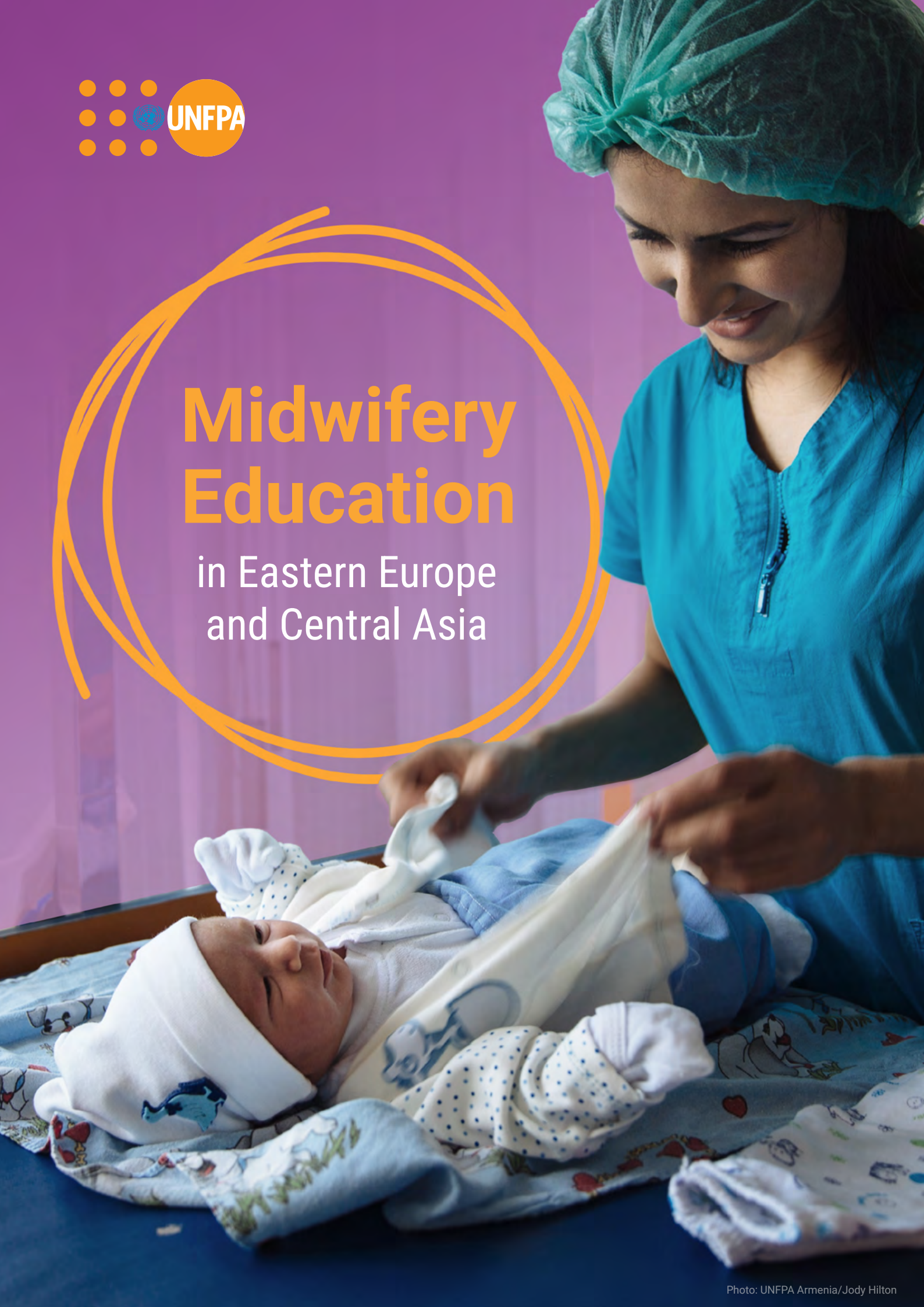




Midwifery Education

in Eastern Europe
and Central Asia



Contents

List of figures	ii
Executive summary	iv
Contributors and acknowledgements	v
Abbreviations and acronyms	vi
Introduction	1
Background	4
The Eastern Europe and Central Asia region	5
United Nations Population Fund	7
International Confederation of Midwives	8
Advancing midwifery and midwives in the Eastern Europe and Central Asia region	9
Theoretical framework	10
The state of midwifery in Eastern Europe and Central Asia: key challenges and recommendations	11
ICM Global Standards for Midwifery Education	12
ICM Essential Competencies for Midwifery Practice	13
UNFPA package of essential SRHR interventions for universal health coverage	14
Methodology	16
Findings	19
Findings: current state of midwifery education programmes in the Eastern Europe and Central Asia region	20
Findings: inclusion of SRHR competencies in midwifery curricula in the Eastern Europe and Central Asia region	28
Recommendations	47
Recommendations with regard to the quality of midwifery education programmes	48
Recommendations for the inclusion of SRHR competencies in midwifery curricula	49
Glossary	50
Bibliography	53
Appendix: Country dashboards	55

List of figures

Figure 1. ICM Essential Competencies for Midwifery Practice	13
Figure 2. Life-course approach to essential SRHR interventions	15
Figure 3. Category compliance in each country or territory	27
Figure 4. Percentage of SRHR competency statements included in midwifery curricula	28
Figure 5. Percentage of SRHR competency statements included in midwifery curricula: average for the Eastern Europe and Central Asia region	29
Figure 6. Inclusion of SRHR interventions in the midwifery curriculum in each country or territory	30
Figure 7. Inclusion of knowledge, skill/behaviour and combined competency statements	31
Figure 8. Time allocated per SRHR intervention	32
Figure 9. Inclusion of general SRHR competencies in each country or territory	33
Figure 10. Inclusion of competencies on counselling and services for modern contraceptives	34
Figure 11. Inclusion of competencies on safe abortion services and treatment following unsafe abortion	35
Figure 12. Inclusion of competencies on detecting and preventing sexual and gender-based violence	36
Figure 13. Inclusion of competencies on counselling and services for sexual health and well-being	37
Figure 14. Inclusion of competencies on detecting, preventing and managing reproductive cancers	38
Figure 15. Inclusion of competencies on prevention and treatment of HIV and other STIs	39
Figure 16. Inclusion of competencies on counselling and services for subfertility and infertility	40
Figure 17. Inclusion of competencies on counselling for menopause and post-menopause	41
Figure 18. Inclusion of competencies on comprehensive sexuality education	42
Figure A1. Albania: average rate of inclusion of SRHR competencies in midwifery curriculum	56
Figure A2. Albania: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	57
Figure A3. Azerbaijan: average rate of inclusion of SRHR competencies in midwifery curriculum	58

Figure A4. Azerbaijan: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	59
Figure A5. Georgia: rate of inclusion of SRHR competencies in midwifery curriculum	60
Figure A6. Georgia: rate of inclusion per SRHR intervention in midwifery curriculum	61
Figure A7. Kazakhstan: average rate of inclusion of SRHR competencies in midwifery curriculum	62
Figure A8. Kazakhstan: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	63
Figure A9. Kyrgyzstan: average rate of inclusion of SRHR competencies in midwifery curriculum	64
Figure A10. Kyrgyzstan: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	65
Figure A11. North Macedonia: average rate of inclusion of SRHR competencies in midwifery curriculum	66
Figure A12. North Macedonia: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	67
Figure A13. Serbia: average rate of inclusion of SRHR competencies in midwifery curriculum	68
Figure A14. Serbia: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	69
Figure A15. Tajikistan: rate of inclusion of SRHR competencies in midwifery curriculum	70
Figure A16. Tajikistan: rate of inclusion per SRHR intervention in midwifery curriculum	71
Figure A17. Türkiye: average rate of inclusion of SRHR competencies in midwifery curriculum	72
Figure A18. Türkiye: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	73
Figure A19. Ukraine: average rate of inclusion of SRHR competencies in midwifery curriculum	74
Figure A20. Ukraine: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	75
Figure A21. Uzbekistan: rate of inclusion of SRHR competencies in midwifery curriculum	76
Figure A22. Uzbekistan: rate of inclusion per SRHR intervention in midwifery curriculum	77
Figure A23. Kosovo: average rate of inclusion of SRHR competencies in midwifery curriculum	78
Figure A24. Kosovo: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum	79

Executive summary

To achieve universal health coverage and the Sustainable Development Goals, urgent investment in midwives is needed to enable them to fulfil their potential. Understanding the current state of midwifery education and the extent to which sexual and reproductive health and rights (SRHR) interventions for universal health coverage are included is necessary to support the countries and territories of Eastern Europe and Central Asia in identifying the specific gaps that can be addressed through midwifery education and care.

This report reflects the findings and recommendations from two assessments that followed publication of the 2022 report *The State of the Midwifery Workforce in Eastern Europe and Central Asia*. Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, Serbia, Tajikistan, Türkiye, Ukraine, Uzbekistan and Kosovo* provided data for one or both of the assessments.

The findings of the assessment of the quality of midwifery education in the Eastern Europe and Central Asia region demonstrate that, out of the five categories covered by the International Confederation of Midwives (ICM) Global Standards for Midwifery Education,¹ the curriculum as well as resources and quality improvement categories need to be strengthened more than the others in the nine countries and territories that took part in the assessment. According to the data provided, midwifery education in Bosnia and Herzegovina, Kazakhstan, Tajikistan and Türkiye meets most of the requirements of the ICM Global Standards. The findings show that Azerbaijan, Belarus, Kyrgyzstan, North Macedonia and Kosovo are the countries and territories most likely to have gaps and challenges in midwifery education.

The findings of the assessment of the level of inclusion of SRHR competencies in midwifery curricula in the Eastern Europe and Central Asia region demonstrate that there is great variation in terms of the inclusion of the various SRHR interventions in the curricula of different countries and territories, as well as among institutions within countries and territories. Overall, little over half of the SRHR competencies required to provide SRHR services needed to achieve universal health coverage for sexual and reproductive health and rights are fully covered in the midwifery curricula in the 12 countries and territories that took part in the assessment. Türkiye, Albania, North Macedonia and Serbia reported the inclusion of between 71 per cent and 74 per cent of the competencies; Kazakhstan, Tajikistan, Ukraine and Uzbekistan, between 49 per cent and 66 per cent; Azerbaijan, Georgia, Kyrgyzstan and Kosovo, between 24 per cent and 34 per cent.

Countries and territories can use this report to address gaps in midwifery education and to improve the quality of care and the landscape of sexual, reproductive, maternal, newborn and adolescent health care.

* All references to Kosovo shall be understood to be in the context of Security Council Resolution 1244 (1999).

1. The ICM Global Standards for Midwifery Education include six categories, two of which were combined into a single category for the assessment.

Contributors and acknowledgements

This report was commissioned by the United Nations Population Fund (UNFPA) Regional Office for Eastern Europe and Central Asia and financed by the UNFPA Maternal Health Task Force's midwifery programme. It is based on two assessments conducted in 2023: one on the current state of midwifery education in Eastern Europe and Central Asia and the other on the inclusion of competencies relating to sexual and reproductive health and rights (SRHR) in the curricula of midwifery education programmes in Eastern Europe and Central Asia.

The main coordinators from UNFPA were Dr. Tamar Khomasuridze, UNFPA Regional Adviser on Sexual and Reproductive Health for Eastern Europe and Central Asia; Dr. Teymur Seyidov, UNFPA Sexual and Reproductive Health Specialist for Eastern Europe and Central Asia; and Dr. Serik Tanirbergenov, UNFPA Kazakhstan Sexual and Reproductive Health Programme Analyst.

The lead writers and researchers were Charlotte Renard (on the current state of midwifery education in Eastern Europe and Central Asia) and Patricia Titulaer (on the inclusion of SRHR competencies in midwifery curricula).

We would like to thank UNFPA Country Office staff, ministries of health and other stakeholders from Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, Serbia, Tajikistan, Türkiye, Ukraine, Uzbekistan and Kosovo for contributing to data collection and providing valuable input for the report.

Abbreviations and acronyms

CAC	Comprehensive abortion care
HIV	Human immunodeficiency virus
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRMNAH	Sexual, reproductive, maternal, newborn and adolescent health
STI	Sexually transmitted infection
UHC	Universal health coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

Introduction



*The State of the World's Midwifery 2021*² builds on previous reports in the *State of the World's Midwifery* series and represents an unprecedented effort to document the whole world's sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) workforce, with a particular focus on midwives. It calls for urgent investment in midwives to enable them to fulfil their potential to contribute to achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs).³

The State of the World's Midwifery 2021 provides evidence that midwives are vital for achieving universal access to sexual and reproductive health (SRH) (SDG targets 3.1, 3.7 and 5.6) by meeting the SRH needs of, and realizing the reproductive rights of, women, men and adolescents. When fully educated, licensed and integrated into an interdisciplinary team, midwives can meet about 90 per cent of the need for essential SRMNAH interventions across the life course.⁴

More recently, the report *The State of the Midwifery Workforce in Eastern Europe and Central Asia* demonstrated similar evidence, as well as the many social and economic benefits of investing in midwifery.⁵ Both reports call on policymakers, governments and their partners to invest in midwives, particularly in the following four key areas: (1) health workforce planning, management, regulation and the work environment, (2) high-quality education and training for midwives, (3) midwife-led improvements to SRMNAH service delivery and (4) midwifery leadership and governance.⁶ This led to the publication of a statement of commitments for advancing midwifery in the European region, which calls on UN Member States, international organizations, academia, the private sector and civil society, including non-governmental organizations, to advance midwifery education, competencies, regulation, leadership and associations in the European region.⁷







The above-mentioned reports raised concerns about the provision of high-quality midwifery education and about differences in the organization of midwifery education between the countries and territories of Eastern Europe and Central Asia. Furthermore, as highlighted in the UNFPA Strategic Plan 2022–2025, national concerns point to several priority sexual and reproductive health areas: in particular, meeting the unmet need for family planning and ending preventable maternal deaths.⁸ Improving the quality of midwifery education will be key to addressing these concerns.

Understanding the current state of midwifery education and the extent to which SRHR interventions for universal health coverage are included is necessary to enable the countries and territories of Eastern Europe and Central Asia to identify the specific gaps that need to be addressed through midwifery education and care. In this context, the UNFPA Regional Office for Eastern Europe and Central Asia

-
2. Sarah Bar-Zeev and others, *The State of the World's Midwifery 2021: Building a Health Workforce to Meet the Needs of Women, Newborns and Adolescents Everywhere* (New York, United Nations Population Fund, 2021).
 3. Sexual and reproductive health is explicitly recognized by the SDGs as essential to health, development and women's empowerment. Sexual and reproductive health is referenced under SDG 3 (good health and well-being), more particularly under target 3.7, which is aimed at "ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education", and SDG 5 (gender equality).
 4. United Nations Population Fund (UNFPA), *The State of the World's Midwifery 2021: Webappendices* (New York, 2021).
 5. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia* (Istanbul, 2022).
 6. UNFPA, *The State of the World's Midwifery 2021: Webappendices*.
 7. UNFPA Regional Office for Eastern Europe and Central Asia, "Statement of commitments for advancing midwifery in the European region", May 2023.
 8. Executive Board of the United Nations Development Programme, UNFPA and the United Nations Office for Project Services, "The UNFPA strategic plan, 2022-2025", 14 July 2021, DP/FPA/2021/8.

commissioned this report, which was executed in two phases. Phase 1 aimed to gain a better understanding of the status of, and the actions needed to improve the quality of, midwifery education in the Eastern Europe and Central Asia region, and phase 2 aimed to gain a better understanding of the extent to which the nine SRHR interventions for universal health coverage⁹ are included in the curricula and whether they prepare midwives to address the SRHR needs of the population. Data from the regional report on the state of the midwifery workforce in Eastern Europe and Central Asia provided the foundation for this report.

The report has the following objectives:

-  to provide up-to-date evidence of the current state of midwifery education and the extent to which the national midwifery programmes in the Eastern Europe and Central Asia region are currently able to meet the ICM Global Standards for Midwifery Education
-  to highlight any disparities in terms of midwifery education in the region and between and within countries and territories
-  to assess the extent to which the national midwifery programmes in the Eastern Europe and Central Asia region include SRHR competencies in their respective curricula
-  to provide recommendations for advancing midwifery education and for integrating SRHR competencies in the countries and territories of Eastern Europe and Central Asia
-  to provide recommendations on expanding the role of midwives beyond just birth attendance in the region (this includes antenatal and postnatal care, counselling on family planning and other sexual and reproductive health services, physiological support and upholding human rights, as recommended by the ICM Essential Competencies for Midwifery Practice)
-  to assess, and provide recommendations on, networking opportunities between international and national nursing associations or professional midwifery associations to promote quality midwifery education in the Eastern Europe and Central Asia region

The report includes data from 14 countries and territories in UNFPA's Eastern Europe and Central Asia region: Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, Serbia, Tajikistan, Türkiye, Ukraine, Uzbekistan and Kosovo. Phase 1 did not include Albania, Georgia, Serbia, Ukraine or Uzbekistan, whereas phase 2 did not include Belarus or Bosnia and Herzegovina.

The purpose of the report is to guide decision makers and professionals within governments, educational institutions, regulatory bodies, health partners and midwives' associations on how and where to focus attention, investment and resources to improve midwifery education and care.

9. UNFPA, *Sexual and reproductive health and rights: an essential element of universal health coverage* (New York, 2019).

