# Belgium (Wallonia and Flanders)

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**Abstract**

This chapter presents the principles of the midwifery curricula and the transition of midwifery students to qualified midwives working in Wallonia (the French-speaking part of Belgium) and Flanders (Dutch-speaking part of Belgium).

It highlights the legal, educational and practical regulations in respect of the profession including the 4-year curricula (in Wallonia) and 3-year curricula (in Flanders), current direct entry education and the fact that currently 99% female students are on programme. In total, more than 50% of the 262 graduated French midwives in 2014 have a non-Belgian secondary school diploma (according to 2014 data). In 2014, a total of 1697 were registered in the midwifery program in Flanders. A total of 364 (21.4%) Flemish and 220 (12.9%) Dutch students just finished their secondary level, and 493 (29%) had the Dutch nationality. Self-registration for 'visa' (license to practise midwifery in Belgium) and accreditation is automatically online whenever graduated from an official midwifery school in Belgium. Most of the Belgian midwives work as salaried midwives in hospital settings and midwives under 30 years old work on an almost full-time job equivalence.

There is currently a lack of evidence on new midwifery practitioners' (NMPs) transition to practise in Wallonia and Flanders. It is recommended that research

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M. Gray et al. (eds.), *Starting Life as a Midwife*,
https://doi.org/10.1007/978-3-319-93852-3_2

is conducted in order to further understand the different issues linked to this area of practise.

**Keywords**
Midwifery regulation · Midwifery practise · Wallonia · Flanders · Belgium

## 2.1 The Legislation Related to Regulation of Midwifery in Belgium

Welcome to Belgium, a small and pleasant European country of about 11.35 million inhabitants!

Belgium is a kingdom, and has a complex democratic political system.

The country is divided into three parts having its own language: Dutch in the north—the most densely populated region, French in the south (from the woodlands) and German in the eastern side of the country. In the capital Brussels, most Belgians speak French and/or Dutch.

Belgium is also divided into two main different administrative levels each with its own parliament and government. These are:

- Territory level: Wallonia region, Flanders region and Brussels-Capital region
- Community level with regard to the spoken language: French and Dutch and German communities

According to Statbel.fgov.be (2019) in 1st January 2017:

The Flanders region has about 6.516.011 people.
The Brussels region has about 1.191.604 people.
The Wallonia region has about 3.614.473 people, including German community.

The German community in Belgium is small (about 76920 people in 2017). They have their own parliament for specific matter such as culture, education, family, etc., and they have some university colleges, particularly for accounting education and nursing. There is currently no midwifery school in this German part of Belgium, so we won't write more about this region.

### 2.1.1 Overview of the Demographics of the Population in Belgium and Links to Midwifery

In 2014 in Belgium, there were 2,521,451 women with 15–49 years of childbearing age (Benahmed et al. 2016, p. 21) with a fertility rate of 1.74 (births per woman) and the mean maternal age for the first child being 28.5 years old, but 28.9 years old in Flanders (Devlieger et al. 2017), 28.3 years old in Wallonia and 30.0 years old in Brussels (Leroy et al. 2018a, b). There were 64,323 deliveries in Flanders in 2016 (Devlieger et al. 2017), 34,808 in Wallonia and 23,414 in Brussels region (Leroy et al.

2017). The caesarean section rate is 20.2% of all births for Belgium (2012) (Benahmed et al. 2016, p. 69) and in 2016 caesarean rate is 20.9% of the births in Flanders, 20.2% of the births in Brussels and 21.5% of the births in Wallonia (Leroy et al. 2018a, b).

About 11,633 midwives have a license to practise in Belgium (Cellule Planification des professions de soins de santé 2018, p. 16). There are on average for 2014: ten births per midwife in Brussels, 13 in Flanders and 22 in Wallonia (Cellule Planification des professions de soins de santé 2018, p. 71), and the number of midwives professionally active in health care sectors as of 31st December 2014 per 1000 women in childbearing age (15–49) for the three regions are (Cellule Planification des professions de soins de santé 2018, p. 68):

– Brussels: 36.75 midwives per women,
– Flanders: 30.89 midwives per women,
– Wallonia: 19.27 midwives per women.

Figure 2.1 presents the repartition of the midwives related to the childbearing age women in Belgium (Cellule Planification des professions de soins de santé 2018,

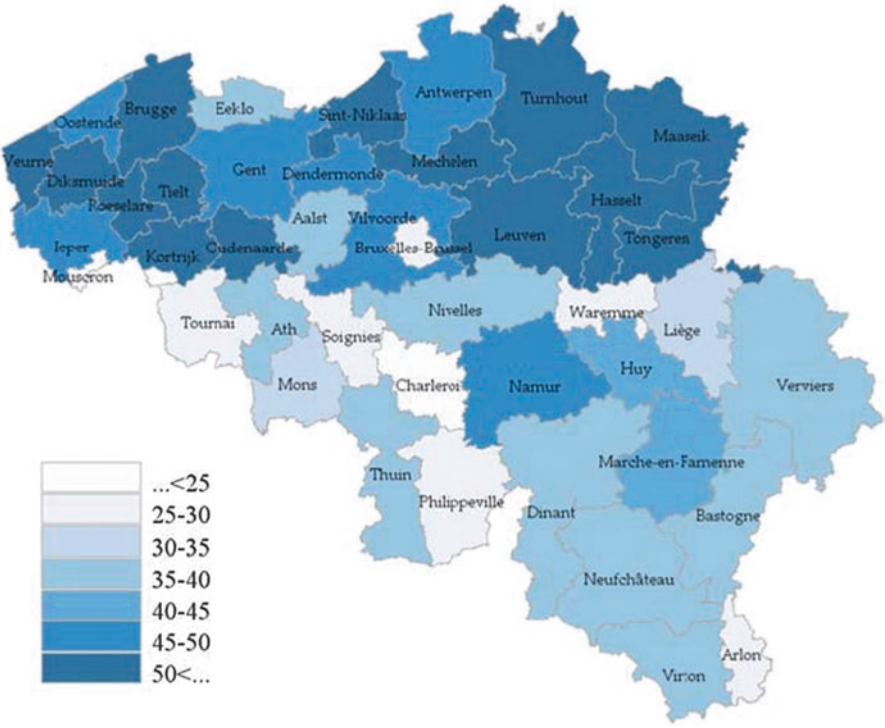



**Fig. 2.1** Geographical distribution in Belgium of all midwives licensed to practise (LTP) per 10,000 women in childbearing age (15–45 years) related to the district of the place of residence (31/12/2014). *Licensed to Practise (LTP)*: includes all the midwives authorised to work as a midwife. This excludes all the midwives with a 'superior' graduation level (doctors, dentist and pharmacologist) as they are expected to work at that 'superior' level (Cellule Planification des professions de soins de santé 2018, p. 20)

Carte 6, p. 63). Obviously, there are more midwives per childbearing age women in the north of the country (Dutch speaking) than in the south. This can easily be related to the population density: about 6,516,000 are living in the north region Flanders, whilst 3,614,500 are living in the south region Wallonia (including 76,900 from the German-speaking region) and 1,191,600 people live in the region Brussels (STATBEL (2018)).

Unlike other countries (for example, the UK and the Netherlands), midwives in Belgium have no legal support through health assistants in the form of Nursery Nurses, Nursing Assistants/Auxiliary Nurses, Healthcare Assistants or any other form of support worker (Benahmed et al. 2016, p. 68).

According to Benahmed et al. (2016, p. 72), there have been two major changes that have occurred in midwifery in Belgium during the last 20 years.

The first major change is towards more autonomy. From 1995 to 2005, there has been a progressive separation between both nursing and midwifery curricula, until now they are completely separate. However, both professions' curricula may be delivered to students within the same schools. From 1993 (in Flanders) and 2006 (in Wallonia) midwives are considered as autonomous health care professionals with a medical responsibility and without medical supervision. This has been a very positive thing for the recognition of the profession (KB 78, 2006). Flanders separated midwifery curricula from nursing curricula in 1993.

The second major change concerns the evolution of post-partum care in Belgium towards a shorter stay in maternity wards and developing more home/community mother-and-baby care services. Belgian midwives have committed themselves to further lead midwifery care in low-risk pregnancies and post-partum care, which may be a typical trend for midwives already practising in other European countries, but it is a new concept for Belgium and its related healthcare.

And, officials intend to reduce care expenses, becoming too heavy for the social security system of health: shortening stays in hospital after births, and other hospital stays, is said helping to reducing social security costs and is encouraged.

The fact that this practise is relatively new partly explains the lack of available information about the evolution of midwifery workforce in Belgium. The SPF (Service Public Fédéral) has undertaken a data analysis of years 2004–2014 to anticipate the needs of midwives in Belgium within the next few years to 2039, regarding births and women's care (Cellule Planification des professions de soins de santé 2018). Analysis and projections are ongoing and will soon be published.

### 2.1.2 General Midwifery Regulation in Belgium

Our midwife Belgian colleague Embo (Embo and Valcke 2016) says:

> Belgium is a small country with a complex administration. The latter influences midwifery practise and education.
>
> There is one federal Minister of Social Affairs and Health who is responsible for all Belgian qualified midwives in terms of legislation and budget and there are two Ministers of Higher Education, one in Flanders (the northern Dutch-speaking region) and one in

Wallonia (the southern French-speaking region), responsible for midwifery education in their regions.

These ministers are bound by the European Directives, federal legislation and professional standards but they are autonomous as to how education is being organised.

This written piece concerns the midwifery curricula of the territory region of Belgium: Wallonia and Flanders. Some figures and information come from the French community level (Communauté française) and/or from Belgium to enhance understanding and provide context.

