The global health community has implemented several initiatives over the past in the interest of accelerating country-by-country progress toward the Millennium Development Goal of improving maternal health. Skilled attendance at every birth has been recognized as an essential component of approaches for reducing maternal and perinatal morbidity and mortality.

Midwives have been acknowledged as a preferred cadre of skilled birth attendant. The International Confederation of Midwives (ICM) speaks for the global community of fully qualified (professional) midwives. The ICM document entitled *Essential Competencies for Basic Midwifery Practice* is a core policy statement that defines the domains and scope of practice for those individuals who meet the international definition of midwife. This article explores the meaning of competence and competency as core concepts for the midwifery profession. An understanding of the meaning of these terms can help midwives speaking individually at the clinical practice level and midwifery associations speaking at the policy level to articulate more clearly the distinction of fully qualified midwives within the skilled birth attendant and sexual and reproductive health workforce. Competence and competency are fundamental to the domains of midwifery education, legislation, and regulation, and to the deployment and retention of professional midwives.

**KEYWORDS:** professional midwifery; competence; essential competencies; skilled attendance
maternal mortality ratio by 75% by 2015. Many of these efforts, particularly in lower resource countries, have included the education of new cadres of personnel who are prepared with a very narrow and limited domain of practice, focused primarily on the knowledge and skills surrounding childbirth and the immediate neonatal and postpartum period. The title of “community midwife” is commonly assigned to these birth providers. Lawn et al. (2010) report that there is some limited, but lesser-quality evidence that these providers are effective in reducing perinatal and neonatal mortality.

The International Confederation of Midwives (ICM) speaks for the global community of fully qualified (professional) midwives, a preferred cadre of skilled birth attendants. The role of the ICM is to define the concept of professional midwifery and to work collaboratively with other global organizations at country levels to promote and to strengthen the voice of professional midwifery in policy and practice arenas. The ICM has promulgated an international definition of the midwife since 1972, with endorsement by the World Health Organization (WHO) and the International Federation of Obstetricians and Gynecologists. The most recent revision was in 2005 (ICM, 2005). The ICM has set forth additional policy and practice statements in the ensuing decades that can assist ICM member associations to translate the core beliefs set forth in these documents into regulatory and workforce policy at their country level.

The ICM document entitled Essential Competencies for Basic Midwifery Practice (a.k.a. Essential Competencies) (Fullerton, Severino, Brogan, & Thompson, 2003; ICM, 2002) is one of these core policy statements. The Essential Competencies document defines the domains and scope of midwifery practice. The ICM expects that the Essential Competencies document will be adopted or expanded at the country level to promote the development of professional midwifery within the country. The ICM published the first set of Essential Competencies in 2002. A second version, updated to reflect the emerging state of evidence-based practice (Fullerton & Thompson, 2005), was approved by the ICM Board in December, 2010.

The purpose of this article is to review the context within which the concepts of competence and competency emerged, to explore the meaning of competency as a core concept for the midwifery profession, and to place this general discussion within the specific context of professional midwifery practice. An understanding of the meaning of competency can help midwives speaking individually at the clinical practice level and midwifery associations speaking at the policy level to articulate more clearly the distinction of fully qualified midwives within the skilled birth attendant and sexual and reproductive health workforce. Competency is fundamental to the domains of midwifery education, legislation, and regulation, and to the deployment and retention of all providers of reproductive health services.

**THE EMERGENCE OF THE CONCEPTS OF COMPETENCE AND COMPETENCY**

De Ketele (2000) asserts that the concepts of competence and competency emerged in the late 20th century when economic globalization stimulated increased competitiveness in the international marketplace. He describes a growing consciousness among employers that there was a perceivable association between higher levels of educational attainment of the workforce and the ability to adapt or conform to job performance requirements. De Ketele therefore described the concept of competency as one of several successive milestones and an advanced step on the pathway of knowledge acquisition.

Employers, motivated by the requirements of competitiveness and profitability, and in search of the most efficient ways to mobilize a workforce, began to create their own training units. The aim was to enable newly hired employees to learn the job-related tasks, to perform them with a quality close to “zero defect,” and further, to be able to identify solutions to problems that arose during the performance of their job functions. To that end, it was necessary to craft a precise delineation of the activities (tasks) that were associated with any specific job title, and to identify the associated knowledge and skills (the competencies) that would have to be acquired to enable satisfactory task performance.

Training units were attuned to the need for an intervention that began from the bottom up. The employment sector worked cooperatively with the education sector to develop a vocational training system that offered the opportunity for learners to prepare themselves for employment through acquisition of smaller units of skill sets that were both progressive and cumulative. Prerequisite knowledge and skills were defined for entry into a learning unit. The competencies that were to be mastered as evidence of successful completion of the unit and the means by which successful mastery of the skill would be measured were similarly defined.