Background



The Eastern Europe and Central Asia region

The Eastern Europe and Central Asia region is characterized by variations in economic, demographic and health development, which have contributed to inequalities in the region. If we look at the Human Development Index, we find that it is very high in 5 countries (mainly in Eastern Europe), high in 10 countries and medium in 2 countries. This is, more or less, coherent with gross national income. Whereas the per capita gross national income is less than US\$5,000 in Kyrgyzstan and Tajikistan, it is above \$30,000 in Türkiye. While the expected number of years of schooling in Türkiye is 18.3, it is no more than 12 in Tajikistan and Uzbekistan.¹⁰

Health reforms

Differences and inequalities are rooted in the history of the region, where most countries and territories used to be part of the Soviet Union or were strongly influenced by it. In the Soviet era, primary health care was based on the centrally planned and hierarchically organized Semashko system. In rural areas, primary care services were provided at rural health clinics and feldsher–midwife points, while in urban areas they were provided at polyclinics.¹¹

Primary health care was one of the strengths of the early Soviet health-care system, enabling most people, in both cities and rural areas, to gain access to basic health services. After the Second World War, however, health policy increasingly focused on secondary and tertiary care, leading to the neglect of primary care and general care in rural areas. After the fall of the Soviet Union, countries supported by international organizations such as the World Health Organization (WHO), UNFPA and the European Union introduced the family medicine model of care to strengthen primary care and make it more accessible to the population. This led to the initiation of far-reaching reforms that were not completed in most of the countries and territories of Eastern Europe and Central Asia due to economic turmoil and conflicts.¹²

In practically all these countries and territories, however, the dominant role of specialists has been maintained, where investment in training or retraining the primary health-care workforce has been minimal. This results in a primary care system that has remained disease- and physician-centred rather than client-centred. The lack of client-centredness in the primary health-care system extends to the status and the role of midwives, who are largely unrecognized and undervalued. The undervaluing of midwives is in turn impacting the extent to which SRMNAH interventions are provided to the population, as midwives are key providers of integrated SRHR services in the context of universal health coverage.

10. United Nations Development Programme, Human Development Index. Available at <https://hdr.undp.org/data-center/human-development-index#/indicies/HDI> (accessed on 29 January 2024).

11. Bernd Rechel, Erica Richardson and Martin McKee, eds., *Trends in Health in the Former Soviet Countries*, Observatory Studies Series, No. 35 (Copenhagen, World Health Organization, 2014).

12. Bernd Rechel and others, "Primary care reforms in Central Asia – on the path to universal health coverage?", *Health Policy OPEN*, vol. 5 (December 2023).

SRMNAH indicators and trends

The Eastern Europe and Central Asia region is characterized by certain trends in sexual and reproductive health indicators, such as relatively high maternal mortality – mostly in Central Asia – an above-average number of abortions, relatively low usage of modern contraceptives and high rates of cervical cancer.¹³

Several countries have unmet needs for family planning that are higher than the global average. Access to prenatal and postnatal care is good in most countries and territories in Eastern Europe and Central Asia. Nearly all births are attended by a skilled birth attendant, who is usually a physician rather than a midwife,¹⁴ making the SRMNAH health system a highly medicalized one. For example, 90 per cent of births in Albania, Armenia and the Republic of Moldova are attended by physicians.¹⁵

Despite these facts, we can see that countries and territories have made impressive progress on SRMNAH outcomes in maternal and neonatal mortality, and stillbirth rates are below global 2030 targets. Progress has been uneven, however, with disparities both between and within countries and territories.¹⁶ These disparities demand intervention in midwifery education, regulation, the adoption of multidisciplinary teams and a functional referral system. If these steps were taken, midwives would be able to meet approximately 90 per cent of the need for essential SRMNAH interventions across the life course.¹⁷

The region currently has a total of 1.7 million SRMNAH workers, 75 per cent of whom are nurses without formal midwifery training, 13 per cent are SRMNAH doctors (general physicians, obstetricians, gynaecologists and paediatricians), and 8 per cent are midwives or nurse-midwives.¹⁸ Although most of the countries and territories of Eastern Europe and Central Asia have sufficient midwives to meet the needs of the population, in terms of size and fertility rate, they largely lack the ability to deliver essential SRMNAH interventions.¹⁹ It should be noted, however, that half of the countries and territories of Eastern Europe and Central Asia have a midwife density below the global average,²⁰ whereas the others have a density above the global average. In other words, there is substantial variation in midwife density across the region.

13. UNFPA Regional Office for Eastern Europe and Central Asia, "Sexual and reproductive health". Available at <https://eeca.unfpa.org/en/node/9632> (accessed on 13 December 2023).

14. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia*, p. 10.

15. *Ibid.*, p. 21.

16. *Ibid.*, p. 10.

17. *Ibid.*, p. 6.

18. *Ibid.*, p. 29.

19. *Ibid.*, p. 71.

20. *Ibid.*, p. 10.

United Nations Population Fund

UNFPA's goal is to ensure sexual and reproductive rights for all. UNFPA's work has been driven since 1994 by the International Conference on Population and Development (ICPD), where, for the first time, a global consensus was reached that placed reproductive rights, human lives and women's interests at the heart of the 2030 Agenda for Sustainable Development.

Building on the ICPD agenda, UNFPA has placed at the centre of its mission, and its Strategic Plan 2022–2025, three transformational goals that include (a) ending preventable maternal deaths, (b) ending the unmet need for family planning and (c) ending gender-based violence and all harmful practices, including child marriage and female genital mutilation.²¹

Since 2008, UNFPA has worked with partners, governments and policymakers to help build a competent, well-trained and well-supported midwifery workforce in low-resource settings. UNFPA focuses on four key areas: strengthening competency-based midwifery training, developing strong regulatory mechanisms to ensure quality services, raising the voices of midwives by establishing and strengthening midwifery associations and calling for increased investments in midwifery services. UNFPA also works to create a supportive environment for midwives by advocating adequate workforce policies for midwives.²²

In the Eastern Europe and Central Asia region, the vast inequalities in access and utilization of sexual and reproductive health services make achieving these goals even more meaningful. None of these goals can be achieved without investment in the SRMNAH workforce, in particular midwives. UNFPA also calls on countries to adopt and implement the comprehensive definition of sexual and reproductive health and rights proposed by the Guttmacher–Lancet Commission to progressively expand equitable access to the recommended package of SRHR interventions throughout the life course, which is essential in order to ensure that no one is left without access to quality, affordable and acceptable SRHR care and services.²³

21. UNFPA, *Investing in three transformative results: realizing powerful returns* (New York, 2022).

22. UNFPA, "Midwifery". Available at <https://www.unfpa.org/midwifery> (accessed on 13 December 2023).

23. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia*; Ann M. Starrs and others, "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission", *The Lancet*, vol. 391 (2018).

International Confederation of Midwives

The International Confederation of Midwives envisions a world where every childbearing woman has access to a midwife's care for herself and her newborn. According to ICM, having access to a midwife is a basic human right for all women, as evidenced in the ICM Bill of Rights²⁴ and the Philosophy and Model of Midwifery Care.²⁵ ICM sets global standards "to strengthen midwifery worldwide by promoting high quality education programmes that prepare midwives who meet the ICM definition of a midwife"²⁶ and to support the work of its members. These standards have been used as a framework for this report to assess the quality of national midwifery education in the countries and territories of Eastern Europe and Central Asia.

Through its network of more than 140 members, ICM encourages international networking between midwives' associations themselves and between partners and professional associations to share knowledge and good practice. In the Eastern Europe and Central Asia region, ICM supports and represents four midwives' association members, located in Kyrgyzstan, Tajikistan, Türkiye and Kosovo. For example, the Tajik Midwives' Association was instrumental in supporting and advocating the appointment of a chief midwife in Tajikistan in 2017, making it the first country in the Eastern Europe and Central Asia region to have a midwife in such a high position.

ICM calls on countries and territories to invest in their respective midwives' associations or to support the creation of a midwives' association where there is none, to improve access to sexual and reproductive health and rights and to support the elimination of maternal and newborn mortality.²⁷

24. International Confederation of Midwives (ICM), Bill of Rights for Women and Midwives, document CD2011_002 V2017.

25. ICM, Philosophy and Model of Midwifery Care, document CD0005_V201406_EN.

26. ICM, ICM Global Standards for Midwifery Education (revised 2021). For the ICM's definition of *midwife*, see ICM, International Definition of the Midwife, document CD2005_001 V2017 ENG.

27. Cristina A. Mattison and Kirsty M. Bourret, "Investing in midwifery associations to improve sexual and reproductive health and rights: a policy brief to ground the Feminist International Assistance Policy in evidence" (Hamilton, Ontario, McMaster Midwifery Research Centre, 2021).

Advancing midwifery and midwives in the Eastern Europe and Central Asia region

Midwives, when educated and regulated in line with the ICM Global Standards and fully integrated into, and supported by, interdisciplinary teams, and in an enabling environment, can provide a wide range of clinical interventions and contribute to broader health goals, such as advancing primary health care, addressing sexual and reproductive rights, promoting self-care interventions and empowering women.²⁸

As evidenced in the ICM scope of practice,²⁹ “midwives have a wide ranging and uniquely skilled place in caring for women not only throughout pregnancy and childbirth, but also in antenatal and postnatal care; neonatal care; [comprehensive abortion care (CAC), sexual and gender-based violence (SGBV), family planning and contraception;] sexual health and fertility services in partnership with women and their families”.³⁰ Midwives can also play pivotal roles in ensuring the quality of midwifery education and regulation, influencing and driving health policies, and creating evidence for midwifery through research.

In 2019, UNFPA, ICM, UNICEF and WHO identified three strategic priorities for strengthening midwifery education: (1) educating and training all midwives to international standards, (2) appointing midwife leaders who can influence key decisions about investment in midwifery education and (3) ensuring better coordination and alignment between stakeholders.³¹

UNFPA together with ICM and other global partners are working to scale up quality midwifery education, policies and services around the world. Together they want to reduce maternal and neonatal mortality and strengthen the midwifery profession and midwifery education in the countries and territories of Eastern Europe and Central Asia.

28. UNFPA, *The State of the World's Midwifery 2021: Webappendices*.

29. ICM, document CD2005_001 V2017 ENG.

30. Patricia Gillen, “Connecting status and professional learning: an analysis of midwives career using the Place© Model”, *Education Sciences*, vol. 9, No. 4 (2019).

31. WHO and others, *Strengthening Quality Midwifery Education for Universal Health Coverage 2030: Framework for Action* (Geneva, WHO, 2019).

Theoretical framework



The theoretical framework presented here draws on key principles from the fields of midwifery education and practice and sexual and reproductive health and rights. The framework underscores the synergies between the findings of the *State of the World's Midwifery* reports (the global report and the report for Eastern Europe and Central Asia), the ICM Global Standards for Midwifery Education, the ICM Essential Competencies for Midwifery Practice and the package of essential SRHR interventions presented in UNFPA's publication *Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage*.

The state of midwifery in Eastern Europe and Central Asia: key challenges and recommendations

In 2022, UNFPA published the first-ever report on the state of the midwifery workforce in Eastern Europe and Central Asia.³² The report follows the same approach used by the *State of the World's Midwifery 2021* report and focuses on the current state of the SRMNAH workforce, current challenges at the regional and national levels, and recommendations to achieve further progress in the Eastern Europe and Central Asia region. Both reports highlight various challenges and gaps with regard to the sexual and reproductive health and rights of the population, including the unmet need for family planning, often overmedicalized models of care, neglected and underfunded primary care, shortcomings in the quality of midwifery education (low-level qualifications, the lack of competency-based curricula, insufficient emphasis on gaining practical experience as well as theoretical knowledge, short programmes, underqualified faculty and the lack of requirements for continuing professional development), regulatory barriers preventing midwives from practising to their full scope of practice and in some cases a lack of distinction between midwives and nurses.

The following recommendations from the above-mentioned reports shaped the assessments for this report:

- ✔ Ensure that midwives are educated according to global standards and enabled to provide high-quality care.
- ✔ Review the available pre-service education pathways to address acknowledged limitations, such as low-level qualifications, the lack of competency-based curricula, insufficient emphasis on gaining both practical experience and theoretical knowledge, and the lack of midwives qualified to teach.
- ✔ Assess the extent to which the content of midwife education curricula aligns with global recommendations.

32. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia*.

ICM Global Standards for Midwifery Education

The ICM Global Standards for Midwifery Education “set a benchmark for programmes that prepare students for entry to practise as a midwife; promote high-quality teaching and learning processes; [and] ensure the *ICM Essential Competencies for Midwifery Practice* (2019) are incorporated into the curriculum”.³³ The standards can be used, for example, “to promote a common understanding and approach to midwifery education [and] guide the development of new programmes or the restructuring of existing programmes where midwives are needed”.³⁴ The standards consist of the following six categories: programme governance, faculty, students, midwifery programme and curriculum, resources and quality improvement.³⁵ For the purposes of the assessment, *resources* and *quality improvement* were combined into a single category.



33. ICM, *ICM Global Standards for Midwifery Education* (revised 2021), p. 1.

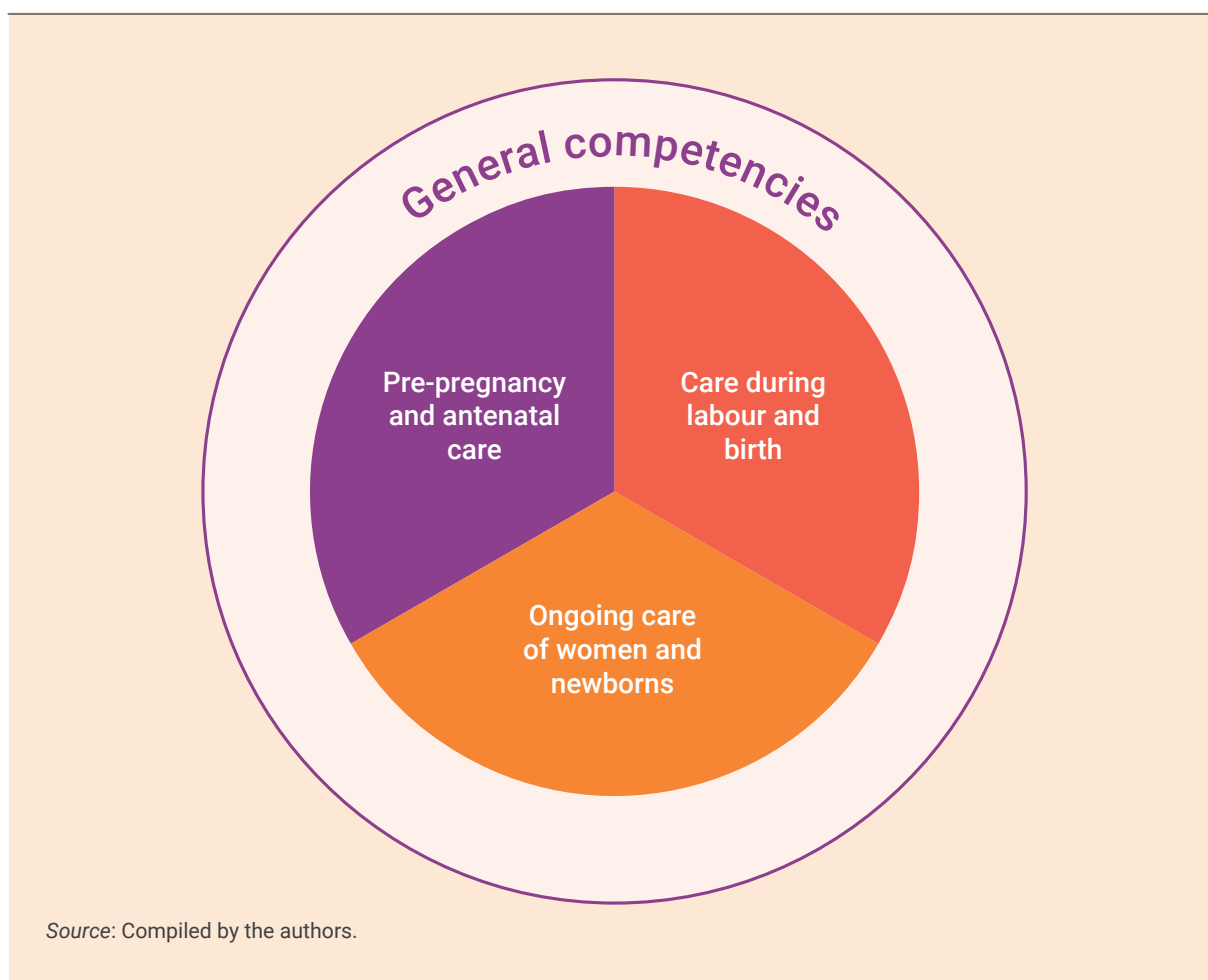
34. *Ibid.*

35. *Ibid.*, pp. 4–9.

ICM Essential Competencies for Midwifery Practice

The ICM Essential Competencies for Midwifery Practice “outline the minimum set of knowledge, skills and professional behaviours required by an individual to use the designation of midwife as defined by ICM when entering midwifery practice”.³⁶ The competencies are framed in four categories – general competencies, competencies specific to pre-pregnancy and antenatal care, competencies specific to care during labour and birth, and competencies specific to the ongoing care of women and newborns – “that [set] out those competencies considered to be essential and that represent those that should be an expected outcome of midwifery pre-service education”.³⁷ SRHR elements are included in all four categories. UNFPA and ICM recently published a sample midwifery curriculum that helps operationalize education to meet the ICM Essential Competencies. Figure 1 shows how the four categories are connected.

