Letter to the International Confederation of Midwives

From: Midwifery Academics, Midwives, Educators, Women and Researchers
To: International Confederation of Midwives (ICM)
Date: Monday 2nd February 2026
Subject: *Concerns Regarding Proposed Revisions to Midwifery Standards of Proficiency in Greece and Their Implications for Midwifery Autonomy, Maternal Health, and Human Rights*

Dear Colleagues,

We are writing to inform the European Midwives Association and the International Confederation of Midwives of significant developments currently underway in Greece concerning proposed revisions to the national Midwifery Standards of Proficiency. We do so as midwifery academics, educators, practising midwives, researchers, and women, with longstanding professional commitment to maternal and newborn health, midwifery education, and evidence-based maternity care.

Our purpose in contacting you is to share a detailed account of these proposed regulatory changes, to outline their potential implications for midwifery autonomy, workforce capacity, maternal health outcomes, and reproductive rights, and to situate these developments within the broader international and European frameworks to which Greece is a party. Given ICM's central role in advancing autonomous midwifery practice, professional standards, and women-centred models of care across the globe, we believe it is important that you are aware of the situation as it currently stands.

The draft Standards of Proficiency under consideration appear to omit two foundational competencies of midwifery practice:

I. the autonomous facilitation of physiological birth, and
II. midwives' prescribing authority within their professional scope.

These omissions are not technical in nature. Rather, they create substantive inconsistencies with existing Greek legislation, diverge from international and European professional standards, and risk undermining recent national policy initiatives that explicitly expand community-based and midwife-led models of care.

What follows is a structured summary of the legal, professional, clinical, and human rights concerns raised by the proposed Standards, supported by national legislation, European law, and international evidence.

General Comments

The principal structural deficiency of the Joint Ministerial Decision (JMD) submitted for signature lies in the differentiation of midwives into public-sector and private-sector practitioners. The Standards of Proficiencies cannot lawfully curtail professional rights as established under existing legislation (Presidential Decree 351/1989). According to this legal framework, the midwifery profession constitutes an autonomous profession and is therefore characterised by uniformity with respect to its general and fundamental professional rights. Beyond the classification of responsibilities, the established purpose of the Standards of Proficiencies is to promote the harmonisation of practice across the entirety of healthcare structures.

Furthermore, it should be noted that the Athens' Midwifery Scientific Association (SEMMA) has completed and formally submitted a comprehensive and rigorously developed proposal for a single, profession-wide Standards of Proficiencies. Substantial elements of this proposal appear to have been incorporated into the JMD currently under consideration.

Specific Comments

The issues that arise indicate an insufficient examination of the subject matter, the presence of institutional discontinuities and internal inconsistencies, as well as an inaccurate assessment of the implications that the JMD is likely to have for the female population of the country. More specifically:

A. Inconsistency with the Existing Legal Framework Governing Midwifery Practice in Greece

The autonomous facilitation of physiological birth by midwives is already recognised in Greek law. Presidential Decree P.D. 351/1989 (Government Gazette A' 159), which defines the scope of practice and professional rights of midwives, clearly provides for the conduct of physiological childbirth at all levels of the National Health System (ΕΣΥ), in private hospitals, in home birth settings, in emergency situations, and during periods of crisis, by the midwife.

This provision establishes the midwife as a regulated health professional with independent responsibility for physiological births across any clinical or community setting. The omission and downgrading of the competence in question are affected in the proposed Standards of Proficiency in two ways: a) through the exclusion of the conduct of physiological birth from Primary Health Care; and b) through the introduction of "medical supervision" within Secondary and Tertiary Care structures. As a result, a regulatory inconsistency is created between professional rights across different healthcare settings, and consequently within the standards governing education, training, and professional practice.

The professional role of the midwife is further safeguarded within the European legal framework, including Directive 2005/36/EC on the recognition of professional qualifications, as amended, which recognises midwifery as an autonomous regulated profession with defined competencies across pregnancy, birth, and the postnatal period. Any national standards reform that materially reduces midwifery competencies risks regulatory misalignment and downstream impacts on education, workforce mobility, and professional equivalence, creating additional and unnecessary discrepancy in the EU Healthcare ecosystem.