These initiatives modeled in the vocational and occupational employment arenas were noted by those involved in professional education (including health professions). Professional task competencies were identified.
Crosscutting and general competencies (e.g., communication and decision-making skills) that would be required across all domains of professional performance were also acknowledged. The field of professional competency assessment began to evolve.

THE CORE CONSTRUCTS OF COMPETENCE AND COMPETENCY

An understanding of the meaning of competency first requires that a distinction be made between the terms competence and competency. Both terms are multilayered and distinct. However, simply stated, many theorists define competence in relationship to behavioral tasks, and competency in relationship to the personal characteristics that underpin the performance of those tasks (Woodruffe, 1993).

The literature presents three common approaches to the description and measurement of competence, although none of them is precisely distinct from the other, and none actually crafts a clear distinction between competence and competency. The debate is summarized by McMullan et al. (2003) as follows. The behavioral (performance) approach defines competence through a description of actions that can be demonstrated or observed and assessed. In this approach, successful performance is only possible when the necessary and underlying knowledge and understanding are present. The generic approach defines competence as broad clusters of abilities, such as knowledge or capacity for critical thinking, that act together to promote expert performance. This approach ignores the context, assuming that these abilities will serve as well in various circumstances. The holistic approach combines the general underlying attributes of the practitioner with the context in which they are applied, and allows the incorporation of ethics and values as elements in competent performance. The Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980), articulated by Benner (1984) in the context of nursing practice, actually incorporates elements of each of these three approaches in her description of competence, portraying them as a developmental sequence in the progression from novice to expert.

Competency, in its turn, has been variously described as a multidimensional construct that involves a complex interaction of cognitive activities related to the gathering of information, the processing of that information for translation into action, described as know-acting (Lasnier, 2000; Le Boterf, 2000), or problem solving, and followed by enactment. Competency is viewed as an integrative concept because it considers, at the same time, the relevant intellectual content, the activities to be conducted at a specified level of performance, and the situations in which those activities are to be performed (Roegiers & De Ketele, 2000).

COMPETENCE IN THE ACADEMIC AND CLINICAL CONTEXT OF MIDWIFERY EDUCATION AND PRACTICE

The qualitative research methodology of concept analysis has been used to explore the concept of competence as it relates to nursing and midwifery education and clinical practice (Axley, 2008; Chiarella, Thoms, Lau, & McInnes, 2008; Cowan, Norman, & Coopamah, 2007; Scott-Tilley, 2008; Valloze, 2009). These reports confirm, at minimum, a consensus that there is no single, universally accepted definition of competence. In fact, the concept itself continues to evolve in pace with advances in science and technology, which challenge us to keep pace with emerging knowledge and new evidence-based clinical practices.

Therefore, various definitions have been developed for use in a relevant application. The ICM has chosen the holistic definitional approach and has defined competence in the context of midwifery education and practice as the combination of knowledge, psychomotor, communication, and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency (ICM, personal communication, 2010).

MIDWIFERY COMPETENCY

Moving forward in the delineation of these constructs, an important next step is consideration of the situational context of professional practice within which competence is demonstrated (the integrative understanding of the concept). The definition of midwifery competency emerges as a combination of knowledge, professional behavior, and specific skills that are demonstrated at a defined level of proficiency in the context of midwifery education and practice. Definitions of the fundamental components of these definitions of competence and midwifery competency are presented in Figure 1.

The 2002 version of the ICM’s Essential Competencies document delineates one crosscutting and five practice-specific domains of midwifery competency. The document details the knowledge, skills, and behaviors that comprise the essence of each domain. (A seventh competency
clinical preventive services that all graduates should be prepared to offer. Similarly, education programs located in low-resource settings may find that including certain skills within the basic program of studies (e.g., manual vacuum evacuation following miscarriage) could be lifesaving for the women served by program graduates. Other midwives may wish to acquire certain skills for the sake of increasing women’s access to particular services.

Many midwives have acquired these additional skills through continued education and/or in-service programs. As midwives gain experience and develop proficiency across the core competencies that are the core elements of entry-level professional practice, they are ready to take on new expanded practice roles.

**COMPETENCY-BASED EDUCATION**

Knowledge, skills, and associated professional attitudes and behaviors for the professional practice of midwifery are taught and modeled within a competency-based midwifery education program. A competency-based curriculum of studies forges links between curriculum content and the expected outcomes of a program of study (Farrand, McMullan, Jowett, & Humphreys, 2006). The defining attributes of a competency-based curriculum are the teaching of knowledge and skills in all domains for the practice role, instruction that focuses on specific outcomes or competencies, allowance for increasing levels of competency, accountability of the learner, practice-based learning, self-assessment, and individualized learning experiences (Scott-Tilley, 2008).