Figure 1. ICM Essential Competencies for Midwifery Practice



36. ICM, *Essential Competencies for Midwifery Practice: 2019 update* (The Hague, 2019), p. 2.

37. Ibid.

UNFPA package of essential SRHR interventions for universal health coverage

Sexual and reproductive health and rights are an essential part of universal health coverage. A comprehensive approach to sexual and reproductive health and rights is cost-effective and affordable for most countries. The comprehensive definition of sexual and reproductive health and rights proposed by the Guttmacher–Lancet Commission covers sexual health, sexual rights, reproductive health and reproductive rights and reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs of all individuals.³⁸ Additionally, it addresses issues such as violence, stigma and respect for bodily autonomy, which profoundly affect individuals' psychological, emotional and social well-being.

The following essential SRHR interventions are proposed as part of a comprehensive approach to sexual and reproductive health and rights:³⁹

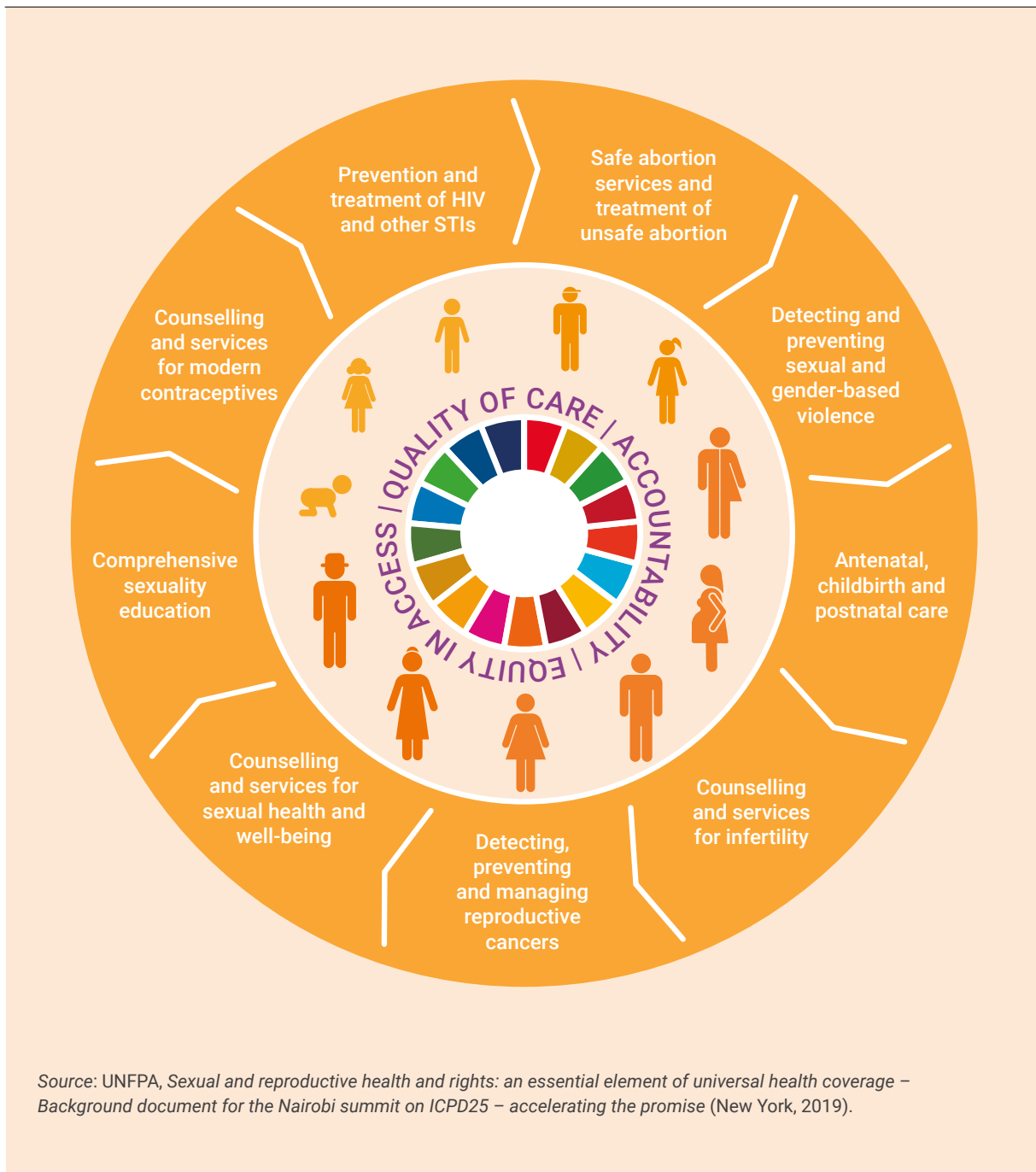
1. comprehensive sexuality education (in and out of school)
2. counselling and services for a range of modern contraceptives, with a defined minimum number of types of methods
3. antenatal, childbirth and postnatal care, including emergency obstetric and newborn care
4. safe abortion services and treatment of the complications of unsafe abortion
5. prevention and treatment of HIV infection and other STIs
6. prevention of, detection of, immediate services for, and referrals for, cases of sexual and gender-based violence
7. prevention, detection and management of reproductive cancers, especially cervical cancer
8. information, counselling and services for subfertility and infertility
9. information, counselling and services for sexual health and well-being

These interventions are shown in Figure 2 in relation to the different life stages, applying a life-course approach, and centred around three cross-cutting principles: equity in access, quality of care and accountability.

38. Starrs and others.

39. UNFPA, *Sexual and reproductive health and rights: an essential element of universal health coverage*.

Figure 2. Life-course approach to essential SRHR interventions



Methodology



The assessment of the quality of midwifery education is based on the ICM Global Standards for Midwifery Education, which consist of 44 standards divided over the following six categories: programme governance, faculty, students, midwifery programme and curriculum, resources and quality improvement. A questionnaire asked respondents a series of questions about the level of compliance of their respective institutions with each of the 44 standards. The respondents could answer *Yes*, *No* or *Partially* in response to each question. Representatives of nine countries or territories completed the questionnaire: Azerbaijan, Belarus, Bosnia and Herzegovina, Kazakhstan, Kyrgyzstan, North Macedonia, Tajikistan, Türkiye and Kosovo.

The assessment of the inclusion of SRHR competencies is based on the nine essential SRHR interventions as part of universal health coverage and considers the role of midwives in their delivery. For the purpose of this assessment, we excluded the interventions relating to antenatal, childbirth, and postnatal and newborn care from the package of essential SRHR interventions. This left us with eight SRHR intervention areas.

We then mapped the ICM competencies for midwifery practice against the eight remaining SRHR interventions, which provided further insights:

1. Since a substantial subset of competencies are universally applicable across all the identified SRHR interventions, a section for general SRHR competencies was added to the questionnaire.
2. Since competencies relating to menopause and post-menopause are referenced in *Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage*, but it is unclear which intervention they should fall under, a separate section was created for menopausal and post-menopausal counselling and morbidities (using the language found in *Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage*).
3. The description of some of the ICM competencies remains quite broad, particularly around family planning and comprehensive abortion care, menopause and infertility. To address this point, WHO's toolkit on competencies relating to family planning and comprehensive abortion care⁴⁰ was consulted, and specific competencies in the areas of family planning and comprehensive abortion care were mapped against the relevant SRHR interventions. In addition, the UNFPA–ICM sample curriculum for midwifery education was reviewed to cover any remaining gaps.

This process culminated in the formulation of a comprehensive questionnaire comprising the following 10 sections: general competencies relating to sexual and reproductive health and rights; counselling and services for modern contraceptives; safe abortion services and treatment following unsafe abortion; detecting and preventing sexual and gender-based violence; counselling and services for sexual health and well-being; detecting, preventing and managing reproductive cancers; prevention and treatment of HIV and other STIs; counselling and services for subfertility and infertility; menopausal and post-menopausal counselling and morbidities; and comprehensive sexuality education.

40. WHO, *Family Planning and Comprehensive Abortion Care Toolkit for the Primary Health Care Workforce*, vol. 3, *Competencies* (Geneva, 2022).

These sections collectively cover 130 SRHR competency statements.

Twelve countries and territories (Albania, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, Serbia, Tajikistan, Türkiye, Ukraine, Uzbekistan and Kosovo) completed the questionnaire, and a total of 26 midwifery education institutions were included.

National consultants recruited by UNFPA Country Offices worked with the respective ministries of health and education as well as midwifery education institutions and associations to complete the questionnaire. Completed questionnaires, validated by the respective countries and territories, were collected and collated in one master file for analysis.

Ethical clearance was not required and thus not obtained.

Findings



This study used the self-assessment method, which has limitations, as it may impact the accuracy and quality of the data. Self-assessment may lead to misinterpretation of the questions and underestimation or overestimation of the quality of the midwifery programme or content of the curriculum. Also, if the respondent was not familiar with the ICM Global Standards for Midwifery Education, the ICM Essential Competencies for Midwifery Practice or the interventions described in the UNFPA publication *Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage*, it might have been a challenge to understand all the components correctly and to respond appropriately.

Furthermore, the assessment would have benefited from additional questions dealing with factors such as the type of midwifery programmes that countries and territories offer (direct-entry programmes, post-nursing midwifery programmes and integrated programmes) to enable an accurate interpretation of the responses to question 49 of the quality assessment, on the minimum length of the midwifery programme.

Finally, this report covers information and data from 14 countries and territories that was collected in two phases (phase 1: the assessment of the current state of midwifery education in Eastern Europe and Central Asia; phase 2: the assessment of the incorporation of SRHR competencies into midwifery curricula in Eastern Europe and Central Asia). Not all countries and territories participated in both assessments. The information from six countries – Albania, Bosnia and Herzegovina, Georgia, Serbia, Ukraine and Uzbekistan – is not yet complete and needs to be read in that context.

Findings: current state of midwifery education programmes in the Eastern Europe and Central Asia region

The following countries and territories are included in this assessment: Azerbaijan, Belarus, Bosnia and Herzegovina, Kazakhstan, Kyrgyzstan, North Macedonia, Tajikistan, Türkiye and Kosovo.

Category 1: programme governance

This category refers to midwifery education policies and how midwifery education systems allocate roles and responsibilities.

Of the nine reporting countries and territories, six reported that they have both policies and legislation that regulate midwives' education and practice. Both North Macedonia and Kosovo appear to not have legislation to regulate the midwifery profession (though both have policies to regulate midwives' education), and Tajikistan appears to have only legislation.

Kosovo specified that it has a framework of legislation and some policies regulating professions and qualifications, including midwifery, but that these laws and policies are not specific to midwifery.

Kosovo also stated that up-to-date professional standards for midwives have not been drafted or approved by the regulatory entity. Without effective, up-to-date and specific legislation for midwives in North Macedonia and Kosovo, there will be limitations in ensuring that ICM's Essential Competencies for Midwifery Practice are incorporated into the curriculum and that midwives develop these competencies and are able to practise autonomously.

Of the nine reporting countries and territories, two – North Macedonia and to some extent Kazakhstan – reported that the head of their respective midwifery education entity is usually a doctor. All seven remaining countries and territories reported that the head of their respective midwifery education entity (department or programme) is a qualified midwife teacher with experience in management or administration. Belarus, however, specified that the head of midwifery education should hold an obstetrician–gynaecologist qualification or a nursing qualification with higher medical education or secondary specialized education and a medical assistant–obstetrician qualification. As per this information, it is unclear whether the head of the midwifery education entity in Belarus is a doctor, a doctor's assistant or a midwife.

As Kazakhstan reported, before 2021 only general-medicine graduates were allowed to be midwives. Since 2021, the register of specialities has considered the midwifery qualification to be an independent speciality. The country commented, however, that the number of students is insufficient to establish a separate midwifery department (as per the requirements, there should be at least 150 students). Due to the lack of teachers with a midwifery qualification, the midwifery speciality is, in most cases, combined with the medical speciality, and the head of the programme has traditionally been a medical doctor (therapist, surgeon, paediatrician, etc).

Bosnia and Herzegovina reported that the heads of its midwifery entities are midwives, except in the Faculty of Health Studies at the University of Sarajevo. All nine reporting countries and territories reported that the head of the respective midwifery entity has overall responsibility for the quality and organization of programme delivery. With the exception of North Macedonia, and to some extent Belarus, these estimates are positive overall given that the ICM Global Standards for Midwifery Education recommend that midwifery education programmes should be led by midwives.

Category 2: faculty

This category refers to the qualifications and competencies of the different faculty members who teach in the midwifery programme. It assesses the extent to which the institution meets the different needs of the faculty members in terms of continuing education, mentoring, communication, and health and well-being. The ICM Global Standards for Education recommend that the faculty should consist primarily of midwives with a professional midwifery qualification and formal preparation for teaching.

Of the nine reporting countries and territories, six indicated that their faculties are comprised predominantly of midwives who work with experts from other disciplines as needed. Azerbaijan, Belarus and North Macedonia reported that their faculties are not comprised predominantly of midwives.

Qualifications of midwifery teachers

All nine reporting countries and territories reported that their midwife teachers and midwifery clinical preceptors or clinical teachers are qualified according to the ICM's definition of a midwife or the respective national or territorial definition. However, it is important to take the information in the following paragraphs into consideration in the analysis.

In Kyrgyzstan, North Macedonia and Kosovo, midwife teachers and midwifery clinical preceptors or clinical teachers are qualified only according to the respective national or territorial definition. Whether the national or territorial definition is based on the ICM's definition would need further investigation.

In Belarus, only a person with higher medical education who holds an obstetrician–gynaecologist qualification or a medical assistant–obstetrician diploma or specialized secondary medical education can teach midwives. As per this information, it is unclear whether midwife teachers in Belarus are doctors, doctor's assistants or midwives, and this matter would need further investigation.

In North Macedonia, Tajikistan and Kosovo, midwife teachers do not receive formal preparation to teach. This echoes the findings of *The State of the Midwifery Workforce in Eastern Europe and Central Asia*. In Kyrgyzstan, whether or not a midwife teacher receives formal preparation to teach depends on the education institution where the teacher practises.

In Kyrgyzstan, depending on the education institution, midwife teachers may or may not engage in ongoing development as midwifery practitioners, teachers, lecturers or leaders. The other eight countries and territories all reported that midwife teachers engage in ongoing development.

Kyrgyzstan and Kosovo reported that midwife clinical teachers maintain only partial competency in both midwifery practice and teaching competencies. In Azerbaijan, the competency of midwife clinical teachers is not maintained at all.

All nine reporting countries and territories indicated that midwife teachers demonstrate competency in practice, hold a current licence or were registered to practise, and they contribute to developing and implementing the midwifery curriculum, as outlined in the ICM Global Standards for Midwifery Education.

Qualifications in other disciplines

All nine reporting countries and territories reported that individuals from other disciplines who teach in the midwifery programme are qualified in the content they teach.

Learning environment

In all nine reporting countries and territories, midwifery faculties provide continuing education and mentoring to clinical preceptors and teachers who teach and evaluate students at clinical sites. All countries and territories also reported that their midwife teachers and clinical teachers communicate regularly to facilitate and evaluate students' learning. They also confirmed, with the exception of North

Macedonia, that the ratio of midwifery students to clinical preceptors or teachers is based on the learning context and the needs of the students.

Of the nine reporting countries and territories, seven reported that they have policies to protect teachers' personal health, safety and well-being in learning environments, as recommended by the ICM Global Standards. No such policies are in place in Kosovo, and they are partially implemented in Kyrgyzstan, which pointed out that the lack of policies during the COVID-19 pandemic exposed midwife teachers to the virus, making them feel vulnerable and unsafe while teaching.

Category 3: students

This category refers to the overall admission policies and student policies and how well the respective faculty integrates the rights, well-being, and qualifications and competencies of students into its midwifery programme.

Admission policies

All nine reporting countries and territories reported that their midwifery programmes have clearly written admission policies. In Kyrgyzstan, however, the admission policies do not include all the components outlined in the ICM Global Standards. For example, they do not include a transparent recruitment process or an equitable selection process and criteria for acceptance. In all nine reporting countries and territories, completion of secondary education is a minimum requirement for admission to the midwifery programme.

Student policies

Five of the nine countries and territories reported that their midwifery programmes have clearly written student policies. In three countries and territories (Azerbaijan, North Macedonia and Kosovo), the student policies do not include all the components outlined in the ICM Global Standards. In North Macedonia and Kosovo, they do not include protection of students' personal health, safety and well-being in the learning environment. In Azerbaijan, student policies do not include mechanisms for students to provide feedback and ongoing evaluation of the curriculum. Although Belarus did not provide data on this matter, it stated that the information is available directly from educational institutions as needed.

Student representation

Of the nine countries and territories, five reported that they provide opportunities for student representation in the respective midwifery programme's governance and committees. Azerbaijan, North Macedonia and Tajikistan do not provide such opportunities, and Belarus did not provide data on this matter.

Midwifery practice

Azerbaijan, Kyrgyzstan, North Macedonia and Kosovo reported that their midwifery students do not

have the practical midwifery experience in facility-based and community care settings necessary to comply with the ICM Essential Competencies or their respective national standards. In North Macedonia, practical experience is limited, as the national standards do not require a ratio of theory and clinical practice. All countries and territories reported that their students provide midwifery care primarily under the supervision of a midwife teacher, midwifery clinical preceptor or clinical teacher.