The regulation of midwifery curricula in Belgium (Wallonia and Flanders) is organised by three policy levels (Benahmed et al. 2016):

- *From European Union*: 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) No 1024/2012 on administrative cooperation through the Internal Market Information System ('the IMI Regulation').
- Direct entry midwifery programmes ensure that students complete a minimum of 4600 h theoretical and practical work. Of this, there must be a minimum 1533 h (one-third) of clinical practise hours. Admission to the programme is possible if the student has achieved a minimum of 12 years of secondary education prior to entering the professional training. Equally, entry to the preregistration midwifery training is possible after completion of a prior nursing curriculum (and including 3600 h minimum, 2 years).
- *From Belgian federal legislation level*:
- Graduation is regulated by AR n°78 du 10/11/1967 related to health care professions, modified by law 13/12/2006 (echography and perineal re-education for midwives) and by law 10/05/2015 (transposition of the EU directives).
- Before 1980, the title 'accoucheuse' was a nurse specialisation and there was no legislative framework.
- *From the Belgian community legislation level*:
- Since 2007, the legal title now is 'sage-femme' in French and 'vroedvrouw' in Dutch—midwife—in order to be in harmony with international denomination and the International Confederation of Midwifes (ICM). According to the Belgian professional framework of the midwife (2016), the midwife is, as in all the world, 'the first choice health professional for childbearing women'; the definition of a midwife is the one of the ICM.

### 2.1.3 General Midwifery Regulation in French Community (Wallonia)

The 'ARES' (Académie de recherche et d'Enseignement Supérieur) is the community level's official higher authority for Wallonia. It guarantees the mission of public service for general interest of higher education, supports education establishments

and insures their global coordination in their missions of education, research and service to the community.

The provision of midwifery curricula in the Wallonia region is provided within nine midwifery university colleges, and nine, divided into 12 campuses, in the Flanders region, all of which are hosted within nursing schools. The main characteristics of the midwifery curricula are that it is a direct entry, 3- or 4-year program provided at bachelor level (Fédération Wallonie-Bruxelles 2016). This is a short-type bachelor, meaning a professional bachelor of 180 or 240 European credits (ECTs) leading directly to a bachelor graduation, whilst a long-type bachelor is organised in two parts, the first one of 180 ECTS leading to a bachelor graduation before entering the second part of the curricula leading to a 120 credits professionalising master degree.

Access to the midwifery curricula is possible to all who have successfully passed the secondary school certificate (after min. 12 years study), has a physical vocational certificate and an extract of clean police record (dating <3 months). There is no entrance selection. Nevertheless, most of midwifery schools are not able to accept all the candidates due of lack of appropriate available clinical placements. This is a problem for the profession, as the quality of the placements (number of deliveries and midwives per shift, number of students per shift, workloads of the midwives supporting continuous professional competence development of students, etc.) could affect the quality of the curricula. According to (Embo and Valcke 2016), 'Worldwide, workplace learning plays a crucial role in midwifery education. Midwifery workplaces continue to be critical learning environments in which knowledge, skills and attitudes are acquired within a real-life professional context.'

This informal limitation in Wallonia and Flanders is well known by the officials but for now, nothing yet is done to address this—see Sect. 2.1.3 for further explanation (Benahmed et al. 2016, p. 48). So, each French school applies its own specific criteria for the admission and choosing its candidates: for example, first arrived, first admitted or analyse the candidate's file, but this may vary. In Flanders, no limitation is allowed.

The midwifery workgroup involved in the SPF (Service Public Fédéral) data analysis of the potential needs for a midwifery workforce in Belgium (see Sect. 2.1.5) within the following 25 years will soon give advice to address this concern.

In 2016, the SPF (Service Public Fédéral) ordered a data analysis of a 10-year period for the years 2004–2014 in order to anticipate the potential needs for a midwifery workforce in Belgium within the following 25 years. This concern is developed in Sect. 2.1.4.

### 2.1.4 Regulation and Evolution of Foreign Midwifery Students in 2009–2014 in Belgium (French and Dutch Community)

From academic years 2006–2007 to 2011–2012, the government of the French community introduced an official regulation for foreign students applying to enter midwifery studies and other paramedical or medical studies. It is the 'Non-resident

Decret' (Décret régulant le nombre d'étudiants dans certains cursus de premier cycle de l'enseignement supérieur 2006). Midwifery schools were expected to accept up to 30% of foreign students calculated by reference of the number of previous academic year first-in-year 1 students. Due to decision of the Constitutional Court, this Decret was legally abrogated for midwifery studies (and some others) since years 2011–2012 (Direction générale de l'Enseignement non obligatoire et de la Recherche scientifique 2011, *Circulaire n° 3606*). The EU states indeed the free movement of studying and working persons inside the European Union. From that moment, midwifery schools in Wallonia once again had the opportunity to self-regulate the access of their foreign students. This varies relating to the number of Belgian candidates, which may vary itself depending on the general knowledge and interest, or news, about midwifery, as developed further in this chapter.

Table 2.1 presents the evolution of graduation in Belgium (Benahmed et al. 2016, p. 59) regarding the place of the midwives' secondary education.

In the years 2009–2014, the number of new graduated midwives in the 'communauté française' (French community) having a secondary certificate from abroad was more important than those coming from Wallonia. No study was undertaken to explain this, but an explanation may be due to the lack of information or interest of the Wallonia public at large regarding what midwifery is. As with other nations, the public may be confused with differences between midwives and nurses. This may be compounded by the fact that until 2005 in Wallonia and 1993 in Flanders both nursing and midwifery were sharing the same education and training curricula, with midwifery then being a nursing specialisation. Often, nursing and midwifery students were of the same university college, wearing the same hospital gowns, thus making differentiation across programmes almost impossible to determine. This trend and interest shown by the public is changing due to more awareness towards midwives and the midwifery profession attributable to, but not exclusively, some well-known television series such as 'Baby Boom' and 'Call the midwife'.

**Table 2.1** Place of secondary education per graduating midwife

| Academic year | Graduated midwives with Belgian secondary school certificate from within the Flanders community | Graduated midwives with secondary school certificate outside of the Flanders community | Graduated midwives in the French community with Belgian secondary school certificate | Graduated midwives in French community with secondary school certificate from the EU and non-EU | Total number of graduated midwives in Belgium |
|---|---|---|---|---|---|
| 2009/2010 | 256 | 98 | 102 | 171 | 627 |
| 2010/2011 | 266 | 74 | 133 | 145 | 618 |
| 2011/2012 | 349 | 88 | 116 | 155 | 708 |
| 2012/2013 | 311 | 87 | 142 | 163 | 703 |
| 2013/2014 | 298 | 80 | 113 | 149 | 640 |

The last few years, employment of the (new) midwives has also been a subject of interest in some newspapers on a recurring basis, as a certain amount of professions are legally declared to be 'lacking of workers' which is not the case of midwifery, but of (specialised) nurses. This opened some debates and interest about nurses and midwives.

In an attempt to raise awareness of the midwifery profession, the professional midwifery association 'Union Professionnelle des Sages-Femmes Belges' (UPSFB) developed a free leaflet for the public, presenting what a midwife in Wallonia is and does. This is entitled 'Entre de bonnes mains, celles de votre sage-femme' which means 'In good hands, those of your midwife'. Union Professionnelle des Sages-femmes Belges. Entre de bonnes mains, celles de votre sage-femme. n.d.-b. The UPSFB also developed a powerful website outlining definitions and practises related to midwifery care provision, which may also positively contribute to a better public accessibility of contemporary and correct information and understanding of midwives. This also happened in Flanders. The Flemish professional organisation of midwives (VBOV) has set up some profiling campaigns both in the written as well as on social media.

All Wallonia midwifery schools accept Belgian and non-Belgian students according to the EU legislation about free moving from one estate to another. Most of the foreign students come from the EU, with the majority arriving from France (Benahmed et al. 2016, p. 57). This could be because France is Belgium's closest neighbour, and we share the same language. Moreover, access to midwifery studies in France is robustly regulated (entrance examination for all candidates and few candidates accepted because they are not allowed to take more than what is fixed by law). Midwifery students coming from France recognise the high-quality level of the midwifery education, even if it is different from France. They use to say Wallonia curricula emphasise more relational and empowering aspects of the profession than in France.

Since 2010, the non-Belgian students in both the midwifery curricula of the Flanders and Wallonia region represent about 30% of the total of the midwifery students 'cohort' (Benahmed et al. 2016, p. 60).

Typically, 99% of the midwifery students in French community are female, and this figure has remained stable for several years (Benahmed et al. 2016, p. 50). It seems that midwifery in Wallonia is indeed dedicated to women, and mostly seen as a woman's job. A male-midwife in Wallonia is called 'homme sage-femme' and so is decided in France in 1982 by Académie française (Belhasse 2009) and in Flanders 'vroedvrouw'. Even if men are accepted and welcome, they may not feel encouraged. The French term 'sage-femme' is strongly feminine, and we always say 'she' when we talk about midwives. The free UPSFB leaflet presenting what does a midwife in Wallonia 'Entre de bonnes mains, celles de votre sage-femme' (Union Professionnelle des Sages-femmes Belges. Entre de bonnes mains, celles de votre sage-femme. n.d.-b.) speaks it only to the feminine: 'she' and 'her'. Historically in Belgium (and in our neighbouring countries), midwives were exclusively women, dedicated to help mothers, babies and families, and a part of the group were nuns. In comparison, nursing in Belgium has only a few more male nurses than in midwifery: 108,810 women and 17,663 men (6%) were economically active on 31/12/2009 (Cellule Planification des professions de soins de santé 2014).

A maximum of 1% of non-union candidate's students in the official university colleges of Belgium are fundable by decree. This leads the university colleges to limit non-union students' access and strictly respect this strain (CIRÉ n.d.).

