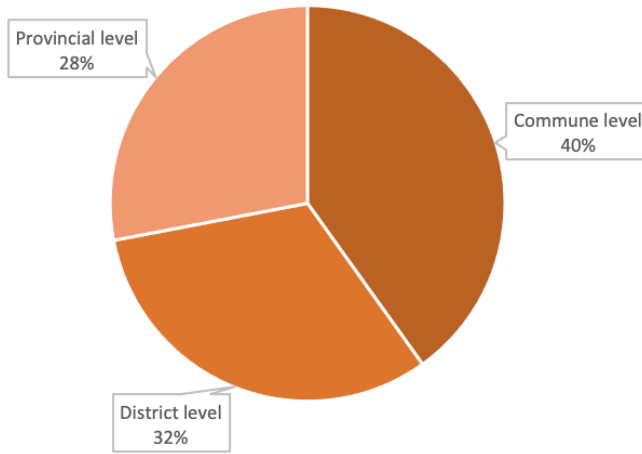


Figure 2. Distribution of Midwives

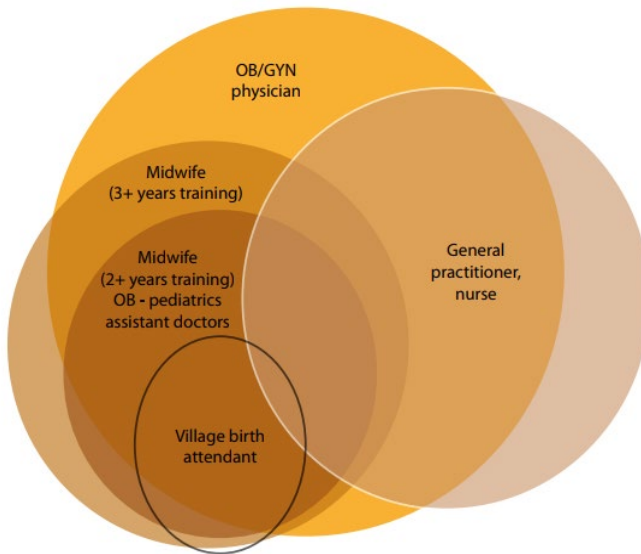


Figure 3. Overlap and independence of different midwifery personnel in Vietnam

Although many factors influence an individual's choice to become a midwife, such as desire to work with babies, or coming from a family tradition where one's mother is a midwife, remuneration levels and the ability to find employment are major factors influencing this decision. Midwives work often requires overnight

shifts with women arriving at all hours of the day in labour and requiring attention. Public sector midwives of the same level of qualification and experience as nurses or technicians are paid at the same salary level (Circular 26). The current basic salary as of 1 July 2019 is 1,490,000 VND per month (Decree 38/2019/ND-CP). This basic salary is then multiplied by salary coefficients which depend on the level of qualifications and years of seniority (experience) [24].

## 5. Challenges and prospects

Table 2. Midwifery’s vision 2030 [24]

Midwives meet 85% of basic essential midwifery service needs, referring clients to doctors only when there are complications.	Needs
Doctors meet the needs of cases facing complications, and are rarely involved in basic midwifery service provision.	<ul style="list-style-type: none"> <li>• Pre-pregnancy</li> <li>• Pregnancy</li> <li>• Birth</li> </ul>
Population workers, VBAs, and STI clinics complement the work of midwives through mobilization of clients to request services, or through alternative points of care.	<ul style="list-style-type: none"> <li>• Post-partum</li> <li>• Neonatal care</li> <li>• Other reproductive health needs</li> </ul>

### *Education*

Although the national competencies for midwives was developed and introduced in line with recommendations by the International Confederation of Midwives (ICM) and ASEAN member states, as well as the National Program of Action for strengthening Nursing and Midwifery services 2012-2020, development and review of curriculums is a huge issue. Reforming the midwifery education programme not enacted consistently yet. Midwifery education has not been brought to post-graduate training programme, which have missed opportunities for midwives to progress in their careers.

High-quality midwifery education is necessary to increase the standard of maternity and neonatal healthcare. The State has also used funds from the state budget to improve the master’s and doctoral level lecturers’ competency in accordance with the most recent Decision No. 911/QD and Project 89 [25, 26]. The training of midwives has continually undergone improvements. National standards and competency-based midwifery training programmes handle all curricula for three or four years [5, 7]. After applying, these programmes have been assessed qualifications in nation and Asia. Additionally, there are specific guidelines and circulars for midwives’ continued education, such as the National Standard Guidelines, the Practice License Requirements in Vietnam, and the Training Program for Skilled Birth Attendants [27, 28, 29, 30, 31].

### *Practice*

It is not easy for Vietnamese midwives to be a “good midwife”, defined as a midwife who are skilled in communication compassionate, kind, supportive (affective domain), knowledgeable (cognitive domain) and skillful (psychomotor domain) [32]. Recent research shows the majority of midwives experience work-related psychological distress as part of their professional routine. High workloads due to low staffing levels, lack of continuity of career, low support from colleagues, challenging clinical situations and low levels of clinical autonomy are all found to be correlated with poor emotional wellbeing among midwives [33]. They also were sometimes vulnerable to criticism, and blamed by patients and their families for unforeseen and unavoidable childbirth complications which could not be prevented, even with the best effort. One in five healthcare professionals experience workplace violence in Vietnam, and midwives are no exception. Midwives reported having to endure work-related burnout which can be aggravated by exposure to workplace violence.