Admission planning

All countries and territories reported that the respective faculty considers resources and workforce plans when making decisions about the number and selection of individuals to receive offers of admission. Belarus pointed out that the maximum number of students to receive offers of admission was determined by the Ministry of Health, not by the faculty.

Category 4: midwifery programme and curriculum

This category refers to the extent to which midwifery programmes and curricula incorporate the key ICM documents such as the Global Standards for Midwifery Education, the Essential Competencies for Midwifery Practice and the Definition of the Midwife.

Standards and competencies

The ICM Global Standards for Midwifery Education address the inclusion of the essential competencies for midwifery practice as the basis of the midwifery curriculum.

All of the nine reporting countries and territories reported that their midwifery curriculum integrates the ICM Essential Competencies or the competencies established by the respective national standards and that they assess students' progress in achieving these competencies.

In Azerbaijan, Kyrgyzstan, North Macedonia and Kosovo, the midwifery curriculum integrates only the competencies established by the respective national standards. Whether those standards are in line with the ICM Essential Competencies was not confirmed as part of the assessment. Kyrgyzstan reported that its national competencies support the physiological processes of pregnancy and birth and the midwife's role in assessment, diagnosis, action, intervention, counselling and referral. Kyrgyzstan pointed out, however, that some competencies needed to be reconsidered. For example, midwives cannot insert intrauterine devices, despite repeated calls to allow them to do so.

Eight of the nine reporting countries and territories indicated that the purpose of their midwifery education programme is to produce competent midwives who meet all the requirements as recommended in the ICM Global Standards. North Macedonia reported that the midwives produced by its midwifery programme do not meet the criteria outlined in the ICM's definition of a midwife or the regulatory standards leading to licensure or registration as a midwife. In Azerbaijan, Kyrgyzstan, North Macedonia and Kosovo, the requirements are based only on the respective national or territorial standards. Whether those standards meet the requirements of the ICM's key foundational documents was not considered in this assessment.

Duration of midwifery education programmes

ICM recommends that direct-entry midwifery education programmes should be at least three years in duration and that post-nursing midwifery education programmes should be at least 18 months in duration.

Direct-entry programmes: Eight of the nine reporting countries and territories indicated that the minimum length of their respective direct-entry programme is 36 months. Belarus commented that its midwifery education programme is 34 months. In *The State of the Midwifery Workforce in Eastern Europe and Central Asia*, Belarus also reported that it offers an integrated nursing and midwifery education programme only and not a direct-entry programme. Therefore, we may conclude that Belarus offers an integrated nursing and midwifery programme of 34 months.

Integrated programme: ICM does not specify a policy on the duration of integrated nursing and midwifery education programmes. Given that the recommended duration of a direct-entry programme is 36 months, it would be reasonable to expect an integrated programme to be longer than 36 months to adequately cover the requirements of both nursing and midwifery.⁴¹ Therefore, the (integrated) midwifery programme in Belarus is slightly shorter than the recommended 36 months.

Post-nursing midwifery programme: Of the nine reporting countries and territories, four (Belarus, Bosnia and Herzegovina, North Macedonia and Tajikistan) reported that the minimum length of their respective post-nursing midwifery programme is shorter than 18 months.

In *The State of the Midwifery Workforce in Eastern Europe and Central Asia*, Bosnia and Herzegovina indicated that it offers a direct-entry midwifery programme, and Belarus indicated that it has an integrated programme. This could explain why both countries responded negatively to the question on the length of their respective post-nursing midwifery programme, which probably means that they do not offer post-nursing midwifery education. North Macedonia did not provide data on its education programmes.

Theory versus practice

ICM recommends a midwifery curriculum that includes both theory and practice elements, with a minimum of 40 per cent theory and a minimum of 50 per cent practice in clinical settings.

Only two of the nine responding countries and territories (Belarus and North Macedonia) do not have a midwifery curriculum that meets the minimum requirements for both theory and practice elements. Belarus indicated that 91 weeks is allocated for theory, which would be 77.7 per cent of the minimum, and 26 weeks is allocated for practice, which is 22.2 per cent of the minimum. In North Macedonia, practical experience is not required by the national standards and therefore is limited in the midwifery programme.

41. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia*, p. 51.

Gender

Of the nine countries and territories that responded, three (Kazakhstan, Tajikistan and Kosovo) reported that the curriculum does not address equality considerations, including the impact of gender inequality on women's health and the midwifery profession. Belarus did not provide data.

Category 5: resources and quality improvement

This category refers to the resources provided by the midwifery programme and faculty to its faculty members and students. It refers as well to the continuous improvement of the quality of the midwifery programme.

Resources

Seven of the nine responding countries and territories reported that their midwifery programme facilitates access for students to support services such as (1) academic accommodation, (2) counselling, (3) mental health counselling and (4) financial aid. Azerbaijan and North Macedonia do not facilitate access to these services at all.

Eight countries and territories indicated that their respective midwifery programmes have a variety of clinical learning sites in sufficient numbers to meet student learning needs. Only North Macedonia reported that its programme partially meets this requirement.

Of the nine countries and territories that responded, only one (Azerbaijan) indicated that it does not have sufficient or up-to-date teaching and learning resources. North Macedonia and Kosovo commented that their midwifery programmes have partially sufficient and up-to date teaching and learning resources. Access to literature and distance learning in Kosovo is very poor or non-existent.

Quality improvement

Seven of the nine responding countries and territories reported that their midwifery faculty conducted regular reviews of multiple aspects of the respective programme as part of quality improvement efforts. Such reviews do not take place in North Macedonia or Kosovo.

Only four countries (Azerbaijan, Kazakhstan, Kyrgyzstan and Türkiye) reported having an external advisory committee in place to provide input into programme operations and development. Belarus did not provide data to respond to this question.

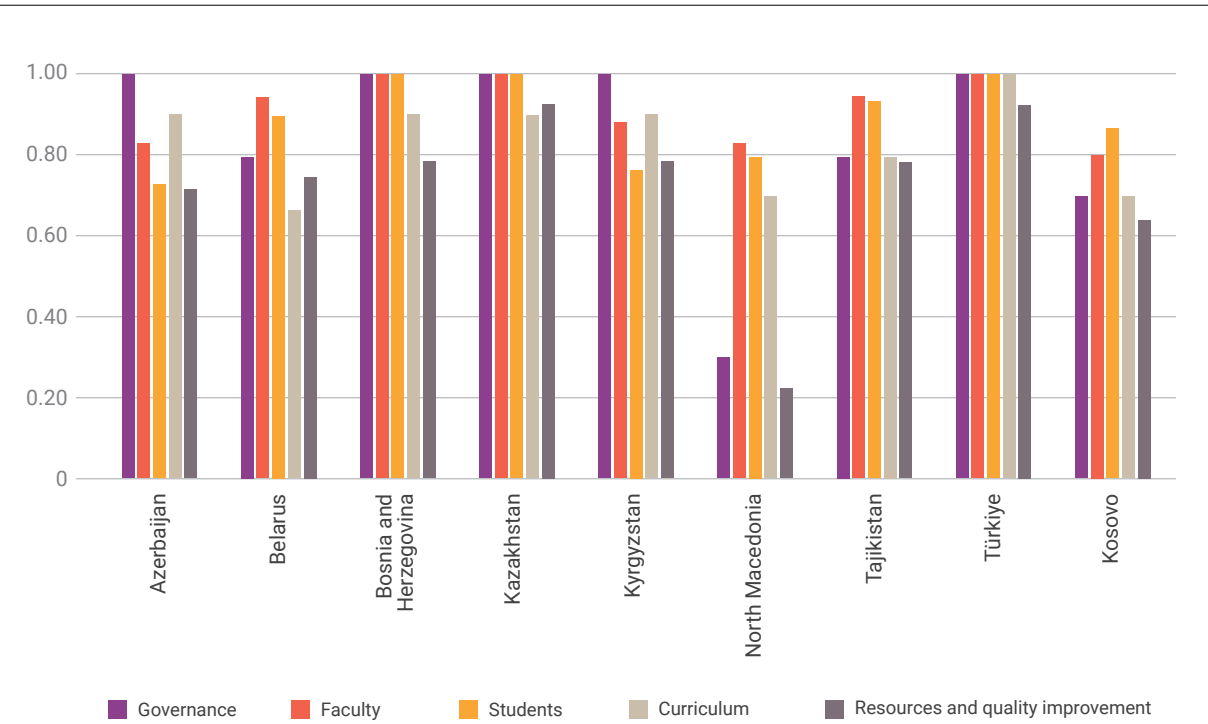
Of the nine responding countries and territories, three (Belarus, Kyrgyzstan and North Macedonia) reported that their midwifery programme does not make current information about the programme publicly available, including the outcome of external reviews and, where applicable, the programme's accreditation status.

Eight of the nine responding countries and territories reported that an external review of their midwifery programme is undertaken at regular intervals and that the results are used for continuous quality improvement. North Macedonia does not undertake such external reviews.

Summary

The findings of this assessment demonstrate that two categories – *curriculum* as well as *resources and quality improvement* – need to be strengthened more than the others. Overall, as per the data provided, midwifery education in Bosnia and Herzegovina, Kazakhstan, Tajikistan and Türkiye meets most requirements of the ICM Global Standards. The findings show that Azerbaijan, Belarus, Kyrgyzstan, North Macedonia and Kosovo are the countries or territories where midwifery education is facing the largest number of gaps and challenges. Most of these findings can be seen in Figure 3.

Figure 3. Category compliance in each country or territory



Source: Compiled by the authors.

Findings: inclusion of SRHR competencies in midwifery curricula in the Eastern Europe and Central Asia region

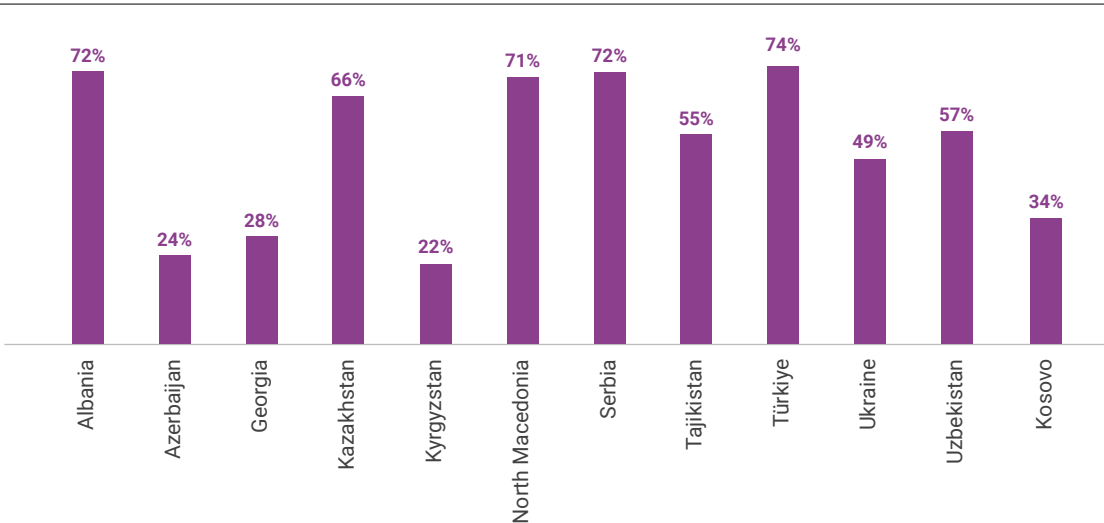
The following countries and territories were included in this assessment: Albania, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, Serbia, Tajikistan, Türkiye, Ukraine, Uzbekistan and Kosovo. Appendix 1 includes profiles detailing the findings for each country or territory. The detailed information in these profiles can be used for country- or territory-specific follow-up.

Overall findings

The SRHR assessment of midwifery curricula shows that there is great variation in terms of the inclusion of the various SRHR interventions in the curricula of different countries and territories, as well as among institutions within countries and territories. Overall, the 12 responding countries and territories report that, on average, 54 per cent of the 130 SRHR competency statements are included in the midwifery curricula, 23 per cent are partially included, and 21 per cent are not included. For 2 per cent of the competency statements, it is unknown whether or not they are included. This means that a little over half of the SRHR competencies required to provide SRHR services as part of universal health coverage are fully covered in the midwifery curricula in the 12 countries and territories.

Türkiye reported that 74 per cent of the SRHR competency statements were included, while Kyrgyzstan reported that 22 per cent were included. We see that the midwifery curricula in Albania, North Macedonia and Serbia include between 71 per cent and 72 per cent of the SRHR competency statements; in Kazakhstan, Tajikistan, Ukraine and Uzbekistan, between 49 per cent and 66 per cent; and in Azerbaijan, Georgia, Kyrgyzstan and Kosovo, between 24 per cent and 34 per cent (see Figure 4).

Figure 4. Percentage of SRHR competency statements included in midwifery curricula



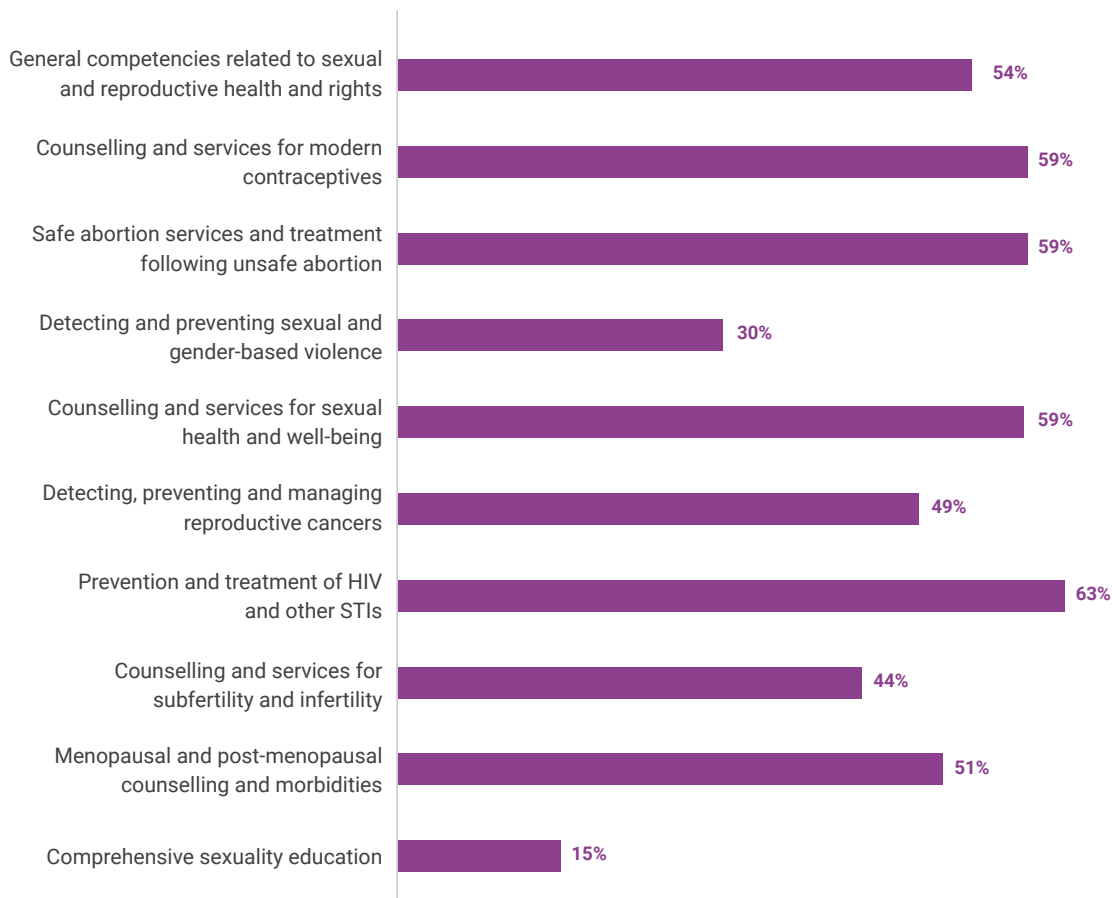
Source: Compiled by the authors.

Coverage level

When we take a closer look at the different essential SRHR interventions (see Figure 2), the competencies that are most frequently included are those relating to prevention and treatment of HIV and other STIs (63 per cent), as well as counselling and services for modern contraceptives (59 per cent), safe abortion services (59 per cent), and sexual health and well-being (59 per cent) (see Figure 5). The competencies that are least likely to be included are those relating to detecting and preventing sexual and gender-based violence (30 per cent) and comprehensive sexuality education (15 per cent). Among the other competencies included are general sexual and reproductive health and rights (54 per cent), menopause (51 per cent), reproductive cancers (49 per cent) and infertility (44 per cent).

Furthermore, there were only two competency statements to respond to regarding sexuality education; hence, a *No* response to one or both statements had a large impact on the overall percentages. The findings demonstrate that none of the essential SRHR interventions are completely covered in the midwifery curricula in the 12 countries and territories.