The graduation rate (interpreted as the relationship between number of graduated midwives after 4 years of study and number of first-year students) for the years 2009–2014 in the 'communauté française' (French community) was 65, 0% (±9, 5), which is a rather good figure. In comparison, it is 54.2% (±4.5) for the whole of Belgium where midwifery training is a minimum of 3 years in the Dutch community and a minimum of 4 years in the French community. Nevertheless, it appears that the French figures are in strong diminution for those years, which could mean that less students are finally graduating after entering the curricula (Benahmed et al. 2016, p. 56). There is no research or evidence yet to explain this. The SPF work about next year's midwifery workforce will maybe help understanding this evolution. In the Wallonia university colleges, the average success rate of the students registered in the bachelor level (180 credits) for the first year is 39%: 31% are men and 45% are women (year 2013–2013). It is a little less in university (36%) (Académie de Recherche et d'Enseignement Supérieur n.d. Statistiques). The graduation rate is not available for university colleges or universities.

### 2.1.5 Evolution of Midwifery Practise Among Young Midwives in the French Community (2004–2014) and Its Opportunities

Registered midwives historically had the legal opportunity to work as a qualified nurse, under the same conditions and care services as nurses. The legislation changed in 2014. Newly graduated midwives after 1st October 2018 will be legally allowed to perform nursing services and delegated medical procedures, but only in obstetric, fertility, gynaecology and neonatology care units (Loi du 10 avril 2014 portant des dispositions diverses en matière de santé (2014)). This is a positive thing, as it is protecting midwifery profession. It is also legally acceptable for a graduated midwife to continue to graduate as a nurse, or vice versa. However, the workload of that mixed curricula becomes heavier, and very few newly graduated students are actually being able to complete it.

In 2016, the SPF (Service Public Fédéral) ordered a data analysis of a 10-year period for the years 2004–2014 in order to anticipate the potential needs for a midwifery workforce in Belgium within the following 25 years. This 2018 report is now available online (Cellule Planification des professions de soins de santé 2018), and it concerns the three regions of Belgium: Flanders, Wallonia and Germany. Analysis of this report and projections for future workforce planning are required in order to advise policymakers in developing future workforce. It is expected that these statistics will help reviewers to understand recent midwifery work conditions for new midwifery practitioners (NMPs) in Belgium in order to make advancements to ensure that maternity services are fit for the future.

The different types of practise identified and considered within the report (Cellule Planification des professions de soins de santé 2018, p. 12) are:

- *Licensed to Practise (LTP)*: includes all the midwives authorised to work as a midwife. This excludes all the midwife having a 'superior' graduation level (doctors, dentist and pharmacologist) as they are expected to work at that 'superior' level.
- *Professionally Active (PA)*: includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent).
- *Practising (PR)*: includes all midwives practising in health care services (according to their nomenclature, having at least two midwifery or nursing services during the year).

Table 2.2 presents the professionally active midwives in Belgium.

In 2014, 11,633 midwives were licensed to practise (LTP) in Belgium, with 75% of them ($n = 8671$) being professionally active (PA) (p. 16). In Wallonia, 4107 midwives have an LTP, among them 69% ($n = 2824$) are PA. Of them, 81, 69% ($n = 1405$) are working exclusively as salaried midwives, and interesting 596 of them are <35 years old. Only, 6.86% of them ($n = 118$) are totally independent midwives, meaning that they are not salaried at all (Cellule Planification des professions de soins de santé 2018, Table 6, p. 27).

Based upon the statistical data recorded at that point in time, it is not known if the flow of incoming new midwives is enough to substitute the retiring midwives, nor if retiring midwives are staying instead of retiring. Regarding the number of births per midwife in Wallonia (Sect. 2.1.1), this workforce could be appropriate, but regarding the increasing workload among hospital wards and in the community, midwives perceive that there is a lack of midwives, especially as they wish to plan 'one women, one midwife' for better care. The SPF (Service Public Fédéral) is continuing with the data analysis for the years 2004–2014 to forecast the needs for the future midwives workforce in Belgium (Cellule Planification des professions de soins de santé 2018); however, these projections have not been presented yet.

This will be a sensitive issue for midwives, families and policymakers: recommendations of the SPF will direct the decisions for the midwifery regulation and workforce in Belgium for the next 25 years.

There are a number of midwives with both nursing and midwifery diplomas. Among midwives having a midwifery diploma in Belgium ($n = 11{,}642$), 59.15% ($n = 6886$) have a midwifery diploma only and 34.21% ($n = 3983$) are dual trained, with the majority of them completing their nursing diploma first.

Table 2.3 presents the activity sectors for midwives in Wallonia and Flanders.

The main activity sector is located within hospital wards (85.02%, $n = 1362$) (Cellule Planification des professions de soins de santé 2018, Table 7a, p. 30). Other sectors include public sector within administration departments (6.12%, $n = 98$) or social services and nurseries (1.50%, $n = 24$). Education is difficult to evaluate for PA midwives living in Wallonia because the main employer (Ministry of Education)

**Table 2.2** Distribution of the professionally active midwives (PA) related to their region of activity and their professional status (31/12/2014)

| | | PA | | Age | | | Communauté | | Domicile | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Région d'activité | Statut professionnel | *N* | *%N* | .. < 35 | 35 < 50 | 50 < .. | FL | FR | RF | RW | RBC | N-Bel |
| Région flamande | | 4133 | 82.63 | 2018 | 1324 | 791 | 3810 | 323 | 4054 | 22 | 13 | 44 |
| | | 403 | 8.06 | 118 | 190 | 95 | 375 | 28 | 399 | 1 | 0 | 3 |
| | | 466 | 9.32 | 139 | 155 | 172 | 437 | 29 | 466 | 0 | 0 | 0 |
| | | *5002* | *100.00* | *2275* | *1669* | *1058* | *4622* | *380* | *4919* | *23* | *13* | *47* |
| Région wallonne | Salarié exclusif | 1405 | 81.69 | 596 | 507 | 302 | 189 | 1216 | 57 | 1264 | 6 | 78 |
| | Statut combiné | 197 | 11.45 | 59 | 94 | 44 | 14 | 183 | 0 | 195 | 1 | 1 |
| | Indépendant exclusif | 118 | 6.86 | 18 | 48 | 52 | 8 | 110 | 0 | 118 | 0 | 0 |
| | | *1720* | *100.00* | *673* | *649* | *398* | *211* | *1509* | *57* | *1577* | *7* | *79* |
| Région Bruxelles-Capitale | Salarié exclusif | 1676 | 86.04 | 720 | 590 | 366 | 894 | 782 | 898 | 324 | 431 | 23 |
| | Statut combiné | 234 | 12.01 | 84 | 93 | 57 | 106 | 128 | 100 | 69 | 64 | 1 |
| | Indépendant exclusif | 38 | 1.95 | 19 | 15 | 4 | 13 | 25 | 0 | 0 | 38 | 0 |
| | | *1948* | *100.00* | *823* | *698* | *427* | *1013* | *935* | *998* | *393* | *533* | *24* |
| Etranger and inconnu | Indépendant exclusif | 1 | 100.00 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 |
| | | *1* | *100.00* | *0* | *0* | *1* | *1* | *0* | *0* | *0* | *0* | *1* |
| Total | Salarié exclusif | 7214 | 83.20 | 3334 | 2421 | 1459 | 4893 | 2321 | 5009 | 1610 | 450 | 145 |
| | Statut combiné | 834 | 9.62 | 261 | 377 | 196 | 495 | 339 | 499 | 265 | 65 | 5 |
| | Indépendant exclusif | 623 | 7.18 | 176 | 218 | 229 | 459 | 164 | 466 | 118 | 38 | 1 |
| | | *8671* | *100.00* | *3771* | *3016* | *1884* | *5847* | *2824* | *5974* | *1993* | *553* | *151* |

*Professionally Active (PA)*: includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
*Région d'activité*: region of activity
*Région flamande*: the Flemish region
*Région wallonne*: the Wallonia region
*Région Bruxelles-Capitale*: the Brussels-Capital region
*Etranger & inconnu*: the foreign and unknown
*Statut professionnel*: professional status
*Salarié exclusif*: exclusively salaried
*Statut combiné*: combined status (means both salaried and independent)
*Indépendant exclusif*: exclusively independent

**Table 2.3** Distribution of the professionally active midwives (PA) related to ONSS and ONSSAPL, and related to region of activity, community and for Belgium (31/12/2014)