Childbirth within Primary Health Care services may occur unexpectedly and without prior notice, including in primiparous and multiparous women, in cases of preterm labour, and in geographically remote areas. Consequently, the absence of a certified midwife during normal childbirth constitutes a matter of the utmost concern for the safety and health of the female and childbearing population.

B. Prescribing authority: alignment with existing national prescribing frameworks should be maintained

The authority of midwives to prescribe within their professional scope is also already recognised under the current national framework governing prescribing by health professionals. In particular:

- Law 4238/2014, including provisions related to Primary Health Care and prescribing rights, and
- the relevant Ministerial Decisions on electronic prescribing, which incorporate midwifery care into the range of health services eligible for prescription activity,

Together establish that prescribing forms part of the professional responsibilities of midwives within defined clinical contexts.

Removing reference to prescribing authority from the standards of proficiency introduces a contradiction between regulatory instruments and risks undermining safe, timely, and accountable care, especially in maternity settings where delays in access to medication can have serious clinical consequences.

C. Greece has also legislated for Birth Centres/ Midwifery Led Units, these require midwife-led physiological birth competence

Greece has formally established the facilitation and delivery of normal childbirth by midwives within Primary Health Care through Article 38 of Law 4999/2022, “Establishment and Operation of Normal Birth Centres”, given that such

Centres fall under the remit of Primary Health Care. Furthermore, Ministerial Decision G2a/oik. 36395/2024 (Government Gazette B΄ 4109/15.07.2024) sets out the regulatory framework governing the operation of Midwifery Units/ Birth Centres.

Midwifery Units/ Birth centres are, by design, built around physiological birth, continuity/relationship-based care, and the relationship and trust between women/birthing people and the midwife, with clear pathways for escalation. A standards document that omits the competence to facilitate physiological birth

autonomously, in the primary care settings, risks creating a regulatory contradiction: Midwifery Units/ Birth Centres are enabled in law, while the professional competencies required to staff them safely are weakened in standards.

D. Community midwifery ("Μαίες στο σπίτι") is also legislated, and depends on full scope

Greece has recently legislated (Law 4999/2022) for home-based and community midwifery services, describing the development of "κατ' οίκον μαιευτική φροντίδα" for pregnant women, postnatal women, and newborns, organised by public and other eligible providers, supporting perinatal care, breastfeeding, and family planning, among other functions.

However, community midwifery cannot be implemented safely or coherently if the national standards of proficiency simultaneously withdraw or fail to state core competencies (such as autonomous physiological birth care and timely access to medicines during childbirth practice). Put simply: the legal creation of services requires a standards framework that enables midwives to practise to full scope (ICM, 2025a). By excluding these competencies from the standards of proficiency, the draft framework risks undermining the operational implementation of these legislative reforms, thereby creating a misalignment between policy objectives and professional regulation.

Why these omissions distort the scientific and professional role of the midwife and put labouring women/birthing people at risk

When standards remove (or fail to state) autonomous physiological birth care and prescribing authority, this does not simply "reassign tasks". It changes the profession in ways that have foreseeable impacts:

- Clinical accountability becomes blurred: If midwives are trained and registered but not authorised in standards to practise core elements of their legal scope, responsibility may be displaced upward (or sideways), increasing fragmentation and medico-legal ambiguity.

- Continuity and responsiveness are weakened: The ability to act promptly, especially when medicines are required in childbirth-related care, affects safety, experience, and system efficiency.
- Midwifery becomes reclassified in practice as subordinate rather than autonomous: This is a distortion of our role, moving from an evidence-based, autonomous professional model to a dependent model, despite the legislative direction toward community services and birth centres.
- Education and workforce sustainability are undermined: Students and early-career midwives are less likely to enter or remain in a profession whose regulated competencies are narrowed, inconsistent, or unclear.
- Women and birthing people are at risk: women residing in remote areas (mountains and islands) and women with premature deliveries are placed at risk where, having access only to the emergency options of the Primary Health Care services, they are unable to receive any form of clinical midwifery care in the absence of an obstetrician/ physician.

For service users, the effects are concrete: less choice of setting, reduced access to continuity midwifery-led models, more delays in time-critical moments, and potential increases in interventions driven by system design rather than clinical need.