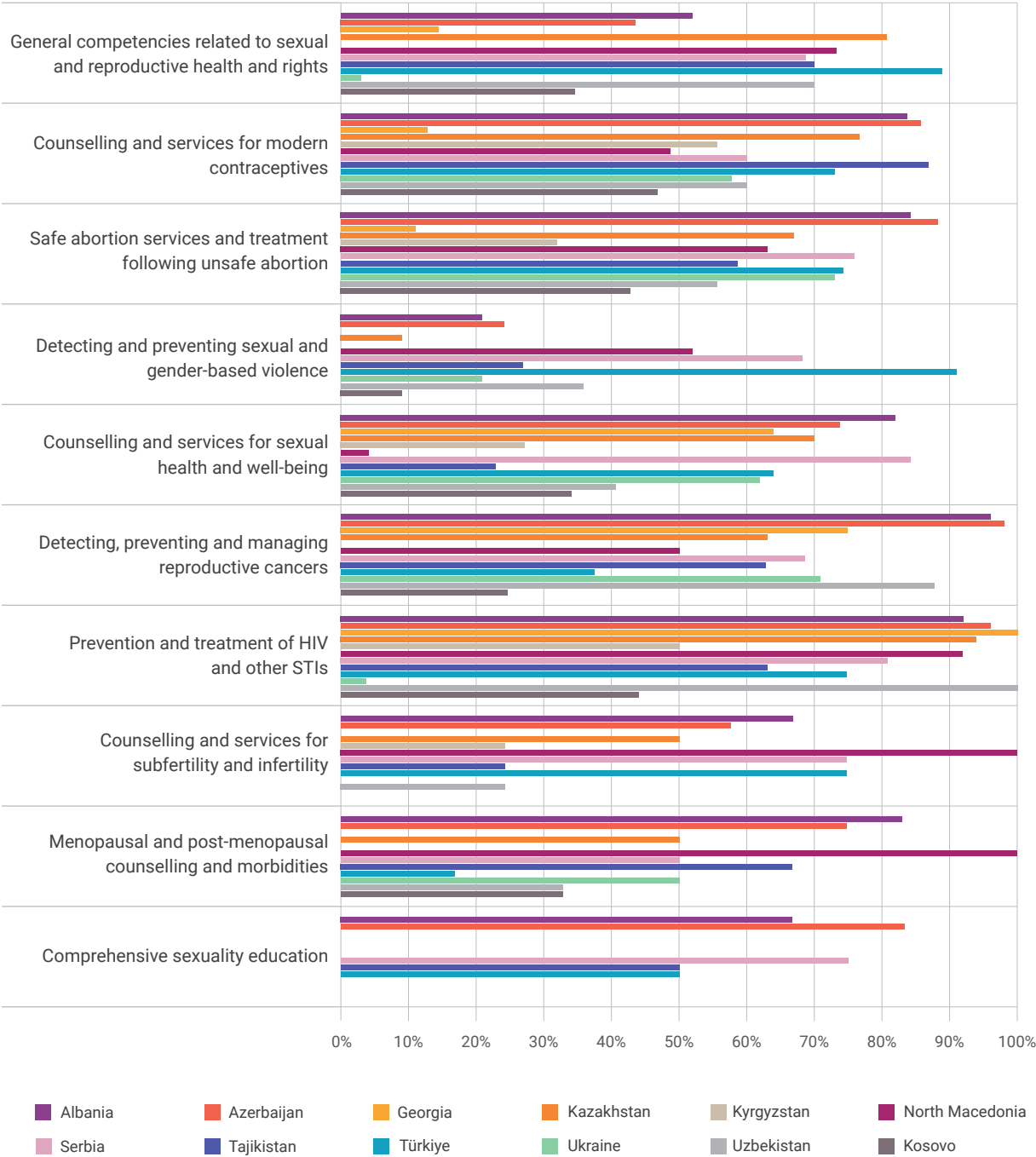
Figure 5. Percentage of SRHR competency statements included in midwifery curricula: average for the Eastern Europe and Central Asia region



Source: Compiled by the authors.

As Figure 6 shows, there are large variations in responses between countries and territories for each section. Where Kyrgyzstan responded that it did not include any of the general SRHR competencies in its curriculum, Türkiye reported having included 89 per cent of these competencies. When it comes to HIV and other STIs, which had the highest rate of inclusion overall, Georgia includes only 1 per cent of the related competency statements, and Uzbekistan includes less than 1 per cent. Türkiye includes most of the SGBV-related competencies (91 per cent), and Serbia includes 68 per cent of them.

Figure 6. Inclusion of SRHR interventions in the midwifery curriculum in each country or territory

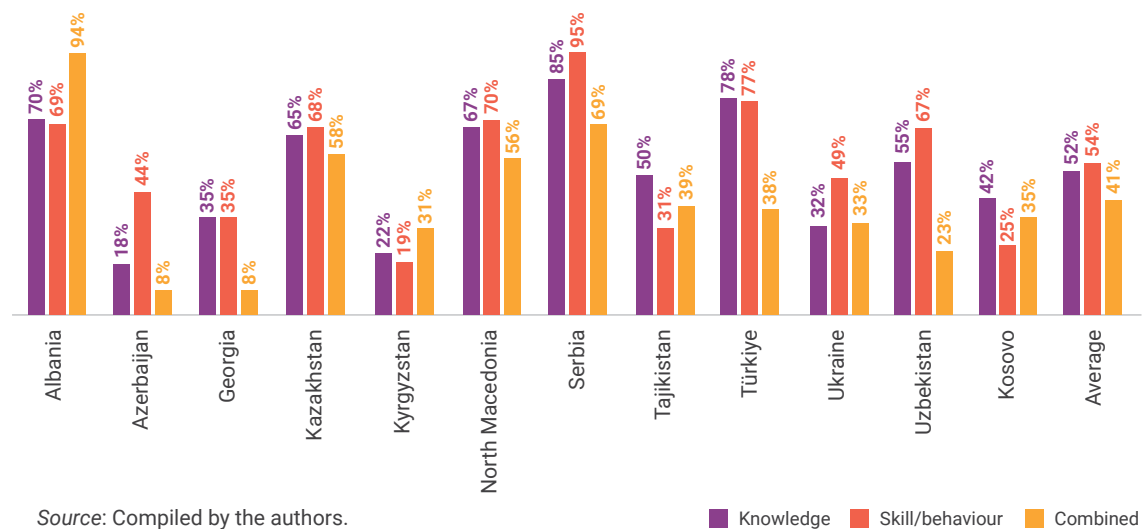


Source: Compiled by the authors.

SRHR competencies: knowledge, skill/behaviour and combined statements

When we take a closer look at the different types of competency statements (see Figure 7) – knowledge, skill/behaviour and combined statements – we see that on average 52 per cent of the knowledge statements, 54 per cent of the skill/behaviour statements and 41 per cent of the combined statements are included in the curricula. Serbia, Albania and Türkiye scored highest on average, while Azerbaijan, Georgia and Kyrgyzstan scored lowest on average. The skill/behaviour statements were included at a slightly higher rate than knowledge statements; this may suggest that skills practice is part of the curriculum. However, the methodology was not assessed.

Figure 7. Inclusion of knowledge, skill/behaviour and combined competency statements



SRHR interventions: time allocated

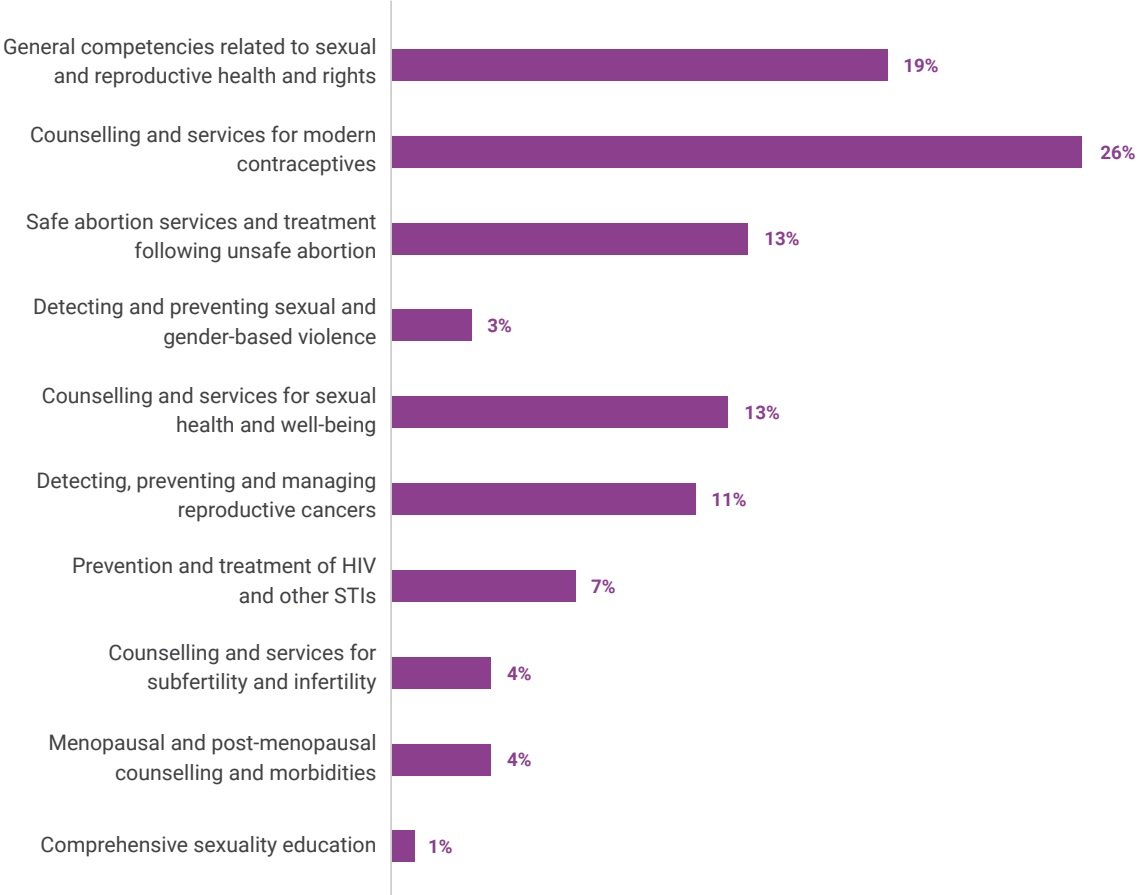
The reported total number of hours spent on SRHR interventions varied from a total of 3.5 hours (North Macedonia) to 736 hours (Kyrgyzstan). However, the responses were not always consistent. North Macedonia provided incomplete information, and Kyrgyzstan's data seemed incorrect compared with its responses to the statements. Kazakhstan, Serbia, Ukraine and Uzbekistan did not provide information on the number of hours allocated to teaching about SRHR interventions.

When the countries or territories that provided no information or incomplete or incorrect data are excluded, the average for Albania, Georgia, Tajikistan, Türkiye and Kosovo is 246.4 hours spent on all SRHR interventions. Türkiye reported 510 hours, whereas Kosovo reported 35 hours.

Except for contraception (the intervention that scored the highest in terms of both inclusion in the curriculum and the amount of time allocated), the number of hours spent per SRHR intervention does not align exactly with the interventions that were reported as being the most included. Overall, 26 per cent of the time allocated to sexual and reproductive health and rights is spent on contraceptives; 19

per cent, on general SRHR competencies; 13 per cent, on sexual health; 13 per cent on comprehensive abortion care; and 11 per cent, on reproductive cancers (see Figure 8).

Figure 8. Time allocated per SRHR intervention



Source: Compiled by the authors.

Findings per SRHR intervention

General SRHR competencies

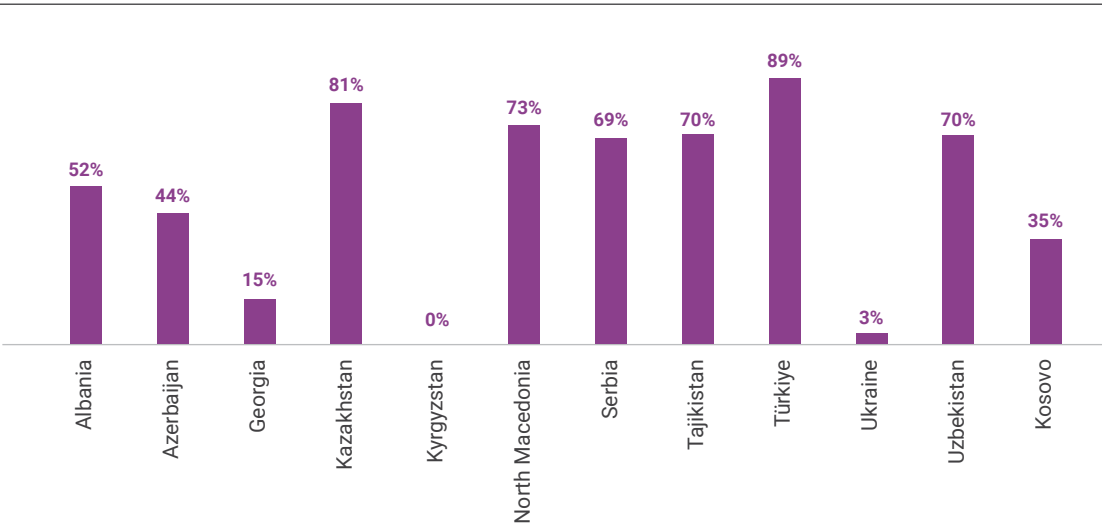
A substantial subset of general SRHR competencies are universally applicable across the identified SRHR interventions. These competencies were covered by 27 competency statements in the questionnaire: they include communication, respectful care and general SRHR theory. Many of these competencies are not limited to sexual and reproductive health and rights but apply to all areas of midwifery care.

“There are no topics in the curriculum devoted to teaching effective interpersonal communication with women, families, health teams and community groups.” – Kyrgyzstan

Of the 12 reporting countries and territories, Georgia, Kyrgyzstan and Ukraine reported that only 0–15 per cent of the general SRHR competencies were included in their curricula. The reason for these low rates of inclusion may be that some of these competencies are included in other topic areas that the respondents did not consider in light of the current assessment. It is recommended that this area be revisited in these countries.

Kazakhstan and Türkiye reported that most of the general SRHR competencies were included in their curricula (81–89 per cent). The remaining seven countries and territories reported that 35–73 per cent of the general SRHR competencies were included (see Figure 9).

Figure 9. Inclusion of general SRHR competencies in each country or territory



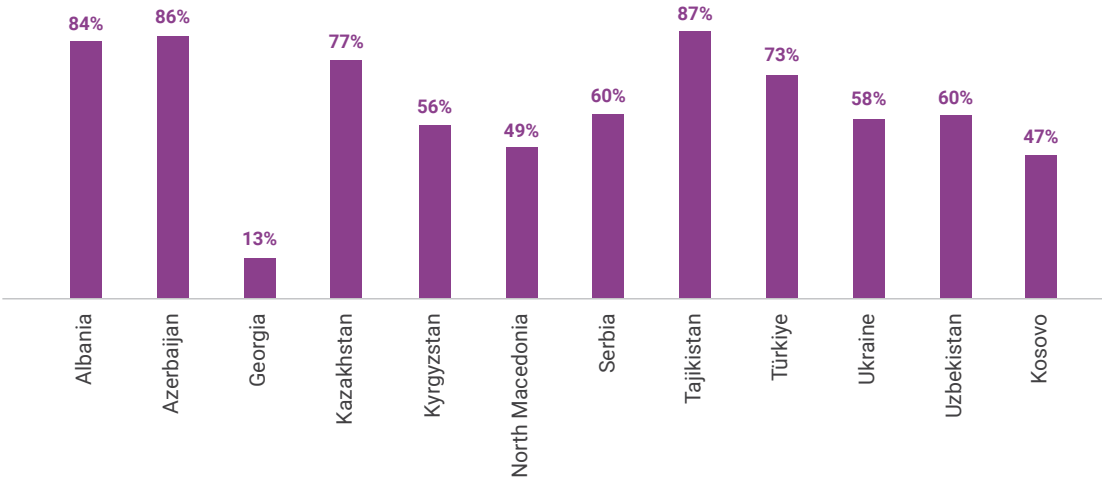
Source: Compiled by the authors.

Counselling and services for modern contraceptives

The unmet need for contraception in the Eastern Europe and Central Asia region is 67 per cent, which is higher than the global average of 63 per cent.⁴² The use of modern contraceptives is around 53 per cent, and the modern contraceptive prevalence has been observed stagnating or even declining in some countries. Poor counselling, high costs, lack of choice and unreliable supply are among the factors preventing people from using modern contraceptives.⁴³ The provision of counselling and contraceptive services is well within the scope of midwifery practice.

The questionnaire included 15 competency statements on counselling and services for modern contraceptives. Three of the twelve responding countries and territories – Albania, Azerbaijan and Tajikistan – report that over 80 per cent of the competency statements relating to modern contraceptives were included. Only Georgia reported a very low inclusion rate, at 13 per cent (see Figure 10).

Figure 10. Inclusion of competencies on counselling and services for modern contraceptives



Source: Compiled by the authors.

42. Gilda Sedgh and others, "Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends", *The Lancet*, vol. 388, No. 10041 (2016).