| | ONSS+ | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Région d'activité | | | | | | Communauté | | | | | |
| | RF | | RW | | RBC | | FL | | FR | | Total | |
| Secteur d'activité | *N* | *%N* | *N* | *%N* | *N* | *%N* | *N* | *%N* | *N* | *%N* | *N* | *%N* |
| *Soins de santé* | *4028* | *88.80* | *1434* | *89.51* | *1011* | *52.93* | *4310* | *79.99* | *2163* | *81.32* | *6473* | *80.43* |
| Hôpital | 3499 | 77.14 | 1362 | 85.02 | 957 | 50.10 | 3786 | 70.27 | 2032 | 76.39 | 5818 | 72.29 |
| MR(S) | 158 | 3.48 | 27 | 1.69 | 25 | 1.31 | 153 | 2.84 | 57 | 2.14 | 210 | 2.61 |
| Activités infirmiers hors hôpital | 245 | 5.40 | 30 | 1.87 | 9 | 0.47 | 239 | 4.44 | 45 | 1.69 | 284 | 3.53 |
| Activités sages-femmes hors hôpital | 7 | 0.15 | 0 | 0 | 0 | 0 | 7 | 0.13 | 0 | 0.00 | 7 | 0.09 |
| Autres secteurs de santé | 139 | 3.06 | 19 | 1.19 | 26 | 1.36 | 145 | 2.69 | 39 | 1.47 | 184 | 2.29 |
| *Action sociale* | *115* | *2.54* | *24* | *1.50* | *46* | *2.41* | *141* | *2.62* | *44* | *1.65* | *185* | *2.30* |
| Action sociale avec hébergement | 25 | 0.55 | 5 | 0.31 | 6 | 0.31 | 28 | 0.52 | 8 | 0.30 | 36 | 0.45 |
| Action sociale sans hébergement | 61 | 1.34 | 10 | 0.62 | 34 | 1.78 | 82 | 1.52 | 23 | 0.86 | 105 | 1.30 |
| Crèches | 30 | 0.66 | 10 | 0.62 | 7 | 0.37 | 32 | 0.59 | 15 | 0.56 | 47 | 0.58 |
| *Enseignement* | *55* | *1.21* | *18* | *1.12* | *579* | *30.31* | *433* | *8.04* | *219* | *8.23* | *652* | *8.10* |
| *Sécurité sociale + CPAS* | *223* | *4.92* | *17* | *1.06* | *17* | *0.89* | *229* | *4.25* | *28* | *1.05* | *257* | *3.19* |
| CPAS | 216 | 4.76 | 17 | 1.06 | 9 | 0.47 | 214 | 3.97 | 28 | 1.05 | 242 | 3.01 |
| Mutualités | 7 | 0.15 | 0 | 0 | 4 | 0.21 | 11 | 0.20 | 0 | 0.00 | 11 | 0.14 |
| Autres | 0 | 0 | 0 | 0 | 4 | 0.21 | 4 | 0.07 | 0 | 0.00 | 4 | 0.05 |
| *Secteur public* | *17* | *0.37* | *98* | *6.12* | *241* | *12.62* | *174* | *3.23* | *182* | *6.84* | *356* | *4.42* |
| Administration publique de la santé, de la formation, de la culture et des autres services sociaux | 0 | 0 | 87 | 5.43 | 205 | 10.73 | 142 | 2.64 | 150 | 5.64 | 292 | 3.63 |
| Autres secteurs publics | 17 | 0.37 | 11 | 0.69 | 36 | 1.88 | 32 | 0.59 | 32 | 1.20 | 64 | 0.80 |
| *Autres secteurs (hors santé)* | *154* | *3.40* | *31* | *1.94* | *83* | *4.35* | *188* | *3.49* | *80* | *3.01* | *268* | *3.33* |
| *Total* | *4536* | *100.00* | *1602* | *100.00* | *1910* | *100.00* | *5388* | *100.00* | *2660* | *100.00* | *8048* | *100.00* |

*Professionally Active (PA):* includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
*Secteur d'activité:* business sector
Région d'activité: region of activity
*Communauté*: community
*ONSSAPL (Office National de Sécurité Sociale des Administrations Provinciales et Locales):* National Office for Social Security of the Local and Provincial Administration
*ONSS (Office National de Sécurité Sociale):* National Office for Social Security
*Soins de santé:* health care
*Action sociale*: social work
*Enseignement:* education
*Sécurité sociale + CPAS*: social security + public centres for social help
*Secteur public*: public sector
*Autres secteurs (hors santé)*: other sectors (non-health sectors)

is based in the Brussels region, and the figures are then located in Brussels even if they work in Wallonia.

Table 2.4 presents the distribution and professional status for midwives.

In Wallonia, among the 617 midwives <35 years old, 545 are exclusively salaried and 15 exclusively independent. The others ($n = 57$) have a combined status (Cellule Planification des professions de soins de santé 2018, Table 10, p. 38).

Table 2.5 presents the age of midwives related to full-time equivalents.

Currently, 450 of these midwives are under 30 years old and those working in the Wallonia region have almost full-time jobs (0.9 full-time equivalent) (Cellule Planification des professions de soins de santé 2018, Table 7b, p. 32).

Table 2.6 presents the age of the professionally active midwives related to the region of activity.

Approximately, 7% of the professionally active (PA) midwives in Wallonia are <25 years old, and about 19% are between 25 and 29 years old. This last group is the most important of the working midwives in Wallonia (Cellule Planification des professions de soins de santé 2018, Fig. 1, p. 29). An explanation could be that a certain amount of the young newly graduated midwives choose to go on studying within master levels, or any complementary graduation (inter-university diploma, for example), and their entry in the working group is therefore delayed.

Table 2.7 presents the different category activities of midwives related to their age.

Among the 1133 midwives in the 'French community' who are under 30 years old with a license to practise (LTP), 67.7% of them ($n = 767$) are professionally active in health care sector (PR) (Cellule Planification des professions de soins de santé 2018, Table 9, p. 37). Within this category, it is difficult to accurately evaluate specific work in mother-and-child health care services, because of the double graduate nursing–midwifery.

## 2.2 A Brief Outline of the Education Leading to Registration as a Midwife in Belgium

### 2.2.1 In the Wallonia Region

The ARES' (Académie de Recherche et d'Enseignement Supérieur 2015) recommendations for the research academy for higher education are that the curricula have to include 240 European credits, distributed as follows within the 4 years (Fig. 2.2):

The integrated and internetwork framework for Bachelor in Midwifery presents eight training competencies, written according to ARES competencies (Groupe inter réseaux des enseignantes sages-femmes 2015). These are as follows:

- *First competence*: To commit herself into training, and building her professional identity

**Table 2.4** Distribution of the professionally active midwives practising in health care services (PR) related to region of activity and professional status (31/12/2014)

| | | PR | | Age | | | Communauté | | Domicile | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Région d'activité | Statut professionnel | *N* | *%N* | .. < 35 | 35 < 50 | 50 < .. | FL | FR | RF | RW | RBC | N-Bel |
| Région flamande | Salarié exclusif | 3672 | 84.96 | 1861 | 1148 | 663 | 3379 | 293 | 3612 | 16 | 7 | 37 |
| | Statut combiné | 379 | 8.77 | 113 | 177 | 89 | 352 | 27 | 376 | 0 | 0 | 3 |
| | Indépendant exclusif | 271 | 6.27 | 116 | 78 | 77 | 248 | 23 | 271 | 0 | 0 | 0 |
| | | *4322* | *100.00* | *2090* | *1403* | *829* | *3979* | *343* | *4259* | *16* | *7* | *40* |
| Région wallonne | Salarié exclusif | 1272 | 82.49 | 545 | 454 | 273 | 175 | 1097 | 51 | 1140 | 6 | 75 |
| | Statut combiné | 192 | 12.45 | 57 | 94 | 41 | 14 | 178 | 0 | 190 | 1 | 1 |
| | Indépendant exclusif | 78 | 5.06 | 15 | 36 | 27 | 5 | 73 | 0 | 78 | 0 | 0 |
| | | *1542* | *100.00* | *617* | *584* | *341* | *194* | *1348* | *51* | *1408* | *7* | *76* |
| Région Bruxelles-Capitale | Salarié exclusif | 893 | 80.52 | 438 | 251 | 204 | 367 | 526 | 349 | 173 | 358 | 13 |
| | Statut combiné | 192 | 17.31 | 77 | 72 | 43 | 76 | 116 | 69 | 59 | 63 | 1 |
| | Indépendant exclusif | 24 | 2.16 | 14 | 9 | 1 | 11 | 13 | 0 | 0 | 24 | 0 |
| | | *1109* | *100.00* | *529* | *332* | *248* | *454* | *655* | *418* | *232* | *445* | *14* |
| Total | Salarié exclusif | 5837 | 83.71 | 2844 | 1853 | 1140 | 3921 | 1916 | 4012 | 1329 | 371 | 125 |
| | Statut combiné | 763 | 10.94 | 247 | 343 | 173 | 442 | 321 | 445 | 249 | 64 | 5 |
| | Indépendant exclusif | 373 | 5.35 | 145 | 123 | 105 | 264 | 109 | 271 | 78 | 24 | 0 |
| | | *6973* | *100.00* | *3236* | *2319* | *1418* | *4627* | *2346* | *4728* | *1656* | *459* | *130* |

*Practising (PR)*: includes all midwives practising in health care services (according to their nomenclature, having at least two midwifery or nursing services during the year)
*Région d'activité*: region of activity
*Région flamande*: the Flemish region
*Région wallonne*: the Wallonia region
*Région Bruxelles-Capitale*: the Brussels-Capital region
*Statut professionnel*: professional status
*Salarié exclusif*: exclusively salaried
*Statut combiné*: combined status (means both salaried and independent)
*Indépendant exclusif*: exclusively independent

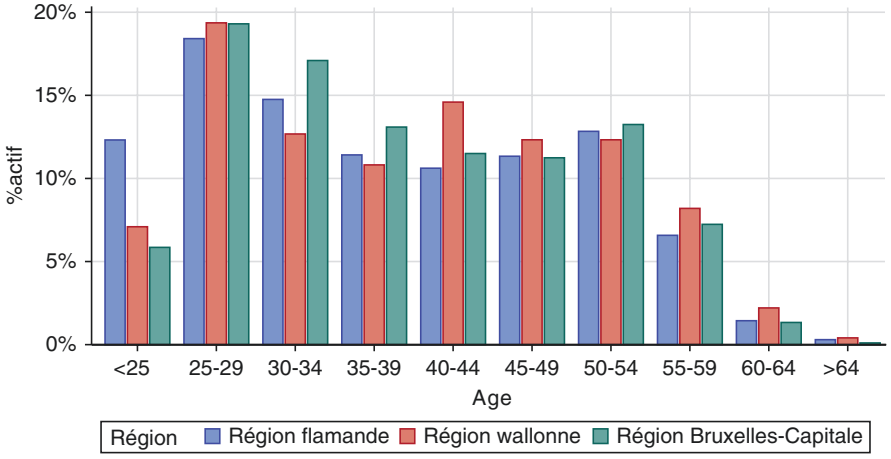
**Table 2.5** Distribution of the professionally active midwives (PA) related to ONSS and ONSSAPL, and to full-time equivalents, related to region of activity, age and business sector (31/12/2014)