International standards and evidence show these competencies are foundational, not optional

A. International Confederation of Midwives (ICM): autonomy and scope of practice

The ICM's International Definition and Scope of Practice of the Midwife (ICM, 2025b; 2024b) defines a midwife as a person educated to ICM standards who is competent in the scope of practice of midwifery. ICM's Essential Competencies (2024a) explicitly situate midwifery as an autonomous and accountable health profession. Removing autonomous physiological birth from standards is therefore inconsistent with the internationally recognised definition of what a midwife *is* and does (ICM, 2024a; 2024b). Autonomous midwifery practice can only be realised within an

enabling environment that allows women and birthing people to fully benefit from professional, autonomous midwifery care (ICM, 2023; Vermeulen et al., 2023).

B. WHO: midwifery models of care improve outcomes and experience

The World Health Organisation (2025; 2024) and ICM (2025) has called for global expansion of midwifery models of care, describing benefits including improved likelihood of healthy vaginal birth and higher satisfaction when women receive care from trusted midwives.

C. Strong synthesis evidence: continuity models reduce intervention and improve experience

The 2024 update of the Cochrane review from *Sandall et al.* on midwife continuity of care models reports that women receiving these models are less likely to experience caesarean and instrumental birth, more likely to have spontaneous vaginal birth, and report more positive experiences. These models depend on midwives practising to full scope, including leading physiological birth care and having the clinical tools (including medicines access, where appropriate) to deliver safe, timely care (ICM, 2025c). This is also strongly supported and further discussed in the 2025 UNFPA/ WHO/ ICM 'Midwifery Accelerator' Global Statement.

System-level implications for maternity care, workforce capability, and maternal health in Greece

Evidence indicates that maternity care in Greece is already characterised by high levels of medical intervention, fragmented models of care, and persistently elevated caesarean section rates, substantially exceeding international benchmarks (Tonakanian et al, 2024; Ioannidou et al., 2022l Antoniou et al, 2021a; 2020). Recent studies report caesarean section rates in Greece consistently above 50%, among the highest in Europe, with a large proportion occurring without clear medical indication (Tonakanian et al, 2024; Kontopanos et al., 2023; Ioannidou et al., 2022; Antoniou et al, 2021a; 2021b; 2020). Such patterns are closely associated with increased medicalisation of labour, reduced opportunities for spontaneous physiological birth,

and diminished continuity of care (Doherty et al., 2025; Sandall et al., 2024; Tonakanian et al, 2024).

The proposed Standards of Proficiency is directly associated with the excessive medicalisation of childbirth, a systematic departure from the physiology of labour, and the absence of continuous, midwife-led care. Within such settings, the role of the midwife is frequently reduced to a supportive, or executory function, rather than constituting an autonomous scientific practice with responsibility for normal pregnancy and childbirth.

Within this context, further narrowing of midwives' scope of practice, particularly the omission of autonomous physiological birth facilitation and prescribing authority, risks reinforcing an already intervention-dominant system. International and Greek-specific evidence suggests that highly medicalised and fragmented maternity care environments are associated with reduced maternal confidence, diminished sense of agency during birth, and poorer psychological experiences, including increased fear and dissatisfaction (Doherty et al., 2025; Bohren and Bradfield, 2024; Ioannidou et al., 2022; Negrini et al., 2021; Pratilas et al., 2019). Where midwives are prevented from leading care for physiological birth, childbirth is more likely to be experienced by women as a process that happens to them, rather than one that is actively supported in accordance with their needs, choices, and physiology. These effects are not limited to the immediate perinatal period but extend to longer-term psychological wellbeing, the mother–infant relationship, and overall trust in the health system (Doherty et al., 2025; Sandall et al, 2024; Doblin et al., 2023; Hague, 2022; Ioannidou et al., 2022; Betran et al., 2016; 2015).