43. Ibid.

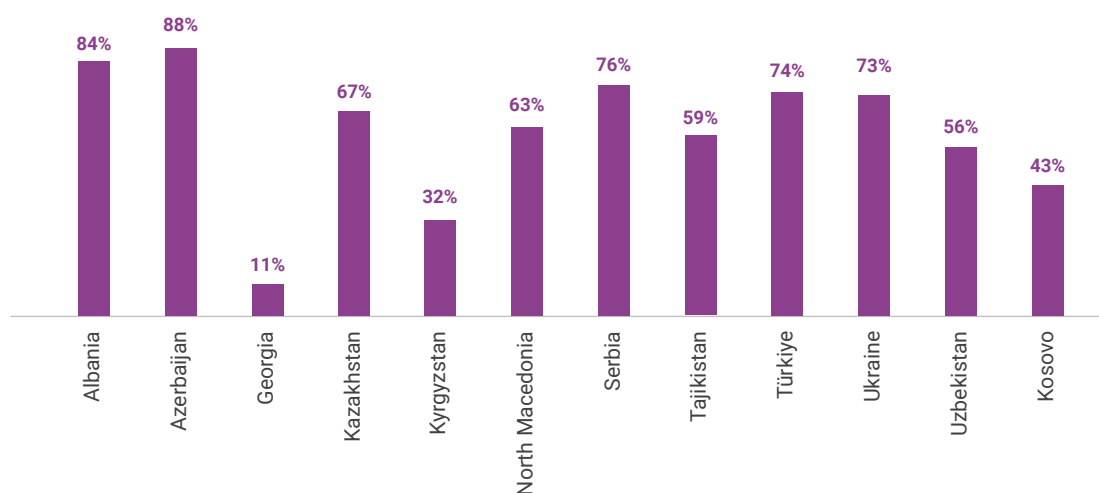
Safe abortion services and treatment following unsafe abortion

Low usage rates for modern contraceptives result in a higher number of unintended pregnancies in the Eastern Europe and Central Asia region. Even though the abortion rate has declined significantly, it remains suboptimal at 42 abortions per 1,000 women.⁴⁴ Counselling and the provision of abortion services are included in the ICM Essential Competencies for Midwifery Practice. WHO also identifies midwives as key providers of comprehensive abortion care. Unsafe abortion contributes up to 13 per cent of maternal mortality globally.⁴⁵ Access to safe abortion services is thus a key strategy in countries' efforts to reduce maternal mortality.

"The midwife has the knowledge, but by law it is not in her legal [competencies] to perform medical abortion, vacuum aspiration and cervical dilatation and evacuation, but to assist ... the doctor during these procedures." – North Macedonia

The assessment included 27 statements on comprehensive abortion care, and an average of 60 per cent of the statements are included in the midwifery curricula. Georgia and Kyrgyzstan reported the lowest rate of inclusion of CAC competencies in their midwifery curricula. Most countries and territories reported that the theory is being taught; in most countries and territories, however, midwives are not allowed to provide abortion care, and thus related skills are not taught in the respective midwifery programme (see Figure 11).

Figure 11. Inclusion of competencies on safe abortion services and treatment following unsafe abortion



Source: Compiled by the authors.

44. Ibid.

45. Lale Say and others, "Global causes of maternal death: a WHO systematic analysis", *The Lancet Global Health*, vol. 2, No. 6 (June 2014).

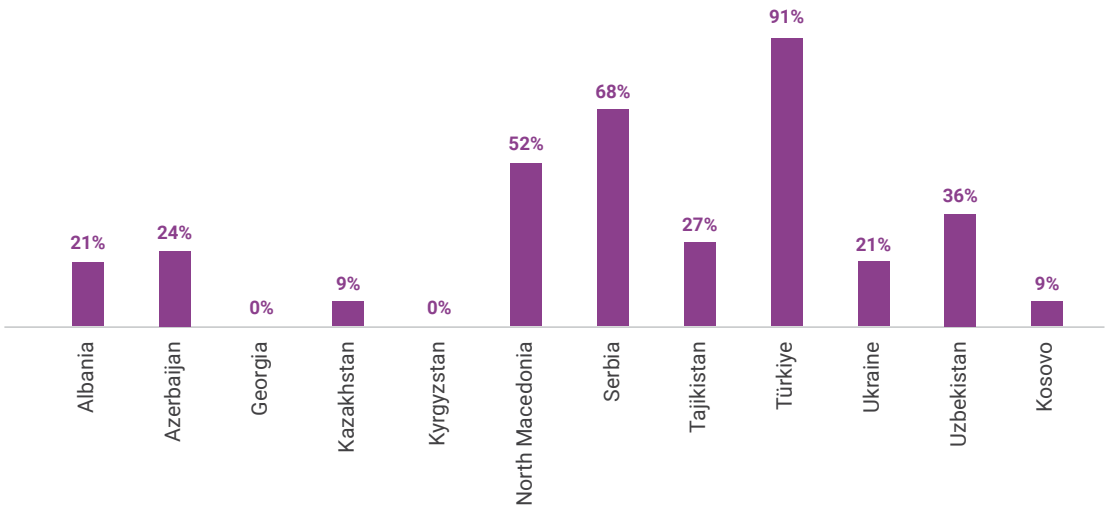
Detecting and preventing sexual and gender-based violence

The persistence of gender-based violence – above all, intimate partner violence – is a critical issue in the Eastern Europe and Central Asia region. Despite some advances, inadequate and discriminatory responses to sexual violence still exist in many countries – an issue of special concern in humanitarian situations. Forced and early marriages are also widespread in many countries in the region.⁴⁶ Following the philosophy of the model for midwifery care, midwives often provide care throughout pregnancy and beyond, thus establishing an environment of trust and creating opportunities for women to share their experience or accept support or referrals.

Eleven competency statements on sexual and gender-based violence were included in the questionnaire. Türkiye reported that 91 per cent of the SGBV-related competencies were included, making it a notable outlier in the Eastern Europe and Central Asia region. Albania, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Ukraine, Uzbekistan and Kosovo all include under 40 per cent of the SGBV competency statements.

The rate of inclusion of SGBV competencies is particularly low (Figure 12), especially when considering that, even prior to the COVID-19 pandemic, 20 per cent of women in Central Asian countries and 17 per cent of women in Eastern European countries and territories experienced intimate partner violence. While the figures for Eastern Europe and Central Asia are below the global average (31 per cent), there are serious disparities throughout the region, with the incidence of intimate partner violence ranging from 6 per cent in Georgia to 46 per cent in the Republic of Moldova.⁴⁷

Figure 12. Inclusion of competencies on detecting and preventing sexual and gender-based violence



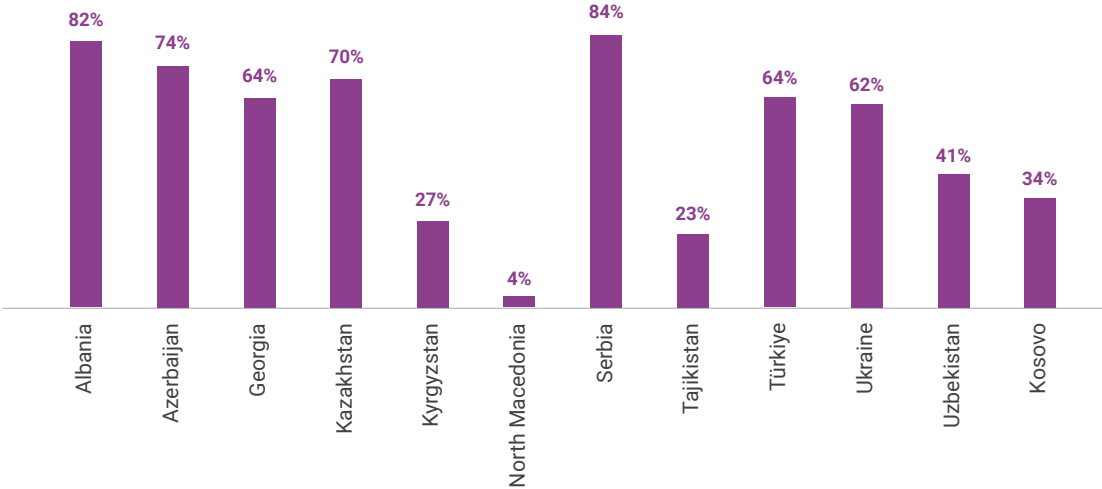
Source: Compiled by the authors.

46. UNFPA Regional Office for Eastern Europe and Central Asia, *Child marriage in Eastern Europe and Central Asia: regional overview* (Istanbul, 2013).
 47. Organisation for Economic Co-operation and Development (OECD), *Gender gaps in Eurasia: the daunting effects of COVID-19* (Paris, 2022), p. 17.

Counselling and services for sexual health and well-being

Information, counselling and services for sexual health and well-being cut across a spectrum of SRHR interventions. SRHR needs are universally applicable to all people throughout the entire life course, and access to accurate and evidence-based information, counselling and services for sexual health and well-being is essential for the effective delivery of several other SRHR interventions. The questionnaire included 22 competency statements relating to sexual health and well-being. Albania and Türkiye reported that 82–84 per cent of the statements were included in their respective curricula, whereas North Macedonia includes only 4 per cent of the statements in its midwifery curriculum. This area should be further explored at the country level, as some topics may be covered under other overarching topics in the curriculum (see Figure 13).

Figure 13. Inclusion of competencies on counselling and services for sexual health and well-being



Source: Compiled by the authors.

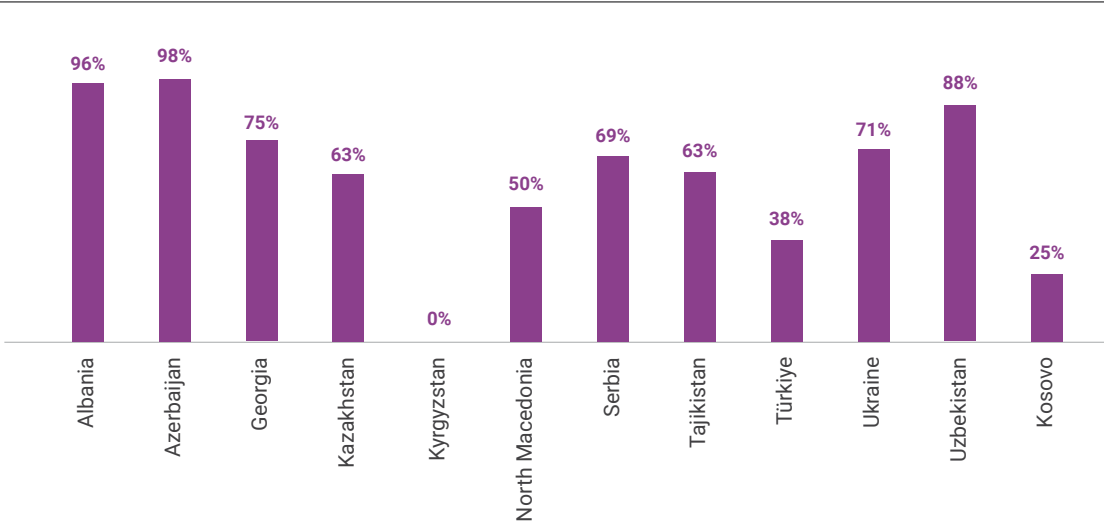
Detecting, preventing and managing reproductive cancers

Cervical cancer is the second most common cause of cancer-related death among women in Eastern Europe and Central Asia: every year over 32,000 new cases and 16,000 deaths are reported in the region,⁴⁸ representing rates up to 10 times higher than in Western Europe.⁴⁹ A lack of quality screening programmes is reported to be one of the contributing factors. Reproductive cancers, particularly cancers affecting women, threaten national health outcomes as well as the development and achievement of universal health coverage. Within the scope of a comprehensive approach to sexual and reproductive health and rights, there is strong evidence supporting the prioritization of key cervical cancer services in the definition of an essential UHC service package.⁵⁰

Eight competency statements on detecting, preventing and managing reproductive cancers were included in the questionnaire. Overall, there is great variation in the degree to which these competency statements are included in the midwifery curricula across the region. Albania and Azerbaijan reported that they included almost all competencies relating to reproductive cancers, whereas Kyrgyzstan does not include the topic at all. This seems to reflect the fact that, prior to 2022, Kyrgyzstan had neither a national screening programme nor an HPV (human papillomavirus) vaccination programme in place. Kosovo reported that 25 per cent of the reproductive cancer competencies were included in its curriculum.

Only 38 per cent of the cervical cancer competencies are included in midwifery curriculum in Türkiye, which is notable particularly in comparison with the higher inclusion rates of the other SRHR interventions (see Figure 14).

Figure 14. Inclusion of competencies on detecting, preventing and managing reproductive cancers



Source: Compiled by the authors.

48. UNFPA, *Cervical cancer: Eastern Europe and Central Asia* (2023).
 49. UNFPA Regional Office for Eastern Europe and Central Asia, "Preventing cervical cancer". Available at <https://eeca.unfpa.org/en/topics/preventing-cervical-cancer> (accessed on 21 February 2024).
 50. UNFPA, *Supplement to background paper on sexual and reproductive health and rights: an essential element of universal health coverage* (New York, 2018).

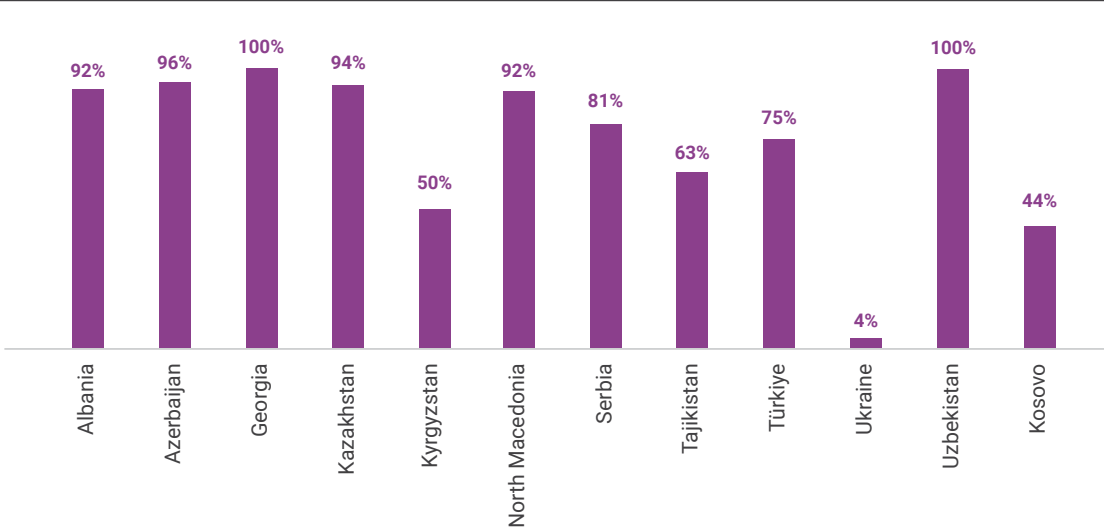
Prevention and treatment of HIV and other STIs

Expanded and more effective global – and national – health sector responses to HIV and AIDS, as well as other STIs, are critical to achieving universal health coverage.

The Eastern Europe and Central Asia region is battling an increasing HIV epidemic: in 2021, 160,000 people in the region were newly infected with HIV, and 44,000 people died due to HIV. Prevention and treatment options remain insufficient.⁵¹ Reducing the burden of other STIs is also critical to achieving universal health coverage.

The questionnaire contained eight competency statements relating to HIV and STI prevention and treatment. Although a high number of these competencies are included in the curricula in most countries and territories in the region, Kyrgyzstan includes only 50 per cent of the competencies, while Kosovo includes just 44 per cent, and Ukraine reports a very low inclusion rate of only 4 per cent (see Figure 15).

Figure 15. Inclusion of competencies on prevention and treatment of HIV and other STIs



Source: Compiled by the authors.

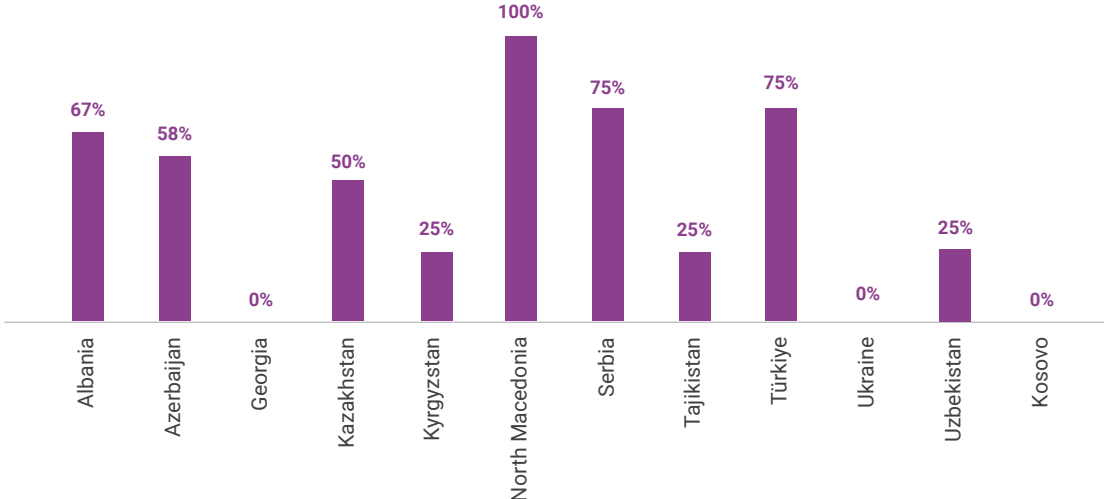
51. Joint United Nations Programme on HIV/AIDS, *In Danger: Global AIDS Update 2022* (Geneva, 2022).