| | | ONSS+ | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Santé | | Aide | | Enseign. | | CPAS+ | | Public | | Autre(hors santé) | | Total | |
| Région d'activité | Age | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. |
| Région flamande | .. < 30 | 1347 | 091 | 25 | 0.86 | 23 | 0.47 | 34 | 0.92 | 2 | 0.75 | 49 | 0.51 | 1458 | 0.90 |
| | 30 < 40 | 1067 | 076 | 40 | 0.71 | 14 | 0.57 | 47 | 0.83 | 3 | 0.68 | 38 | 0.72 | 1198 | 0.77 |
| | 40 < 50 | 867 | 074 | 27 | 0.68 | 6 | 0.62 | 66 | 0.73 | 4 | 0.81 | 32 | 0.69 | 994 | 0.74 |
| | 50 < 60 | 709 | 071 | 22 | 0.77 | 11 | 0.45 | 74 | 0.73 | 7 | 0.67 | 33 | 0.66 | 841 | 0.72 |
| | 60 < ... | 38 | 065 | 1 | 1.00 | 1 | 0.08 | 2 | 1.00 | 1 | 1.00 | 2 | 0.15 | 45 | 0.65 |
| | Tot | 4028 | 079 | 115 | 0.75 | 55 | 0.50 | 223 | 0.78 | 17 | 0.73 | 154 | 0.63 | 4536 | 0.79 |
| Région wallonne | .. < 30 | 405 | 091 | 2 | 0.65 | 3 | 0.69 | 1 | 1.00 | 34 | 0.93 | 6 | 0.48 | 450 | 0.90 |
| | 30 < 40 | 344 | 076 | 7 | 0.66 | 6 | 0.27 | 3 | 0.53 | 19 | 0.69 | 9 | 0.80 | 381 | 0.76 |
| | 40 < 50 | 375 | 076 | 9 | 0.66 | 5 | 0.22 | 6 | 0.75 | 32 | 0.80 | 5 | 0.41 | 425 | 0.76 |
| | 50 < 60 | 283 | 075 | 6 | 0.49 | 4 | 0.52 | 6 | 0.80 | 13 | 0.78 | 10 | 0.78 | 317 | 0.76 |
| | 60 < .. | 27 | 077 | 0 | 0 | 0 | 0 | 1 | 1.00 | 0 | 0 | 1 | 0.85 | 29 | 0.78 |
| | Tot | 1434 | 080 | 24 | 0.62 | 18 | 0.38 | 17 | 0.76 | 98 | 0.82 | 31 | 0.67 | 1602 | 0.80 |
| Région Bruxelles-Capitale | .. < 30 | 331 | 091 | 4 | 0.39 | 63 | 0.71 | 0 | 0 | 66 | 0.86 | 35 | 0.18 | 479 | 0.86 |
| | 30 < 40 | 267 | 075 | 16 | 0.79 | 174 | 0.67 | 6 | 0.96 | 111 | 0.75 | 20 | 0.51 | 576 | 0.74 |
| | 40 < 50 | 185 | 075 | 13 | 0.82 | 194 | 0.72 | 6 | 0.96 | 40 | 0.77 | 7 | 0.41 | 432 | 0.76 |
| | 50 < 60 | 210 | 075 | 13 | 0.73 | 143 | 0.64 | 4 | 0.85 | 22 | 0.74 | 19 | 0.55 | 395 | 0.73 |
| | 60 < .. | 18 | 086 | 0 | 0 | 5 | 0.42 | 1 | 1.00 | 2 | 0.64 | 2 | 0.14 | 28 | 0.72 |
| | Tot | 1011 | 081 | 46 | 0.75 | 579 | 0.68 | 17 | 0.94 | 241 | 0.78 | 83 | 0.36 | 1910 | 0.77 |

| Région d'activité | Age | ONSS+ | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Santé | | Aide | | Enseign. | | CPAS+ | | Public | | Autre(hors santé) | | Total | |
| | | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. | *N* | ETP Moy. |
| Total | .. < 30 | 2083 | 091 | 31 | 0.79 | 89 | 0.65 | 35 | 0.92 | 102 | 0.88 | 90 | 0.38 | 2387 | 0.89 |
| | 30 < 40 | 1678 | 076 | 63 | 0.72 | 194 | 0.65 | 56 | 0.83 | 133 | 0.74 | 67 | 0.67 | 2155 | 0.76 |
| | 40 < 50 | 1427 | 075 | 49 | 0.71 | 205 | 0.70 | 78 | 0.75 | 76 | 0.78 | 44 | 0.61 | 1851 | 0.75 |
| | 50 < 60 | 1202 | 073 | 41 | 0.72 | 158 | 0.63 | 84 | 0.74 | 42 | 0.74 | 62 | 0.65 | 1553 | 0.73 |
| | 60 < .. | 83 | 074 | 1 | 1.00 | 6 | 0.36 | 4 | 1.00 | 3 | 0.76 | 5 | 0.29 | 102 | 0.71 |
| | Tot | 6473 | 080 | 185 | 0.73 | 652 | 0.66 | 257 | 0.79 | 356 | 0.79 | 268 | 0.55 | 8048 | 0.79 |

*Professionally Active (PA):* includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
*Région d'activité*: region of activity
*Région flamande*: the Flemish region
*Région wallonne*: the Wallonia region
*Région Bruxelles-Capitale*: the Brussels-Capital region
*Secteur d'activité*: business sector
*Santé*: health
*Aide*: help
*Enseignement*: education
*CPAS*: public centres for social help
*Public*: public
*Autre (hors santé)*: others (non-health sectors)
*Equivalents temps-plein*: full-time equivalents
*ETP moy.*: full-time equivalents average

**Table 2.6** Proportion of the professionally active midwives (PA) related to age and to activity region, (31/12/2014)




*Professionally Active (PA)*: includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
*Région flamande*: the Flemish region
*Région wallonne*: the Wallonia region
*Région Bruxelles-Capitale*: the Brussels-Capital region

- *Learning outcomes*:
  - Actively take part to develop her learning
  - Take part to mentorship by peers
  - Develop her professional identity
- *Second competence*: To make allowance for deontology, ethics, laws and rules
- *Learning outcomes*:
  - Respect legislation, laws, rules and deontology that are specific to midwifery
  - Perform ethical approach
- *Third competence*: To take part in management of human resources, equipment and administration
- *Learning outcomes*:
  - Plan her duty regarding situation and organisational imperative
  - Collaborate with different multidisciplinary members of the team
  - Take part to quality process
- *Fourth competence*: To realise clinical approach (diagnosis and intervention/support strategies) during preconceptional time, prenatal, perinatal and postnatal time
- *Learning outcomes*:
  - Search for relevant information sources
  - Take part in the diagnosis
  - Decide what intervention and support to set related to the diagnosis
  - Evaluate and adjust

**Table 2.7** Repartition of the midwives (LTP-PA-PA) related to the community and age (31/12/2014)

| | | LTP | PA | | PR | |
|---|---|---|---|---|---|---|
| Communauté | Age | *N* | *n* | *%n* | *n* | *%n* |
| Communauté flamande | .. < 30 | 1936 | 1599 | 82.6 | 1412 | 72.9 |
| | 30 < 40 | 1873 | 1656 | 88.4 | 1279 | 68.3 |
| | 40 < 50 | 1486 | 1325 | 89.2 | 1000 | 67.3 |
| | 50 < 60 | 1429 | 1166 | 81.6 | 879 | 61.5 |
| | 60 < 70 | 418 | 97 | 23.2 | 56 | 13.4 |
| | 70 < .. | 384 | 4 | 1.0 | 1 | 0.3 |
| | | *7526* | *5847* | *77.7* | *4627* | *61.5* |
| Communauté française | .. < 30 | 1133 | 883 | 77.9 | 767 | 67.7 |
| | 30 < 40 | 821 | 645 | 78.6 | 545 | 66.4 |
| | 40 < 50 | 830 | 679 | 81.8 | 552 | 66.5 |
| | 50 < 60 | 753 | 557 | 74.0 | 437 | 58.0 |
| | 60 < 70 | 243 | 57 | 23.5 | 45 | 18.5 |
| | 70 < .. | 327 | 3 | 0.9 | – | – |
| | | *4107* | *2824* | *68.8* | *2346* | *57.1* |
| Total | .. < 30 | 3069 | 2482 | 80.9 | 2179 | 71.0 |
| | 30 < 40 | 2694 | 2301 | 85.4 | 1824 | 67.7 |
| | 40 < 50 | 2316 | 2004 | 86.5 | 1552 | 67.0 |
| | 50 < 60 | 2182 | 1723 | 79.0 | 1316 | 60.3 |
| | 60 < 70 | 661 | 154 | 23.3 | 101 | 15.3 |
| | 70 < .. | 711 | 7 | 1.0 | 1 | 0.1 |
| | | *11633* | *8671* | *74.5* | *6973* | *59.9* |

*Licensed to Practise (LTP)*: includes all the midwives authorised to work as a midwife. This excludes all the midwife having a 'superior' graduation level (doctors, dentist and pharmacologist) as they are expected to work at that 'superior' level
*Professionally Active (PA)*: includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
*Practising (PR)*: includes all midwives practising in health care services (according to their nomenclature, having at least two midwifery or nursing services during the year)
*Région flamande*: the Flemish region
*Région wallonne*: the Wallonia region
*Région Bruxelles-Capitale*: the Brussels-Capital region