Guidance documents developed for midwifery education programs by the ICM and the WHO and
similar global technical assistance agencies often include recommendations concerning the minimum numbers of clinical practice experiences that students should acquire before they are considered eligible for graduation. These minimum numbers have been derived from both anecdotal evidence and formal research that has demonstrated an association between progressive levels of experience and the ability to demonstrate a predetermined level of skill in task performance. However, although it is the case that recommended minimum numbers of experiences are associated with competency development, it is also the case that acquiring specific numbers of experiences does not necessarily mean that competency has been achieved by any individual learner.

**ADDITIONAL CONSIDERATIONS**

A first essential corollary to competent midwifery performance is the concept of an enabling environment for practice. An overarching framework of political, economic, and sociocultural support for midwives and midwifery practice must exist before such support can be translated at the educational and clinical practice levels into pragmatic and tangible concepts, such as the accessibility of reproductive health guidelines, peer support for the midwife's day-to-day work performance, and the supplies and equipment that are essential for the performance of the task (Morrissey & Schmidt, 2008). Hussein et al. (2004) have proposed a new methodology for measuring the proportion of skilled attendance at childbirth, which goes beyond designating the attendant by credential, but, instead, creates a composite measure of delivery care that indicates the degree to which the attendant functioned within a practice environment, which facilitated the delivery of high-quality health care services. In other words, did the skilled provider have needed supplies, equipment, and transport available to provide good care? This unique approach takes into consideration the fact that a skilled provider may not be...
able to save lives if she or he does not have the resources available to allow the delivery of clinically proficient care services—both are needed. Kayongo, Rubardt, Butera, Mboninyibuika, and Madili (2006) demonstrated that placing a focus on maintaining functional health facilities aided the providers in those facilities to increase the proportion of emergency obstetrical and neonatal care services that they were able to offer.

Additional corollaries to competent midwifery performance are the allied concepts of confidence or capability. The midwife may have demonstrated the ability to perform a task to a certain expected level of technical accuracy at a given time, but may not yet have attained any degree of internal assurance that she or he could do so if called on to perform that skill, and particularly so in emergency situations, or when other skilled assistance is not immediately available (Farrand et al., 2006; Gardner, Hase, Gardner, Dunn, & Carryer, 2008). Additionally, technical competency attained for any skill and the correlated confidence related to task performance are rarely sustained at the same level, even from day-to-day (Scotland & Bullough, 2004), because the conditions, circumstances, and uncommon situations that affect peak performance change.

Finally, in any clinical situation, competence may differ from performance. Competence itself is only of value as a prerequisite for performance in a real clinical situation. It may well be about recognizing one’s own limits, which, in turn, is related to the concept of professional behaviors that are grounded in the ethics of professional practice. The competent midwifery practitioner would make decisions considering the human and reproductive rights of women and families, and not based on personal attitudes or values (ICM, 2003; Vanaki & Memarian, 2009).

**DISCUSSION**

A delineation of the competencies that should be expected of the fully qualified midwife at entry into practice of the profession is fundamental to understanding the role of the professional midwife. It also has very pragmatic applications in academic settings and in the workplace.

Professional midwifery education programs are always faced with the challenge (and sometimes pressure) of enrolling sufficient numbers of students to meet country workforce needs. This challenge is counterbalanced by the very real resource limitations that most programs encounter. Such limitations may include faculty/student ratio, classroom, library and skills lab resources, and access to clinical practice experiences. In some countries, these challenges include educational policies that focus on shorter term workforce solutions that include the training of more narrowly qualified birth providers (e.g., the community midwife) who compete for access to clinical experiences and teaching resources. A commitment to competency-based education should play some role in helping policy makers and educational administrators make educational policy decisions in the context of the rights of students to acquire the knowledge, professional behaviors, and skills relevant to the professional role, and in the context of the rights of the clients to expect skilled care from their providers.

Simultaneously, it is useful for employers and employees to have a clear understanding of the scope of work that can be expected of the midwife in the workplace, so that midwifery skills can be fully and appropriately used, and that the scope of practice is neither exploited nor constrained (Homer et al., 2007). The job description for a midwife should be based on linkage between the competency-based education that the midwife has completed, the reproductive health guidelines that are in place in the country, and the midwife’s personal assessment of her or his confidence and competence to practice that role. For example, midwives in Brazil were able to advocate for a more appropriate utilization of midwifery practitioners by documenting the “disconnect” between their competency-based education and the role to which they were assigned in the public health care system (Narchi, 2009). Doctors, midwives, and other health professionals working in a public referral hospital in Palestine identified the fact that the widely held perception that midwives were at the lowest level of the health professional hierarchy made it very difficult for them to be effective advocates for improvements in the quality of care offered to women and infants, including the resources required for quality service (Hassan-Bitar & Narrainen, 2009).