At the same time, these developments raise significant concerns regarding the protection of fundamental human and reproductive rights. Limiting midwives' capacity to autonomously support physiological birth effectively reduces the availability of lawful care options and, in practice, restricts women's right to choose the place and mode of birth. This right is recognised within international human rights law (ICESCR/GC22 + CEDAW GR24), the European legal framework (ECHR Article 8), and national legal principles (Greek Constitution (Arts 2(1), 5(1), 5(5)). Access to midwife-led models of care, such as Midwifery Units/ Birth Centres, community-based midwifery services

and, where provided for, home birth, constitutes a core element of reproductive autonomy and of women's right to make free and informed decisions regarding childbirth.

Within the Greek constitutional framework, the protection of maternal and reproductive health derives from fundamental principles including respect for human dignity (Arts 2(1)), the free development of personality and bodily autonomy (Arts 5(1)), and the right to health (Arts 5(5)). The effective exercise of these rights requires not only their formal recognition in law, but also practical and functional access to diverse, lawful, and evidence-based maternity care models. From this perspective, the contraction of midwives' professional competencies risks operating as an indirect limitation of constitutionally protected rights, by constraining women's real access to care pathways that support autonomy, dignity, and informed choice during childbirth. In this context, the contraction of the professional competencies of midwives may result in an indirect restriction of constitutionally protected rights.

The consequences extend beyond service users to the midwifery workforce itself and its future capability. As opportunities for midwives to support and conduct physiological births decline, so too does the maintenance and transmission of core midwifery skills (Feeley et al., 2025; Byrom et al., 2025). This has particular significance for midwifery education in Greece, where students already report difficulty accessing sufficient exposure to normal labour and birth in clinical placements. In a system dominated by operative and pharmacologically managed births, students face increasing challenges in achieving the required number of physiological births to meet educational and regulatory standards. Over time, this risks producing a workforce with reduced confidence and diminished clinical capacity to support physiological birth, further reinforcing dependence on medicalised care pathways (Byrom et al, 2025; Harrak, 2025; Feeley et al., 2025; Darling et al, 2021). The additional follow-up burden to the Greek Health care ecosystem will be the increase of midwifery migration to countries with more midwifery autonomy and respectful maternity and care, exacerbating the Brain Drain and opposing the current government's efforts for Brain Re-gain.

These dynamics create a self-reinforcing cycle: reduced physiological birth leads to diminished professional skill and confidence, which in turn legitimises further restriction of scope and greater dependence on obstetric intervention. Evidence suggests that such cycles contribute to sustained high caesarean section rates, increasing fragmentation of care, and escalating costs, without corresponding improvements in outcomes (Doherty et al., 2025; Tonakanian et al, 2024; Kontopanos et al., 2023; Ioannidou et al., 2022; Antoniou et al, 2021a; 2020). Conversely, continuity-of-care models led by midwives, when supported by a clear and full professional scope of practice, are associated with lower intervention rates, improved maternal satisfaction, and better system efficiency (Sandall et al., 2024).

Taken together, this evidence indicates that omission of autonomous physiological birth and prescribing authority from the Standards of Proficiency would not constitute a neutral regulatory adjustment. Rather, it risks exacerbating existing structural weaknesses in Greek maternity care, with foreseeable adverse consequences for maternal health outcomes, midwifery education and skill retention, and the long-term sustainability of the midwifery workforce.

Purpose of This Communication and Request for Awareness

We share this letter with the International Confederation of Midwives for your information and situational awareness, given the clear intersections with international midwifery standards, EU professional regulation, and global commitments to respectful, evidence-based maternity care.

The developments described raise concerns not only for midwifery practice in Greece, but also for:

1. the coherence of professional regulation within the European Union,
2. the alignment of national standards with ICM's Essential Competencies and Definition of the Midwife, and
3. the sustainability of midwife-led models of care in contexts already characterised by high medicalisation and workforce pressures.

At this stage, we are not seeking formal intervention. However, we consider it important to ensure that ICM is informed of these regulatory shifts and their potential implications, should expert dialogue, technical guidance, or professional support be required at a later stage.

We would welcome the opportunity, if appropriate, to:

1. share further updates or evidence summaries,
2. engage in professional dialogue regarding safeguards for midwifery autonomy and scope of practice within regulatory reforms.

Thank you for your continued leadership in advancing autonomous, woman-centred midwifery care across Europe and globally. We remain available for any further information you may require.

Yours sincerely,

Hellenic British Midwifery Association
Hellenic Union of Independent Midwives

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