- *Fifth competence*: To perform health care deliveries during preconceptional time, prenatal, perinatal and postnatal time
- *Learning outcomes*:
  - Prepare and realise the health care deliveries using appropriate resources
  - Ensure follow-up of the services
- *Sixth competence*: To ensure professional communication towards clients and professional staff
- *Learning outcomes*:
  - Pass on verbal or written information
  - Use techniques of communication appropriated to the context
  - Develop help-relationship

| **Programme minimum Sage-Femme/*Minimum midwifery program*** | **240 crédits (ECTS)** |
|---|---|
| Sciences Fondamentales et biomédicales/ *Basic and biomedical sciences* | 42 |
| Sciences humaines et sociales/ *Human and social sciences* | 15 |
| Sciences professionnelles / *Professional sciences* | 45 |
| Activités d'intégration professionnelle/ *Professional integration* or *clinical placements* | 75 |
| Recherche appliquée /*Applied research* | 15 |
| TOTAL commun | 192 |
| Liberté PO/ *Choice of the university college* | 48 |
| **TOTAL Général** | **240** |

**Fig. 2.2** Distribution of the European credits within the current curricula

- *Seventh competence*: To carry out collective and individual health promotion and education approaches
- *Learning outcomes*:
  - Identify needs, resources and expectations in health of the target audience
  - Plan educative and psycho-affective interventions
  - Realise the interventions
  - Evaluate and adjust the process or the intervention
- *Eighth competence*: to conceptualise a scientific-research process in midwifery
- *Learning outcomes:*
  - Develop a reflective thinking on her practise and improving it by evidence-based
  - Establish her practise on evidence-based

The competencies framework (Groupe inter réseaux des enseignantes sages-femmes. (2015). *Référentiel de compétences intégré inter réseaux en Bachelier Sage-femme*) identifies nine professional fields for midwifery training, which may be achieved either in or out of hospital settings, including training in simulation centres:

1. General adult care
2. Mental care and psychiatry
3. Preconceptional and prenatal health
4. Birth
5. Postnatal health
6. Health promotion
7. Care in high-risk pregnancies
8. Care in neonatology
9. Care in mourning, including termination of pregnancy and palliative care

The clinical placement training in these highlighted different professional fields may help midwifery students in their transition to practise. This is because the midwifery students are gradually exposed to the expectations required for the role of an NMP in order to gain confidence in the realities of what is like as an NMP. According to Gray et al. (2016), this could help 'the transition to the model of practise'. In

addition, it seems that more and more working placements (hospitals) ask to their NMP to be polyvalent and to regularly change their place of work to different wards, such as post-partum, neonatology, high-risk pregnancies, delivery and prenatal consultation. This flexibility may be anticipated through various clinical placements, as proposed during the curricula and reflects the realities once qualified.

It is also legally required by the EU that the midwifery student fulfils a specified number of births with attendance of an experienced midwife or obstetrician, and an amount of different practical gestures of care before graduation. The gestures have to be identified and signed in a special list evidencing achievement. Since 1987, in order for midwifery students to meet requirements for midwifery qualification and registration, they are required to perform (Di Zenzo 2012): 100 prenatal consultation, 40 high-risk pregnancies care, 40 deliveries and 100 post-partum examination. Omission of this legal aspect could lead to refuse the graduation and ultimately access to midwifery status.

### 2.2.2 In the Flanders Region

The competence framework in Flanders is based on:

- The European directives,
- The International Confederation of Midwives (ICM) Essential Competencies for Basic Midwifery Practice (2010, amended 2013),
- The relevant Belgian professional legislation and professional competencies (2015),
- And, the existing education programs (2008).

The competencies or learning outcomes:

1. Physiology, care and guidance
2. Risk detection and risk selection
3. Pathology, care and guidance
4. Psychosocial context
5. Ethics and legislation
6. Health educator
7. Collaboration and communication
8. Coaching
9. Personal and professional development
10. Evidence-based care
11. Quality and care

In Flanders, we have one professional profile combined with one educational profile. There are different curricula in the nine educational programs spreaded around twelve campuses. They all have 180 ECTS, about ½ clinical education (in school/at the workplace) and the obliged 3 ECTS: pharmacology (new legislation prescription).

## 2.3 The Regulation Related to Initial and Ongoing Registration in Belgium

Once all programme requirements have been met, for the newly qualified midwife there is no required national or regional examination before entering the midwifery registration in Belgium. Any graduated midwife is required to self-register prior to working clinically as a midwife in order to receive a visa and accreditation provided by the Public Health Services (SPF Santé Publique). Both are automatically provided if the NMPs' graduated from an official Belgian midwifery school. If not, an online procedure is available for midwives to apply. There is a special request for midwifery accreditation for prescribing drugs (SPF Santé Publique, Sécurité de la chaîne alimentaire et Environnement). The legal drugs list for prescribing midwives is newly updated and available online (SPF Santé publique, Sécurité de la chaîne alimentaire et Environnement. Formulaire de demande d'habilitation pour prescrire certains médicaments de façon autonome pour les sages-femmes. n.d.). This accreditation is mandatory if the midwife intends to work as an independent midwife, and is often sought by employers if he/she is salaried. Before 2014, this accreditation was optional in the curricula, and registered midwives had access to post-training certification in prescribing drugs. It is now legally included in the curricula and compulsory to any student midwife. The post-training certification in prescribing drugs is still available for older midwives.

Having a professional insurance is optional if the midwife is salaried and mandatory if working as an independent midwife. Independent midwives have to request a personal identity number for agreement and regulation. The midwives use specific and personal certificates of care and prescription pads, and have to join a mutual insurance company.

All midwives are legally required to undergo 75-h post-training development per 5 years as a regulation after graduation. Previously, the content of these development activities needed to be approved and were monitored by the Federal Council for Midwives (SPF Circulaire du 15 mars 2010, publié le 05 mai 2010) but it has recently been cancelled (Arrêté royal modifiant l'arrêté royal du 1er février 1991 relatif à l'exercice de la profession de sage-femme 2018). The midwife has the opportunity to choose and self-pay for training opportunities. Employers also encourage training and may organise, and or offer to pay for the midwife to attend. If the midwife does not satisfy this condition, she will receive a notice to ensure that she completes it. If she still does not satisfy the requirements after 1 year following the notice, her professional qualification could be removed, meaning that she is unable to continue practising as a midwife.

There are three midwifery professional associations, two in Wallonia and another in Flanders. All three of them are together in an umbrella organisation: the Belgian Midwives Association (BMA), which is the national midwifery association, linked in European Midwives Association (EMA).

– 'Association francophone des sage-femmes catholiques' (AFSFC) or 'French-speaking Association of catholic midwives'

– 'Union Professionnelle des sages-femmes belges' (UPSFB) or 'Professional Union of Belgian Midwives'
– 'Vlaamse Beroepsorganisatie van Vroedvrouwen' (VBOV) or 'Flemish professional organisation of Midwives'

In Wallonia, membership is optional and 39% of the 2824 midwives PA in Wallonia are members. Reasons could be a lack of information about the associations, or the fees (60–70 euros per year for a qualified midwife, less for midwifery students and retired midwives), or still the lack of interest. The associations work to develop, highlight and uphold all aspects of midwifery within official health, social and education authorities, by all the other healthcare professionals, and the general public; they support, protect and represent all midwives. They organise midwifery congresses, events, trainings, they hold a website, and they develop new education tools. All midwives committed in the associations are working for free with a view to enhancing the knowledge and understanding of quality health care provision of midwives and services to improve the nation's health outcomes ultimately. As good practise, the associations are both regularly asked to meet the future new midwives during the curricula and to share them about the practise, the midwifery representation and all concerns of a future NMP. The midwifery schools encourage students to attend congresses and events of the associations, and to develop through them their sense of community.

## 2.4 The Transition of New Midwives After Registration as a Midwife in Wallonia: Discussion

There is currently no research or evidence about transition to practise in Wallonia for new midwives. Even if researchers suggest that 'clinical practise experiences influence where the future midwifery practitioner will choose to work after graduation' (McCall et al. (2009) in Gray et al. 2016), there seems to be a concern in Wallonia about employment. A certain amount of the NMPs have no choice in where they will work and apply to many hospitals before securing a salaried job, sometimes in wards they didn't intend to work. Midwifery is not considered as a business in shortage (as specialised nurses) in Belgium, and for several years it has been observed that new midwives cannot easily locate a job according to their qualifications or preferred area of interest, such as part-time jobs, wards out of mother-and-baby care (e.g. surgery rooms), hospital settings far from home or simply take part in the midwifery recruitment reserve. However, once the Cellule Planification des professions de soins de santé (2018) has completed their forecast for the future of the midwifery work force, there may be a culture of new thinking related to the employment opportunities, but this would not be a quick action on behalf of the regulatory bodies of government. In the same way, it seems that some NMP's choice is to become independent earlier than planned, because of employment difficulties and this may be the option available to them.

On consideration of these points, one can question if there are too many newly graduated midwives in Belgium and whether there needs to be a reduction in the numbers of training places available. Conversely, it could be postulated that there may not be enough midwives to perform appropriate healthcare services to mothers, babies and families. As highlighted earlier, there is a consideration that there is a problem with retiring-aged midwives staying along in the job past their expected date of retirement. All of these major considerations about midwifery employment are to be solved through the current SPF analysis of the data collected for the years 2004–2014. Different scenarios of the evolution of the midwifery workforce should emerge, and the commission will give advice to the Minister of Health. However, a significant level of concern is already emerging from the data and current discussions, and will have influence on the ultimate decisions made. These include:

- Midwifery curricula are different between Flanders (3 years) and Wallonia (4 years); this is not coherent.
- Midwifery schools have to preserve the quality of the curricula within national and international regulation, but there is no regulation about the number of incoming students.
- Hospital settings are the principal workplace for midwives; her/his autonomy needs to be reinforced within those settings, including fertility wards, gynaecology and neonatology.
- Midwives give global care to women and families, and that means they are concerned by mental health and well-being. This requires time which is difficult to evaluate especially in situations of vulnerability.
- Midwives are more and more needed in first-line care services and in the community, e.g. due to shorter maternity stay and needs of sparing public money.
- Midwives ask for more 'one-to-one care' for women (and families).