Data also reveals a significant shortage of skilled birth attendants in hard-to-reach regions and a significant difference in the competency of workers who are working in the lowlands compared to the highlands. 94% of practicing midwives are trained at secondary level and only 0.8% has bachelor qualifications. According to Circular 26 that only midwives at level IV can provide family planning services, approximately 33,000 secondary and elementary midwives and obstetric-pediatric assistant doctors need to be upgraded to 3-year qualifications by 2025. There is a major concern about the feasibility of implementing the Circular 26 roadmap due to the still limited capacity of current midwifery training institutions [34]. Moreover, Circular 26’s scopes of responsibilities for level IV midwives, and the timeline and alternative options for upgrade training needs to be revised urgently [34]. It is expected that recruiting more midwives and increasing training will improve the experience of working Vietnamese midwives. There is a need to scale up the midwifery workforce, globally and in Vietnam, to decrease their workload in maternity care and to improve quality of care for women and their newborns. This will not only improve health outcomes for mother and infants, but it will also deliver benefits to midwives themselves in terms of lower burnout rates and higher levels of job satisfaction [33].

The Vietnamese government and the Ministry of Health introduced midwifery competency standards in 2014, and they are currently gradually catching up to international standards. Midwives must practice for at least nine months before receiving a practicing licence. In collaboration with institutions, the Ministry of Health recently created a new road map for issuing and renewing practice licences based on national exams. It is easier to update knowledge. Numerous contemporary techniques are employed to develop maternity models and practice areas where midwives and students play a significant role, as well as to raise the calibre of midwifery services. Artificial intelligence (AI) could “democratize” healthcare on

a global scale. It helps to decrease the unequal treatment of the wealthy and the poor in the nation. Especially for developing countries, AI promises to improve access and quality of care for people, which are hampered by poor infrastructure and skills [35].

### *Research*

Being involved in research is of increasing importance for midwives, serving to strengthen the continuous development of the profession. Yet, midwives' skill to make use of research to inform practice, competence of evidence-based practice and ability to enable and carry out research is severely limited. Several studies on the factors that hinder midwives' participation and utilization of research identified lack of time on the job, a lack of knowledge, lack of funding, poor attitude/perception towards research and a lack of research support services as the key constraints. Midwives are not only midwives in their professional lives, but they also have other roles to fulfil, for example, being mentors to students and managers of clinical areas, a mother of a family. Thus, these are barriers to the engagement of midwives in research.

The midwifery competency standard [36] also demonstrates that research is one of the midwives' competencies. In the education system, the training programme also includes topics for students to learn how to undertake scientific research, ranging from fundamental to advanced. Students may conduct their graduation thesis in accordance with their preferences or work on research projects under the supervision of the faculty. In practice, the competency of midwives in the changing environment can be increased through diversifying resources, encouraging a positive work environment, and encouraging the use of evidence-based and creative practice.

### *Policy*

A midwife association, defined by ICM as 'a platform for developing strong, supportive, positive relationships among midwives and between the profession of midwifery and other stakeholders such as governments and other health care providers' [37], is often an important key stakeholders and can play an important role in policy discussions. However, potential role of a midwife association in Vietnam is not recognized fully. The share of voice by the midwifery association is less significant comparing to the nursing council and association as well as the top most officials in the Ministry of Health. The midwifery association has not been always directly involved in midwifery education and services, standards and policies. It is important for midwife associations to take up their role and responsibility understanding its members, their needs and strengths, protecting the rights of midwives through legal processes, preserve the professional rights and responsibilities of midwives. The Midwifery association should actively have more education sessions for midwives, whereby they can increase the knowledge and

skill to achieve MDG goals 4 and 5, revitalize the global partnership for sustainable development of the profession.

The Vietnam Midwifery Association reported that if there is a government servant law, when midwives support 87% of deliveries, have a clear work description, and are educated, midwifery will become a fully independent profession, titles, academic degrees, all levels of management, the use of midwife-led care models, independence in decision-making about midwifery care, and research on midwives' scopes of practice.

In 2011, the government and the ministry of health released the code of skilled occupation for midwives. Recognizing midwifery as a separate profession, enhancing the position and function of midwives in delivering healthcare to Vietnamese citizens. Standardize the nursing/students' systematic management. enhancing midwifery associations' roles at all levels: Participating in the creation of plans, policies, and training materials; receiving compensation; ensuring the welfare of students; spreading awareness about the value of midwifery in the community and within the healthcare system; and coming up with real solutions to allow the profession to flourish and become independent. [38].

For midwives, this means that they must be aware of their role as change agents, actively learn, develop their own skills, and ensure their midwifery competencies through self-training; actively collaborate with unit leaders to implement activities that will improve midwifery services; actively promote the creation of the Midwifery Association; and actively inform the public about the importance of independent midwifery.

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ISBN 978-83-8277-181-7