The ICM encourages countries to adapt the core set of basic competencies to reflect the particular needs and circumstances of the country. For example, midwives in Africa collaborated to expand the competencies to reflect the role of midwives in combating malaria and HIV/AIDS in that region (WHO, 2006). In a second example, a Delphi survey of stakeholders in Tunisia, including midwives, health providers, health program managers, women, educators, professional organizations, and decision makers, explored the contributions that midwives could make to meeting health care needs in that country. Findings were operationalized through delineation of core competencies for midwifery practice, thus establishing midwives as a contributing member of the reproductive health workforce (Gherissi, 2008). The ICM also
urges countries to use the Essential Competencies as complementary to the competency delineation documents produced by and for other cadres who also provide sexual and reproductive health care services (Barry, Allegrange, Lamarre, Auld, & Taub, 2009; WHO, 2011).

The cultural and political appropriateness of each of the core competencies should also be considered (Butler, Fraser, & Murphy, 2008). The ICM has taken great care to craft the statement of core competencies with sensitivity for language and culture. Nevertheless, it is the case that some of the tasks that have been defined as basic knowledge or skill are not yet authorized for midwifery practice by regulatory policy in certain countries.

In many countries, midwives are also educated and credentialed as nurses. These combined programs may require a longer period of study to acquire competencies for both professions (e.g., midwifery studies following completion of nursing studies), and may, therefore, be more expensive for students and for educational institutions. There is an acknowledged advantage to dual preparation. Individuals have personal choice in some countries to practice either or both of those roles, thus generating opportunities for job mobility and autonomy in career choices. In other countries, graduates must complete an obligatory period of public service. Human resource departments have the option of assigning these dual-credentialed nurse–midwives to any setting, based on the priority workforce needs of the health facility. These dual-credentialed practitioners are also more broadly prepared for practice in health facilities where only a few health workers are assigned, for example, in rural health clinics or health posts (Francis, 2009; Hundley et al., 2007; Ireland et al., 2007). On the other hand, there is the risk of de-skilling when practitioners practice one role to the exclusion of the other. Unless human resource personnel and supervisors recognize their added value, the advantage of unique midwifery skills can be lost (Scotland & Bullough, 2004). Similarly, it is sometimes the case that individuals are prepared as midwives but never actually work as midwives. This could be viewed as a waste of precious educational resources.

CONCLUSIONS AND IMPLICATIONS FOR GLOBAL PRACTICE

A clear understanding of the concepts of competence and competency serves an important purpose for individual midwives and for the education and practice communities where they serve. These concepts underpin the global call to action to strengthen midwifery to save lives and promote the health of women and newborns (ICM et al., 2010).

The ICM Essential Competencies provides the individual midwife with an external reference criterion for the knowledge, professional behaviors, and skills that define professional midwifery practice, against which she or he can assess the individual level of need for continued learning. Midwives can also use the concept of competency as a means to analyze new practices as they are asked to consider adding them to their practice. For example, a midwife being asked to assume responsibility for vacuum extraction can use competency as a logical framework for exploring whether she or he has sufficient access to the evidence-based information, skilled experts, anatomic models, clinical equipment, supplies, and patient experiences needed to obtain the knowledge, communication, clinical decision, and psychomotor skills associated with developing and maintaining competence in this new area.

Competencies provide educational administrators with a means of ensuring that curriculum and educational resources are directed toward achieving learning outcomes that are consistent with safe, beginning-level midwifery practice. The ICM recently developed global standards and guidelines for midwifery education that can serve as a framework for strengthening the initial preparation of fully qualified midwives based on the ICM Essential Competencies.

Competencies can be used by national regulators, midwifery councils, and regional health district and local facility managers responsible for maintaining the quality of care. A reproductive health care system that relies on midwives (or any other cadre of birth attendant) who are less than competent to provide care at entry into practice and over the professional practice lifetime is dangerous to women, their families, and communities. Specifically, midwifery competencies can be used to prioritize delivery of continuing education and skills assessment that are most needed to ensure that effective services are delivered by the midwifery workforce. A focus can be placed on clinical services that require the most complex set of skills, that do not require frequent performance, and that have high potential for morbidity, if not performed competently.

The concepts of competence, competency, and competency-based education have received a great deal of attention in recent years. Widespread understanding and application of these essential constructs can lead to transformative educational, clinical, and regulatory improvements in nations struggling to build a quality midwifery workforce aimed at meeting relevant MDGs.
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