### 2.4.1 About Becoming a Salaried Midwife

As already written, the most common employment status in Wallonia for NMPs is an employee contract within a health service (mainly hospital wards), as is the case for all Belgian midwives (Cellule Planification des professions de soins de santé 2018). The NMPs work almost full-time jobs (0.9 full-time equivalent). This could be interesting in case of NMP wishing to undergo other studies, e.g. at Master level, and wishing to still earn a living, but this could be difficult for others who need a full-time job to be able live, such as those with families. It seems that they are also frequently offered temporary contracts. Furthermore, a temporally contract could be a barrier to sign for a personal loan which may have long-term consequences for the individual midwife.

In other midwifery age groups in Wallonia and Belgium, the full-time equivalent is decreasing as the age is increasing: 0.76 full-time equivalent for 30–40 years, 0.75 full-time equivalent for 40–50 years, 0.73 full-time equivalent for 50–60 years and 0.74 full-time equivalent for >60 years (Cellule Planification des professions de

soins de santé 2018). This is probably by choice as the workload is increasing and stressful, but there is no evidence to support this concept.

It is common place for the NMPs to tell their experiences of working and covering the whole scope of midwifery practise within one hospital's wards. The benefits of doing so mean that NMPs gain autonomous practise more quickly and become a 'polyvalent' midwife who will meet the holistic needs of the women they provide care for. Therefore, the NMPs are asked to change the ward they work on after a number of months, and experience a variation of shift patterns to ensure that they have appropriate skills for future practise to support women and their families. In Belgium, mothers and children services are mainly hospital based and physician led, but new services offer midwifery-led continuity of care models, e.g. in prenatal wards, home-based post-partum services and birth centres inside hospital. Nevertheless, it seems that transition to practise within those traditional health care institutions are more 'with the institution' rather than 'with women' for the NMPs, but there currently is no evidence to support this from either perspective.

There is currently no knowledge of any institutional programs dedicated to support new midwives in their transition from student to qualified practise, or mentors dedicated to consolidate skills and knowledge required for NMPs. Transition to practise processes are likely to vary within each hospital dependent upon their individualised processes and support programmes.

With this in mind, it is probable that each hospital varies in the supervision and evaluation they offer for each NMP. It makes sense that there should be at least a mid-year and first-year evaluation for the NMPs following preceptorship and reflective principles, or a ward-evaluation before moving to other areas, focusing on individual planned goals and learning needs. These ideally will be based on their own individualised professional clinical competence, including professional development in terms of decision-making, collaborative working relationships, gaining management experience, enhancing effective care processes, etc. Whilst this is a plausible consideration for the future, research is required to address this gap in practise and add to the evidence base.

### 2.4.2 About Becoming an Independent Midwife

NMPs in Wallonia are transitioned to practise as soon as they are employed, or become independent midwives. This moment may be delayed, due to a shortage of employment opportunities for midwives in Wallonia, or because some NMPs choose to continue with their studying (e.g. Master Degree). For those NMPs who work in a midwifery-led unit or find themselves in an independent place of work within a birthing house, mentorship appears to be more present and better organised. We call it 'compagnonnage' which means (young) peer midwife-to-(experienced) peer midwife mentorship, within a dimension of sharing reflexivity allowing professional development (Donnay and Charlier 2008, Castiaux 2010). The terminologies infer a nurturing support from more experienced NMPs to the up and coming new workforce.

The UPSFB professional association highly recommends this mentoring practise for the new midwives to support births outside hospital wards (in birthing centres or midwifery-led birthing houses or at home) in their 'Charter for births at home and in birthing houses'. Union Professionnelle des Sages-femmes Belges. Charte de la naissance à domicile et en maison de naissance. n.d.-a.:

> Commencer sa pratique de l'accompagnement global par une période de *compagnonnage* en travaillant en « binôme » avec une sage-femme expérimentée dans ce domaine afin d'acquérir l'expérience nécessaire à une pratique autonome responsable.—Faciliter la transmission et le partage de ses connaissances » (UPSFB, Charte de la naissance à domicile et en maison de naissance). The English interpretation is: « To begin her/his working practise of global follow-up—of the mothers—with a time of *compagnonnage/mentorship* 'peer-working' with a field-experienced midwife, in order to gain the necessary experience for an autonomous and responsible practise—to facilitate the transmission and the sharing of knowledge.

The new independent midwife (working within birthing houses) is expected to sign up this Charter before her professional details are put on the UPSFB website. This is a kind of protection for mothers and families, and for the professional association hosting the website, and a quality control for all. This is not required for salaried midwives because they are supposed to adhere in their own hospital's chart or protocol of care.

### 2.4.3 About 'Mentorship' During Midwifery Studies and After

The French term 'compagnonnage' is used in Wallonia midwifery as a professional specific term very early in the curricula. The first competence of the Integrated and Internetwork Framework for the Bachelor in Midwifery (Groupe inter réseaux des enseignantes sages-femmes. (2015). *Référentiel de compétences intégré inter réseaux en Bachelier Sage-femme*) is to commit herself into training, building her professional identity to present it in this way: 'Contribuer au compagnonnage par les pairs'. This includes professional qualities of respect and empathy, assertiveness and responsibility but also critical analysis and security. Similar terms may be used in English, within learning experiences for care practitioners (nurses or midwives), e.g. 'Mentorship' as Anderson and Shannon (1988) described it in Ashwin et al. (2015) 'mentorship as a nurturing process which involves an experienced and more skilled person who acts as role model and who teaches, encourages and counsels another less skilled and less experienced person so that the latter is able to develop professionally'. Ashwin (Ashwin et al. 2015) also mentioned 'preceptorship' and 'midwifery preceptor' in the same spirit. 'Companionship' as by Simkin and Ancheta (2009) describes in Ntombana et al (2014) 'the accompaniment and continuous support offered to woman in labour. Such support is provided through talking, keeping the woman company and rubbing her back during each contraction in the first stage of labour'. This aspect is highly important in following and supporting women in labour, but it does not include the peer-to-peer aspects we previously developed. In all Flemish educational programs also mentorship is a mandatory item. As written

in the learning outcome 'coaching' 'the midwifery student coaches fellow students from their own and other disciplines to ensure quality care'.

Considering the evidence presented, the best translation of 'compagnonnage' in French could be 'mentorship' in English. Midwifery students are then familiar with this concept, and it is encouraged within each and every clinical block placement. During their curricula, all the midwifery students in Belgium experience professional work in the clinical placements and receive mentorship on behalf on the midwives of the team. Besides, in each ward hosting midwifery students, it is expected that there are 'referent' midwives nominated by the officials of the hospital to assist and support the students in building skills and knowledge to promote the growth of self-confidence. Indeed: 'Importantly, accepting students at the workplace means that the team members collaboratively feel responsible to observe students, to guide reflective activities and to give feedback on performances. Only a small number of motivated supervisors should take the responsibility for guiding the continuous process of competency development'(Embo and Valcke (2016)). Again, there is no evidence base to support these concepts other than custom and practise.

A professional profile around supporting nursing students in clinical placements was recently built collaboratively between four Wallonia nursing schools (Dury et al. 2016). The role of the 'nurse referent' was determined as follows:

*Établir une relation pédagogique efficiente*/to establish a collaborative paedagogical relationship
*Faciliter les apprentissages*/to facilitate learning
*Créer un contexte de soin propice aux apprentissages*/to create a care context favourable to learning
*Fonder sa pratique sur des preuves*/to work with evidence-based
*Évaluer et responsabiliser*/to evaluate and empower
*Évaluer la qualité de la formation pratique*/to evaluate quality of practical training
*Exercer un leadership*/to perform leadership

It appears that the 'referent midwife' could have a similar role to the 'referent nurse', for supporting the midwifery students. In addition, the Professional Profile of the Belgian Midwives (Conseil Fédéral des Sages-Femmes 2016) is very clear about mentorship whereby the midwife is a coach/mentor for her colleagues and midwifery students.

> Compétence 10: Coach
> Coacher et accompagner les collègues et les étudiants de sa propre discipline ainsi que d'autres disciplines, en vue de garantir des soins de haute qualité.
>
> – Elle remplit le rôle de mentor pour les collègues et les étudiants;
> – Elle donne un feed-back oral et/ou écrit aux collègues et aux étudiants en vue de garantir des soins de qualité;
> – Elle est un modèle pour les collègues, les étudiants et les professionnels des soins de santé d'autres disciplines.

Means: To coach/mentor and accompany colleagues and disciplinary and other students, in order to guarantee a high-quality level of care.

- -She/he is a mentor for her/his colleagues and students;
- -She/he gives an oral/written feedback to colleagues and students in order to guarantee high-quality level of care.
- -She/he is a role model for colleagues, students and healthcare professionals of other disciplines.

Nevertheless, it seems that not all the midwives of the teams/shifts intend to be a 'mentor' or a 'referent' or a 'preceptor' of the midwifery students. This can result in less commitment of the midwives towards the students. This withdrawal from mentorship in midwifery could lead the midwifery students into less active commitment in their own setting of goals (Spencer, 2010, cited by Embo and Valcke 2016): 'Midwifery workplaces continue to be critical learning environments in which knowledge, skills and attitudes are acquired within a real-life professional context. To benefit from workplace learning, learners must take an active part in their own education by setting goals and monitor their progress towards these goals.'

Unfortunately, we have no evidence about how the midwifery students feel when they go for training in areas where the midwives are less supportive. A recent study of Mestdagh et al. (2018) stated that midwifery students perceive less support from midwives who don't have the tendency to behave proactive on the working floor.