Information, counselling and services for subfertility and infertility

Information and counselling on, and the prevention and treatment of, infertility have received little attention within the field of sexual and reproductive health and rights despite the fact that infertility services have been included in the definition of reproductive health care and reproductive rights since the International Conference on Population and Development in 1994. Infertility services are hence a significant element of the UHC agenda and should be included in a comprehensive approach to sexual and reproductive health and rights even in low-fertility contexts such as in the Eastern Europe and Central Asia region.

Despite the fact that subfertility and infertility information, counselling and services are part of the scope of midwifery practice, 3 out of 12 responding countries and territories – Georgia, Ukraine and Kosovo – reported that they did not include these services in their respective curricula. Kyrgyzstan, Tajikistan and Uzbekistan include 25 per cent of the related competencies, and North Macedonia reported that all related competencies are included (see Figure 16).

Figure 16. Inclusion of competencies on counselling and services for subfertility and infertility



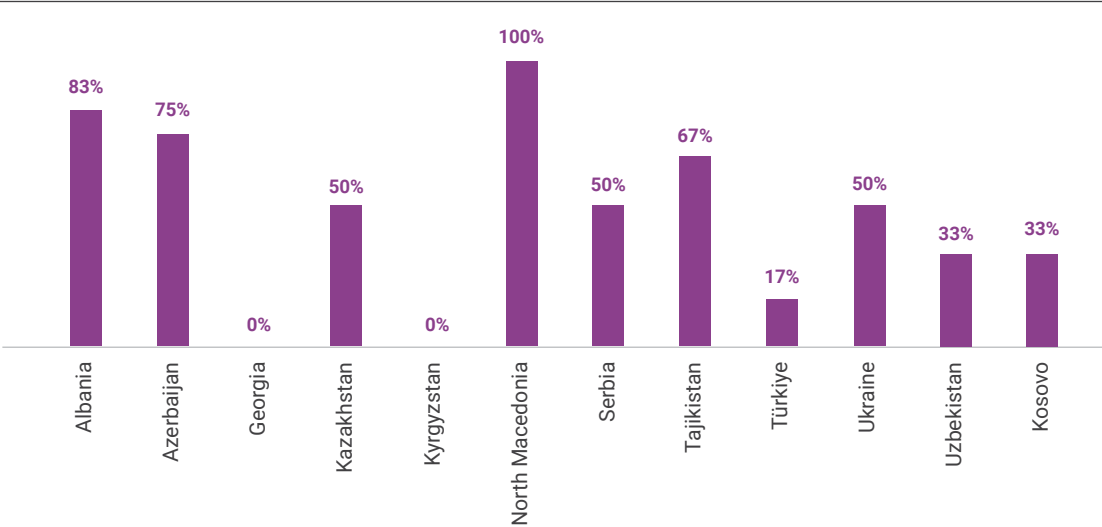
Source: Compiled by the authors.

Counselling for menopausal and post-menopausal morbidities

Menopause and its related morbidities are an often neglected health issue that can have a significant humanistic and economic burden on women of (mostly) middle age, and they are more and more considered a public health priority.⁵² Midwives provide care throughout women’s life cycle; competency in providing information and counselling on the topic is thus relevant for inclusion in midwifery curricula.

Only Georgia and Kyrgyzstan report not including menopause in their curriculum, and North Macedonia reports that all relevant competencies are included (see Figure 17).

Figure 17. Inclusion of competencies on counselling for menopause and post-menopause



Source: Compiled by the authors.

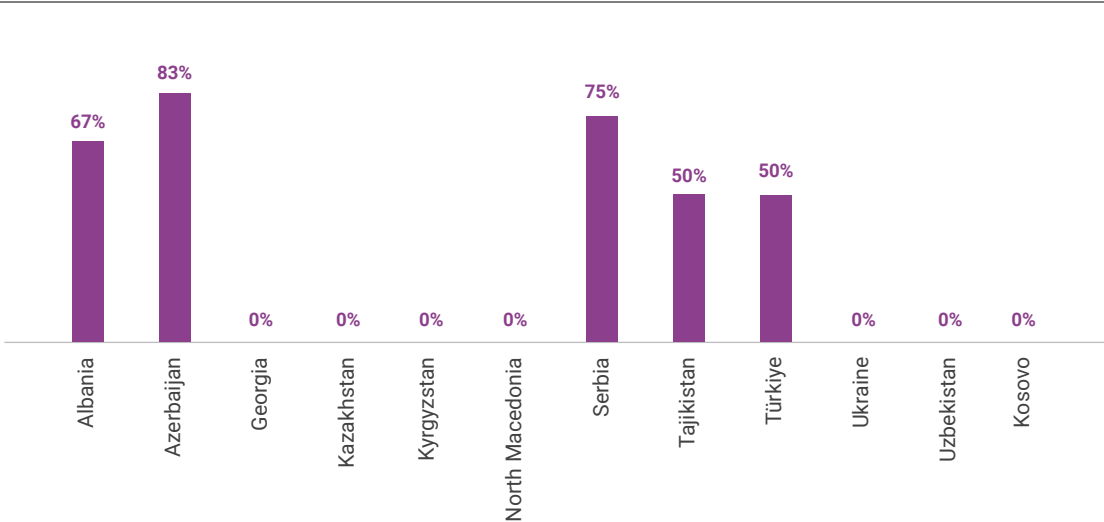
52. Barbara E. Macpherson and Naomi D. Quinton, "Menopause and healthcare professional education: a scoping review", *Maturitas*, vol. 166 (December 2022).

Comprehensive sexuality education

Comprehensive sexuality education enables people of all ages to make informed decisions about their sexuality and health. Provided over several years, comprehensive sexuality education introduces age-appropriate, scientifically accurate information consistent with the evolving capacities of young people. In addition to providing information, it encourages confidence and improved communication skills, and it should take place in formal and informal settings. Sexuality education is available in most countries and territories in the Eastern Europe and Central Asia region, but it is often limited and sometimes perpetuates cultural biases and stereotypes rather than promoting human rights and gender equality.⁵³ Midwives are perfectly placed to address young people as well as others who have a need for information on the topic.

Sexuality education is the SRHR intervention that is included the least in the reporting countries and territories. Seven countries or territories report not including it at all. In the remaining countries and territories, the percentage of competencies included ranges from a low of 50 per cent, in Tajikistan and Türkiye, to a high of 83 per cent, in Azerbaijan (see Figure 18).

Figure 18. Inclusion of competencies on comprehensive sexuality education



Source: Compiled by the authors.

53. UNFPA Regional Office for Eastern Europe and Central Asia, "Comprehensive sexuality education". Available at <https://eeca.unfpa.org/en/node/9642> (accessed on 16 February 2024).

Discussion

The quality of a midwifery education programme directly affects the quality of care midwives are able to provide once they join the health workforce. Further, the content of such a programme needs to be aligned with the population's needs to ensure that midwifery care is effective and that it contributes to the achievement of universal health coverage.

The two assessments included in this report demonstrate that the countries or territories most likely to have gaps and face challenges in terms of the quality of midwifery education are Azerbaijan, Belarus, Kyrgyzstan, North Macedonia and Kosovo, and the countries or territories most likely to have gaps and face challenges in terms of the inclusion of SRHR competencies in their respective midwifery curricula are Azerbaijan, Georgia, Kyrgyzstan and Kosovo.

The findings of the assessment of the current state of midwifery education in Eastern Europe and Central Asia demonstrate that both categories – *curriculum* as well as *resources and quality improvement* – need to be strengthened more than the others. Overall, as per the data provided, midwifery education in Bosnia and Herzegovina, Kazakhstan, Tajikistan and Türkiye meets most requirements of the ICM Global Standards.



Midwives in education

Some of the factors that prevent the SRMNAH workforce from meeting all of the needs for SRMNAH-related care in the region include variations in the level and quality of education and training programmes as well as the limited number of qualified educators. On average, only 28 per cent of midwife educators in the countries and territories of Eastern Europe and Central Asia are midwives, ranging from 4 per cent in Kosovo to 60 per cent in Türkiye.⁵⁴ The ICM Global Standards recommend that midwifery education programmes should be led by midwives and that the faculty should consist primarily of midwives with a professional midwifery qualification and formal preparation for teaching.

Establishment and implementation of a full scope of practice for midwives

Midwives provide many essential clinical SRMNAH interventions and can play a broader role in activities such as advancing primary health care and universal health coverage, responding to violence against women, and addressing sexual and reproductive rights.⁵⁵ Using midwives to their full potential in the countries and territories of Eastern Europe and Central Asia would reduce the gaps in terms of access to SRMNAH services in the region. Although nearly all births in the region are attended by a skilled birth attendant, most such attendants are doctors.⁵⁶ If most of the skilled birth attendants were midwives, and if midwives were educated and regulated according to the ICM Global Standards and Essential Competencies for Midwifery Practice, it would help reduce overmedicalization and promote physiological birth and therefore improved quality of care.

Regulation of midwives

Midwife regulators have an important role to play. Midwives are often regulated by a government agency that regulates nursing or the medical profession in general. The appointment of specialized midwife regulators would ensure that legislation governing the work of midwives is separate from the laws that govern nursing and that midwives' scope of practice is based on the ICM Essential Competencies for Midwifery Practice and implemented in the respective country or territory.⁵⁷ In Eastern Europe and Central Asia, only 7 out of 13 reporting countries and territories have legislation in place that recognizes midwifery as distinct from nursing.⁵⁸

Midwives in leadership and research

The question of midwifery leadership in the countries and territories of Eastern Europe and Central Asia could be included in high-level national policy, planning and budgeting processes to improve decision-making about investments in midwifery education and primary care to help achieve universal health coverage. Out of the 13 countries and territories that responded, just one (Tajikistan) reported

54. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia*, p. 52.

55. ICM, *Essential Competencies for Midwifery Practice*.

56. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia*, p. 10.

57. UNFPA, *Sexual and reproductive health and rights: an essential element of universal health coverage*.

58. UNFPA Regional Office for Eastern Europe and Central Asia, *The State of the Midwifery Workforce in Eastern Europe and Central Asia*, p. 57.

having any midwife leaders at all.⁵⁹ Investment in the SRMNAH workforce, especially midwives, is essential for achieving universal health coverage and ensuring progress towards the achievement of the SDGs. It is also one of the most powerful accelerators of human progress, delivering strong returns to economies and societies through lasting benefits for individuals and families.⁶⁰

Inclusion of SRHR interventions

The assessment of the inclusion of SRHR competencies in midwifery curricula in Eastern Europe and Central Asia demonstrates that none of the 12 responding countries and territories cover the full scope of sexual and reproductive health and rights that is needed for delivering essential SRH service packages in the context of a life-course approach.

Inclusion of essential SRHR interventions in the context of universal health coverage

Of the SRHR intervention areas covered in the questionnaire, competencies relating to HIV and other STIs were most frequently included in the respective curricula (74 per cent on average), except for Ukraine, where the related competencies were included at a remarkably low rate of 4 per cent. Despite their high rate of inclusion, little time – nine hours on average – is allocated for these competencies in the curricula. There is a need to assess to what extent the topic is taught and practised, and whether the allocated time is sufficient.

The relatively high rate of inclusion of competencies relating to HIV and other STIs could be explained by the fact that the HIV epidemic has grown in the Eastern Europe and Central Asia region over the past decade, contrary to the situation in other regions.

Reports indicated that, on average, 63 per cent of the contraception-related competencies are included, with three countries or territories (Georgia, North Macedonia and Kosovo) including under 50 per cent. In addition to their high rate of inclusion, more time is allocated to contraception (63.2 hours) than any other category – for example, 45.6 hours is allocated to general SRHR competencies, which is a much broader category than contraception – but only 50 per cent of the contraception-related competencies, on average, are reported to be included in the curricula among the 12 responding countries and territories. Many of the competencies included in this section are related to communication, respectful care and protection of reproductive rights; hence, it is important for every midwife to fully understand and be able to practise these competencies.

Azerbaijan, Georgia, Kyrgyzstan, Ukraine and Kosovo scored very low on this intervention, while only Kazakhstan and Türkiye reported that over 80 per cent of the SRHR interventions in this category were included in their respective curriculum.

Sixty per cent of the interventions relating to comprehensive abortion care were included, on average, with Georgia, Kyrgyzstan and Kosovo being on the lower end.

59. OECD, *Gender gaps in Eurasia*.

60. WHO and others, *Strengthening Quality Midwifery Education for Universal Health Coverage 2030*.

Although the lowest average score was reported for comprehensive sexuality education, this category consisted of only two competency statements, which affected the outcome disproportionately compared with other SRHR interventions.

Sexual and gender-based violence also scored very low, with an average of only 30 per cent of the competencies included, and an average of less than 8 hours of teaching time was allocated out of the total average of 246 hours. Türkiye was a notable exception, with 91 per cent of the SGBV competencies included. That said, it allocates only 26 hours to this intervention out of a total of 510 hours reported.

Inclusion rates for sexual health, reproductive cancers, infertility and menopause varied, with responses as high as 100 per cent (e.g. North Macedonia, on menopause and infertility) and as low as 0 per cent (e.g. Georgia and Kosovo, also on menopause and infertility).

SRHR competencies: knowledge, skill/behaviour and combined statements

Interestingly, the competencies covered by the three different types of statements (knowledge, skill/behaviour and combined) were reported as included at very similar rates: 52 per cent of knowledge statements, 54 per cent of skill/behaviour statements and 41 per cent of combined statements were included, on average. This means that both theory and practice are included more or less equally, suggesting that the desired ratio between theory and practice is adhered to, as per ICM recommendations. It should be noted that the time allocated to the various SRHR interventions does not support this adherence in every case (see the above example of SGBV-related competencies in Türkiye).

Alignment of the curriculum with regulations

As became clear from some of the comments that were provided by the respondents, since midwives are not fully regulated to practise as independent medical practitioners in many countries and territories, and since physicians often provide SRHR services, it is possible that SRHR-related competencies are not fully included in the midwifery curricula across the region.

Recommendations



Investing in improving the quality of midwifery education and regulation to enable midwives to provide the kinds of interventions they are competent to provide, including SRHR services, is key to achieving universal health coverage and safeguarding the sexual and reproductive rights of the population.

Not all the countries and territories covered in this report responded to the questionnaires for both the assessment of the current state of midwifery education and the assessment of the inclusion of SRHR competencies in midwifery curricula in Eastern Europe and Central Asia. To ensure a more complete regional overview of midwifery education, it is highly recommended that all countries and territories complete both assessments presented in this report.

If implemented, the steps covered in the following recommendations can help countries and territories fill in the gaps and respond to challenges as part of their efforts to improve the quality of midwifery care and the SRMNAH landscape.

Recommendations with regard to the quality of midwifery education programmes

- Ensure that midwife educators are available in sufficient numbers and equipped with the skills and knowledge they need to teach at both the pre- and post-diploma levels.
- Ensure that midwives are educated according to global standards and are able to provide high-quality care.
- Make a clear professional distinction between nursing and midwifery educational programmes.
- Encourage collaborative staffing models and platforms for interdisciplinary collaboration in pre-service education.
- Train midwives to become midwife educators.
- Build and maintain an enabling learning environment for midwives who teach in midwifery programmes.
- Review the available pre-service education pathways to address acknowledged limitations, such as low-level qualifications, lack of competency-based curricula, insufficient emphasis on gaining both practical experience and theoretical knowledge, and a lack of midwives qualified to teach.
- Ensure that the midwifery curricula address equality considerations, including the impact of gender inequality on women's health and the midwifery profession.
- Ensure that midwifery programmes facilitate access for students to support services such as (1) academic accommodation, (2) counselling, (3) mental health counselling and (4) financial aid.
- Strengthen midwifery departments in universities, including by investing in postgraduate study and research opportunities.
- Ensure that midwifery programmes establish an external advisory committee to provide input into programme operations and development as part of quality improvement.
- Appoint midwives to leadership positions within midwifery educational institutions responsible for midwifery programmes.

- Expand the scope of practice of midwives based on the ICM Essential Competencies for Midwifery Practice and the UNFPA publication *Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage* to position midwives as strong, autonomous partners in caring for women and newborns.
- Assess and reform the regulations for midwives where needed to enable midwives to provide the interventions for which they should be the preferred provider.
- Review national standards and national competencies and ensure that they meet the ICM Global Standards and integrate the ICM Essential Competencies for Midwifery Practice.
- Invest in and support midwives' associations in your country or support the creation of a midwives' association in countries where there is none.

Recommendations for the inclusion of SRHR competencies in midwifery curricula

Based on the findings of the assessment of the inclusion of SRHR interventions in midwifery curricula, we recommend the integration of the following actions into broader plans and actions to strengthen midwifery:

- Determine the extent to which midwifery education addresses the practical implementation and application of SRHR interventions in the countries and territories of Eastern Europe and Central Asia.
- Identify any gaps or discrepancies between the intended inclusion of SRHR interventions and their actual implementation in midwifery education.
- Examine the resources, teaching methodologies and learning materials used to educate midwifery students on the SRHR interventions.
- Explore the perspectives of midwifery educators and students regarding the effectiveness and sufficiency of the current curriculum in preparing midwives to address SRHR needs.
- Assess the level of awareness among midwifery graduates of the essential package of SRHR interventions and their confidence in applying these interventions in clinical practice.
- Examine the impact of cultural, societal and institutional factors on the integration of SRHR interventions into midwifery curricula, particularly for sexual and gender-based violence.
- Advocate the strengthening of midwifery education curricula in line with international standards and best practices.
- Advance cooperation between countries and territories to accelerate the exchange of knowledge and best practices within and beyond the Eastern Europe and Central Asia region.
- Support professional midwives' associations to take the lead in implementing some of the above recommendations, including by providing expertise for the revision of national midwifery education programmes and international networking within and beyond the countries and territories of Eastern Europe and Central Asia.