A high turnover of students could be one explanation for how midwives embrace the support and education of the next generation of midwives. Clinical placements in midwifery vary in length, lasting from 2 to 6 weeks or more, depending on the school and the availability of placements. Whilst there are national and international recommendations for a required amount of hours in clinical placement, there is no national or regional recommendation for duration of block placement, and hence there is a lack of peer-mentoring program system. All Belgian schools of midwifery face a significant number of students, whilst current birth rates are low. This leads to a saturation of students in clinical placements and a necessity to frequently change programmed activities to ensure that all of the students have the similar opportunities to learn. To address this current trend, students are encouraged to consider mobility abroad; however, this does not alleviate the problem. This is an area in need of review as evidence suggests that "short periods of 1–2-week block placements do not enable nursing students enough time to settle into the clinical setting, which influences their experience of 'belongingness'. Clinical staff are also less likely to feel a sense of ownership of the process of block placement, resulting in inadequate time being allocated to meet students' needs" (Birks et al. 2017). Furthermore, Gray et al. (2016) suggest 'that completion of an intensive, formal, final year placement for graduates may be beneficial to assist with transition to qualified practise with guidance and support from a preceptor'.

Further research is required to understand how Belgian midwives perform their 'mentorship' or 'referent' role with the midwifery students and the NMPs, as described by their professional profile. In addition, research is required to elicit what it is that the NMPs need in Belgium in order to begin under optimum conditions her/his new midwifery work.

### 2.4.4 About 'Mentorship' During Midwifery Studies and After (Flanders)

In Flanders, a shared educational program was built to educate midwives in their role as a professional mentor for midwifery students. The concepts taught in this course are:

- Regulations on higher education and the place of clinical education in the program
- Evidence-based practise
- Relational intelligence
- Learning styles
- Reflection
- Systematic student guidance
- Time management
- Liability of the mentor
- Mentorship and coaching
- Place and role of the mentor in the team

## 2.5 Reflective Experience by a New Midwife in Her First Year of Practise: Pauline GALLOY, New Midwifery Practitioner of Wallonia

Pauline graduated as a midwife in June 2017. She succeeded with 76% pass rate overall. She applied for work in several Wallonia hospitals. During her last days of clinical placements in July 2017, she had a positive one-to-one contact with the chief-midwife of the delivery rooms. She has been engaged as salaried since 1st of August in a general private hospital after a positive job interview. The mother-and-child area includes birth rooms (1640 deliveries in 2017), two post-partum wards (hosting stable high-risk pregnancies) and a neonatology ward for standard/stable premature babies. When Pauline was hired, there were no full-time jobs or long-term contracts available. According to Pauline, the officials seem to prefer having more NMPs in order to have more choice about when the time will come to propose permanent contracts. So, Pauline and seven other NMPs were hired in approximately summer 2017 with fixed-term contracts and part-time jobs. They typically are required to work 1 week-end in two, and 3–4 night shifts per month.

The NMPs were informed that they would have to be polyvalent midwives, as it is the official's choice to meet the service delivery requirements. Therefore, Pauline had a ward-change plan from 01/08/2017 to 31/12/2017, then from 01/01/2018 till 31/03/2018, and last from 01/04/2018 until 01/09/2018. Her first role was an 80% time job (during the first 5 months) and then a 75% full-time equivalent job (since 01/01/2018). Here is her ward planning:

- Begin with neonatology: 2 months;

- Then, standard post-partum ward (without emergency unit without high-care pregnancy): 4 months;
- For the moment, post-partum ward including high-risk pregnancies: 2 months;
- Furthermore, delivery ward: at least 2 months;
- Later: home post-partum to be organised.

No NMPs started working in the delivery rooms as it was planned for later, only if they appear to be competent in working in those areas. It seems that only experienced midwives have the opportunity to remain in the same ward if they wish. Most of them do not change wards anymore choosing to remain in one place and hence becoming the expert and consistent 'face' of that particular area. There were eight NMPs to be engaged; four remain in the mother-and-child wards and have short-term contracts; three did not have their contracts renewed after few months and have since left the place of employment, and one had been invited to work within the surgery ward (recovering room) or to leave the organisation. She chose to stay in the recovering room.

The NMPs all received information that there would be an evaluation of their practise in relation to specific objectives after month 1, month 3 and month 6. They were aware that this evaluation was to be conducted by the chief-ward, using specific documents to assess knowledge, skills and behaviours. For Pauline, there was no prior evaluation until now. The only form of assessment was conducted by her colleagues at the end of her neonatology ward job, and this was a rather informal process.

**Would It Be Nice to Have an Evaluation?**

I think yes but I'm conscious that the workload of my chief-midwife is high and I know perfectly well that I would be evaluated if it was necessary, if my work was not appropriate. That is why I don't feel frustrated about it. However, as beginner, I think I still have more to learn and to improve. That's the reason why I made a habit of regularly asking my colleagues if I do well. It allows me to progress through their advices and to show them I'm committed.

I also heard about new evaluation plans for all the midwives, according to quality management, but I still have to receive further information about it.

**How Were your First Days in Each New Ward?**

The very first day in the hospital, I was welcomed by a special nurse dedicated to the new workers. Together with other new nurses and midwives, we had a full guided tour of the hospital buildings. We had opportunities to ask questions, and had a discussion about what working in that hospital meant (values, etc.).

Each time I started to work in a new ward, I had a doubled team for work during 3 days (three shifts). My referent midwife was experienced, but not specially dedicated to the NMPs, or specially paid or trained for it. I think she was chosen thanks to her qualities of patience and sharing. Unfortunately, when the workload was heavy, my referent had not much time for coaching and I had to learn many things by myself. It is important to note that the team was really hospitable with me and I

knew that I could rely on them if I had any doubts or problem. In relation to this, it is important to emphasise that knowledge and skills are not enough to feel good in a new job as midwife. One must also have to be able to fit into a new team, which involves that you be sociable and committed. Fortunately for me, I think that was my case. That is why I feel pretty good in my new team.

About the content of my coaching, I consider that my referent was coaching me 75% about administration work (for hospital) and 25% about mothers and baby caring.

I was once asked to help for solo night shifts in the post-partum ward when I was still working in neonatology. It was a challenge as I had not worked in the post-partum ward yet, but I'm not used to saying 'no', so I agreed to do it. I also think I didn't dare to say 'no' because of my short-term contract status. I got stressed at the beginning of the first nightshift, but at the end of the nights, I felt proud to succeed in doing it.

**What Helps you to Face the New Practise?**

I had a special compulsory 2-day session about breastfeeding held by a midwife IBCLC (International Board Certified Lactation Consultant) of the ward. We were about five NMPs and it helped me to answer parent's questions. I gained self-confidence and coherence of the team.

Furthermore, I have no personal experience of breastfeeding yet, and I know I am looking young. Mothers need to trust in midwives and need reassurance so I try to show self-confidence towards mothers, even if I am afraid or not sure. This breast-feeding session is really helpful in that way, and I feel I need more up-to-date sessions to develop my competencies and support mothers.

**Do You Have to Mentor Midwifery Students?**

I have to work every day with midwifery students (2nd or 3rd year), and it is a challenge! I try to talk and explain in a sharing-practises model. I luckily do not take part yet in their final assessment, I only evaluate on time. I don't like to negatively assess, if necessary, I prefer to have a face-to-face conversation rather than to write it down. I feel that midwifery students love to work with me because I take time—when it is possible—to give them explanation and advices. I like following the student's evolution during the placement, it is interesting and also helps me self-assessing.

**What About Your Preparation to Practise During Midwifery Curricula?**

I think I was well prepared for the job during my midwifery curricula. First of all, I consider that my theoretical bases are pretty good. And, about my practise, I think I was well prepared through all my multiple clinical placements. I wish it would have been better to have longer clinical placement in the same ward (more than 4 weeks), rather than many different shorter placements (2–3 weeks). This could allow me to better commit in the team and the job, and enhance my knowledge. I know that this is on study at school, we already talked about it, but it seems difficult to realise because of the general organisation of midwifery studies in Belgium.

On the whole, I developed adaptability and resourcefulness mainly through my international motilities in midwifery placements (6 weeks in Italy during my 2nd year, and 5 weeks in Cambodia during my 4th year). These were great opportunities for me to share different visions of midwifery and mother-and-baby care. I had to go through the language and culture barriers to provide appropriate care and support and that made me feel stronger and more self-confident.

**How Do You Feel After 8 Months Working as a New Practising Midwife?**
The very first days of my new job as a midwife, I felt the work was rather stressful but I very quickly managed to cope with it. I think it is related to each person's nature, and I consider myself as a permanent committed and open-minded person, so it helps a lot! Feeling and acting as a responsible midwife makes me learning quickly, becoming autonomous and relying less on others. I now feel more confident, at ease. I have not seen everything yet of the job, such as emergencies or critical situations, and I know I need much to improve myself, but I really enjoy my new job. My staff seems to appreciate me, I have the luck to work in a hospital I chose, in wards related to my midwifery diploma, and I will have opportunities to grow professionally.

Isn't this really great and exciting for an NMP?

## 2.6 To Conclude…

Belgium is a small but administrative complex country and this influences midwifery education and practise (Embo and Valcke 2016). The regulation for midwifery is according to different legal levels of region, community and Europe. In 2014, the fertility rate was 1.74, and the mean age for the first child was 28.5 years old for Belgium. In the French-speaking part Wallonia, we graduated 262 new midwives, from nine midwifery university colleges and in the Flanders we graduated 330 new midwives from nine midwifery university colleges (Benahmed et al. 2016). Most of the Belgian midwives work in hospital settings as salaried midwives (Cellule Planification des professions de soins de santé 2018), mainly in physician-led models, but new midwifery-led models are emerging. Preparing NMPs to transition to their first year of practise is a concern for all midwifery schools and lecturers, and especially around the mentorship, or 'compagnonnage' as developing in Wallonia.

It is unfortunate that there is a paucity of evidence linked to transition to practise for new midwifery practitioners (NMPs). Research should be done to highlight the roles of the midwifery school, the block placements, the 'mentor midwife' and the new team in transition to practise.

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