Glossary

Adolescent	A person between 10 and 19 years of age (inclusive)
Leadership (in relation to midwives)	<p>“Leadership”, as defined in this report, may refer to a number of management, supervisory and executive titles:</p> <ul style="list-style-type: none">• within health ministries (e.g. chief midwife, midwife adviser, national midwife director, maternity advisory positions)• leading regional or local maternity facilities (e.g. midwife director, midwife adviser to the chief executive or senior team, midwives in charge of maternity units/wards)• leading professional midwives’ associations (e.g. president, chief executive, director)• leading midwifery regulatory authorities (e.g. chair of midwifery council, chief executive, director)• leading midwifery education programmes (e.g. head of midwifery school, director of midwifery, head of midwifery programme)⁶¹
Maternal mortality ratio	The number of maternal deaths during a given time period per 100,000 live births during the same period ⁶²
Midwife	<p>“A responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.</p> <p>“The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care.</p> <p>“A midwife may practise in any setting including the home, community, hospitals, clinics or health units.”⁶³</p>
Midwife-led care	A midwife is the lead health-care professional responsible for planning, organizing and delivering care. ⁶⁴

61. Bar-Zeev and others, p. 63.

62. WHO, “Maternal mortality ratio (per 100 000 live births)”, The Global Health Observatory. Available at <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (accessed on 29 July 2022).

63. ICM, document CD2005_001 V2017 ENG.

64. ICM, Midwifery Led Care, the First Choice for All Women, document PS2011_012 V2017 ENG.

Neonatal mortality rate	The number of deaths during the first 28 completed days of life per 1,000 live births in a given year or period ⁶⁵
Nurse	<p>“A person who has successfully completed a programme of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practise nursing. ... Basic nursing education is a formally recognised programme of study providing a broad and sound foundation in the behavioural, life, and nursing sciences for the general practice of nursing, for a leadership role, and for post-basic education for specialty or advanced nursing practice. The nurse is prepared and authorized:</p> <p>“(1) To engage in the general scope of nursing practice, including the promotion of health, prevention of illness and care of physically ill, mentally ill and disabled people of all ages and in all health care and other community settings</p> <p>“(2) To carry out health care teaching</p> <p>“(3) To participate fully as a member of the health care team</p> <p>“(4) To supervise and train nursing and health care auxiliaries</p> <p>“(5) To be involved in research”⁶⁶</p>
Sexual and reproductive health	Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so.
Sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) care	The continuum of sexual and reproductive health care and maternal and newborn health care, including for adolescents
SRMNAH doctors*	Generalist medical practitioners, obstetricians, gynaecologists and paediatricians
Stillbirth rate	The number of babies born with no sign of life at 28 weeks or more of gestation per 1,000 total births ⁶⁷

65. WHO, “Neonatal mortality rate (0 to 27 days) per 1000 live births) (SDG 3.2.2)”, The Global Health Observatory. Available at [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/neonatal-mortality-rate-\(per-1000-live-births\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/neonatal-mortality-rate-(per-1000-live-births)) (accessed on 29 July 2022).

66. International Council of Nurses, “Nursing definitions”. Available at <https://www.icn.ch/nursing-policy/nursing-definitions> (accessed on 29 July 2022).

67. UNICEF, “Stillbirth”. Available at <https://data.unicef.org/topic/child-survival/stillbirths/> (accessed on 29 July 2022).

Total fertility rate	The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality. It is expressed as children per woman. ⁶⁸
Unmet need for family planning	The percentage of women of reproductive age who have an unmet need for family planning – that is, those wishing to stop or delay childbearing but not using any method of contraception ⁶⁹
Universal health coverage	All people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

68. WHO, “Total fertility rate (per woman)”, The Global Health Observatory. Available at <https://www.who.int/data/gho/indicator-metadata-registry/indicator/123> (accessed on 16 February 2024).

69. United Nations, Department of Economic and Social Affairs, “Unmet need for family planning”. Available at https://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2014/Metadata/WCU2014_UNMET_NEED_metadata.pdf (accessed on 29 July 2022).

Bibliography

Bar-Zeev, Sarah, and others. *The State of the World's Midwifery 2021: Building a Health Workforce to Meet the Needs of Women, Newborns and Adolescents Everywhere*. New York: United Nations Population Fund, 2021.

Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services. The UNFPA strategic plan, 2022-2025. 14 July 2021. DP/FPA/2021/8.

Gillen, Patricia. Connecting status and professional learning: an analysis of midwives career using the Place© Model. *Education Sciences*, vol. 9, No. 4 (2019).

International Confederation of Midwives (ICM). Bill of Rights for Women and Midwives. CD2011_002 V2017.

_____. *Essential Competencies for Midwifery Practice: 2019 update*. The Hague, 2019.

_____. ICM Global Standards for Midwifery Education (revised 2021).

_____. International Definition of the Midwife. CD2005_001 V2017 ENG.

_____. Midwifery Led Care, the First Choice for All Women. PS2011_012 V2017 ENG.

_____. Philosophy and Model of Midwifery Care. CD0005_V201406_EN.

International Council of Nurses. Nursing definitions.

Joint United Nations Programme on HIV/AIDS. *In Danger: Global AIDS Update 2022*. Geneva, 2022.

Macpherson, Barbara E., and Naomi D. Quinton. Menopause and healthcare professional education: a scoping review. *Maturitas*, vol. 166 (December 2022).

Mattison, Cristina A., and Kirsty M. Bourret. Investing in midwifery associations to improve sexual and reproductive health and rights: a policy brief to ground the Feminist International Assistance Policy in evidence. Hamilton, Ontario: McMaster Midwifery Research Centre, 2021.

Organisation for Economic Co-operation and Development. *Gender gaps in Eurasia: the daunting effects of COVID-19*. Paris, 2022.

Rechel, Bernd, and others. Primary care reforms in Central Asia – on the path to universal health coverage? *Health Policy OPEN*, vol. 5 (December 2023).

Rechel, Bernd, Erica Richardson and Martin McKee, eds. *Trends in Health in the Former Soviet Countries*, Observatory Studies Series, No. 35. Copenhagen: World Health Organization, 2014.

Say, Lale, and others. Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health*, vol. 2, No. 6 (June 2014).

Sedgh, Gilda, and others. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *The Lancet*, vol. 388, No. 10041 (2016).

Starrs, Ann M., and others. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *The Lancet*, vol. 391 (2018).

United Nations, Department of Economic and Social Affairs. Unmet need for family planning.

UNICEF. Stillbirth.

United Nations Development Programme. Human Development Index.

United Nations Population Fund (UNFPA). *Cervical cancer: Eastern Europe and Central Asia*. 2023.

_____. *Investing in three transformative results: realizing powerful returns*. New York, 2022.

_____. Midwifery.

_____. *Sexual and reproductive health and rights: an essential element of universal health coverage*. New York, 2019.

_____. *Supplement to background paper on sexual and reproductive health and rights: an essential element of universal health coverage*. New York, 2018.

_____. *The State of the World's Midwifery 2021: Webappendices*. New York, 2021.

UNFPA Regional Office for Eastern Europe and Central Asia. *Child marriage in Eastern Europe and Central Asia: regional overview*. Istanbul, 2013.

_____. Comprehensive sexuality education.

_____. Preventing cervical cancer.

_____. Sexual and reproductive health.

_____. Statement of commitments for advancing midwifery in the European region, May 2023.

_____. *The State of the Midwifery Workforce in Eastern Europe and Central Asia*. Istanbul, 2022.

World Health Organization (WHO). *Family Planning and Comprehensive Abortion Care Toolkit for the Primary Health Care Workforce*, vol. 3, *Competencies*. Geneva, 2022.

_____. Maternal mortality ratio (per 100 000 live births). The Global Health Observatory.

_____. Neonatal mortality rate (0 to 27 days) per 1000 live births) (SDG 3.2.2). The Global Health Observatory.

_____. Total fertility rate (per woman). The Global Health Observatory.

WHO and others. *Strengthening Quality Midwifery Education for Universal Health Coverage 2030: Framework for Action*. Geneva: WHO, 2019.

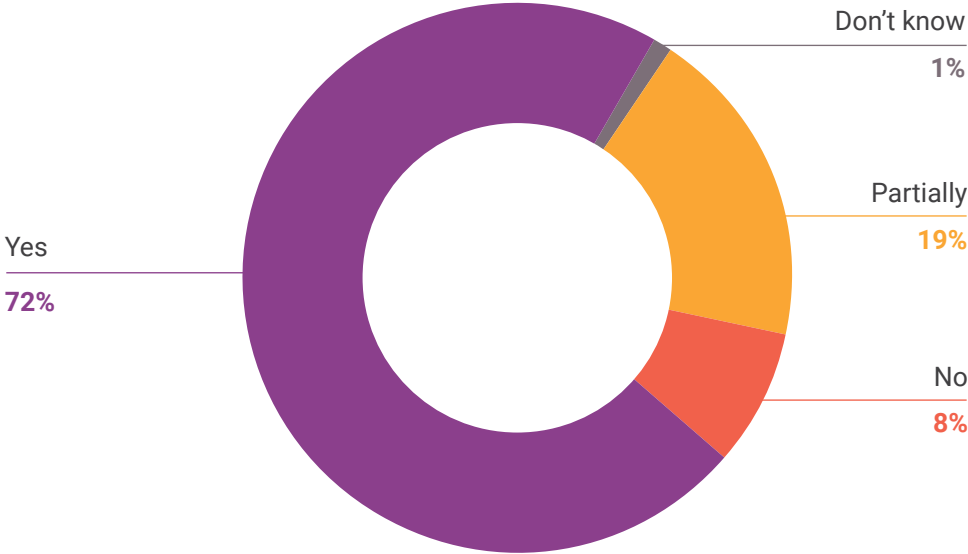
Appendix: Country dashboards

Albania

- Institutions providing midwifery education in Albania**
- Faculty of Technical Medical Sciences, University of Tirana
 - Faculty of Natural and Human Sciences, University of Korca
 - Faculty of Technical Medical Sciences, European University of Tirana

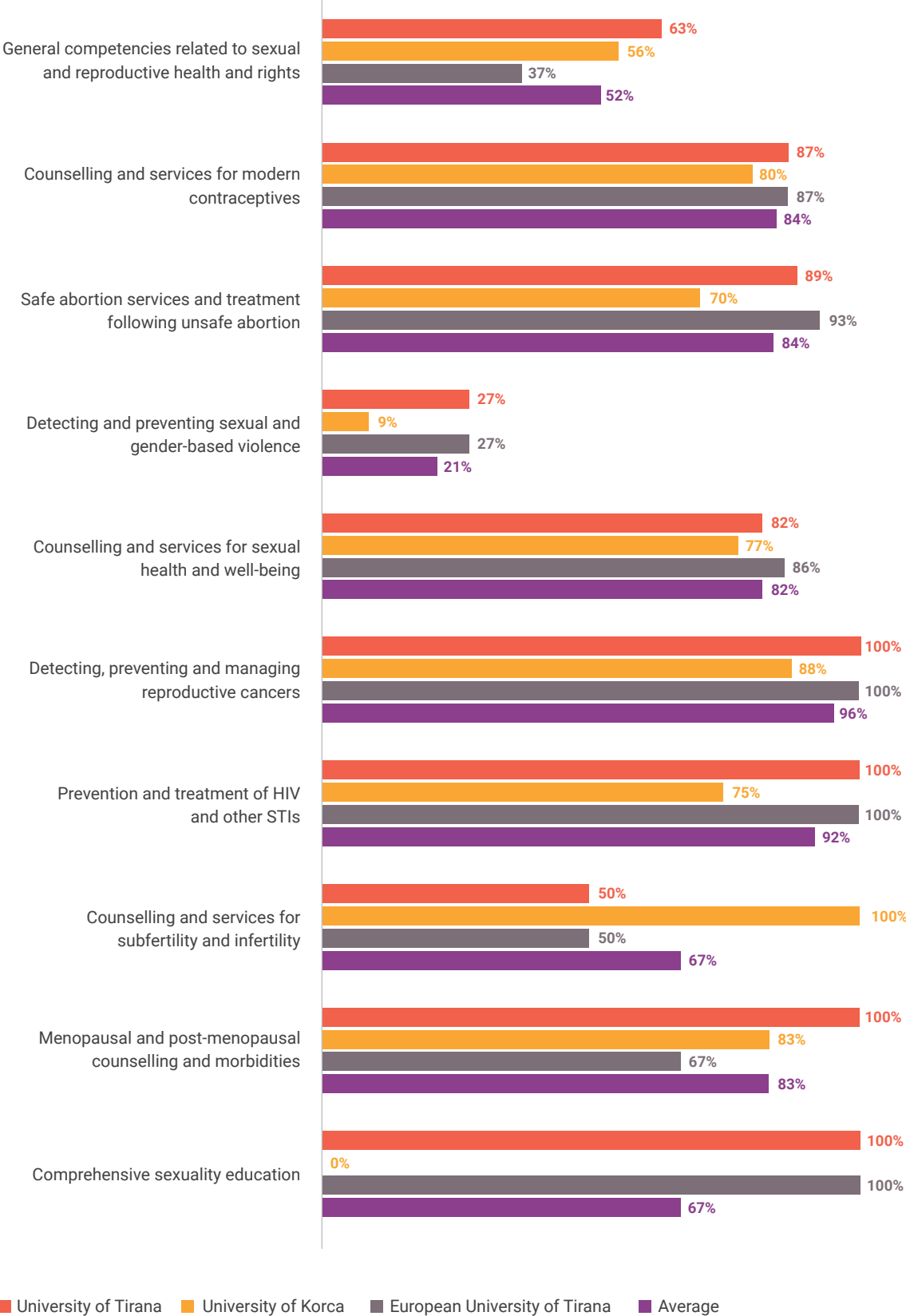
Albania reported that 72 per cent of the SRHR competencies are included and 19 per cent are partially included in the midwifery curricula of the three above-mentioned institutions, on average. The average amount of time spent on sexual and reproductive health and rights in the curricula is 149 hours, 23 per cent of which is spent on contraception; 20 per cent, on reproductive cancers; and 17 per cent, on general SRHR competencies. The three institutions show similar trends in their inclusion rates for the SRHR intervention areas. Notable differences can be found in terms of SGBV-related competencies – all three institutions had a low score, with the University of Korca being the lowest of the three (9 per cent versus 27 per cent at both other institutions) – and subfertility and infertility, where the University of Korca scores much higher (100 per cent) than the other two (50 per cent at both other institutions). The lowest percentages for all three institutions are for SGBV-related competencies and general SRHR competencies. On average, the three institutions responded Yes to 70 per cent of the knowledge statements, 69 per cent of the skill/behaviour statements and 94 per cent of the combined statements.

Figure A1. Albania: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A2. Albania: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



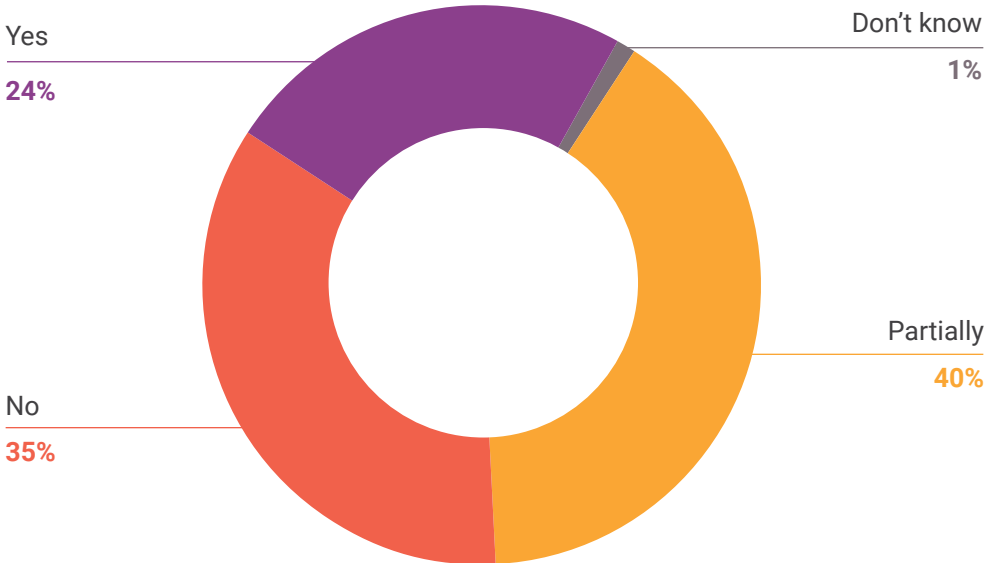
Source: Compiled by the authors.

Azerbaijan

- Institutions providing midwifery education in Azerbaijan**
- Scientific Research Institute of Obstetrics and Gynaecology
 - Gynaecology and Women's Clinic No. 5

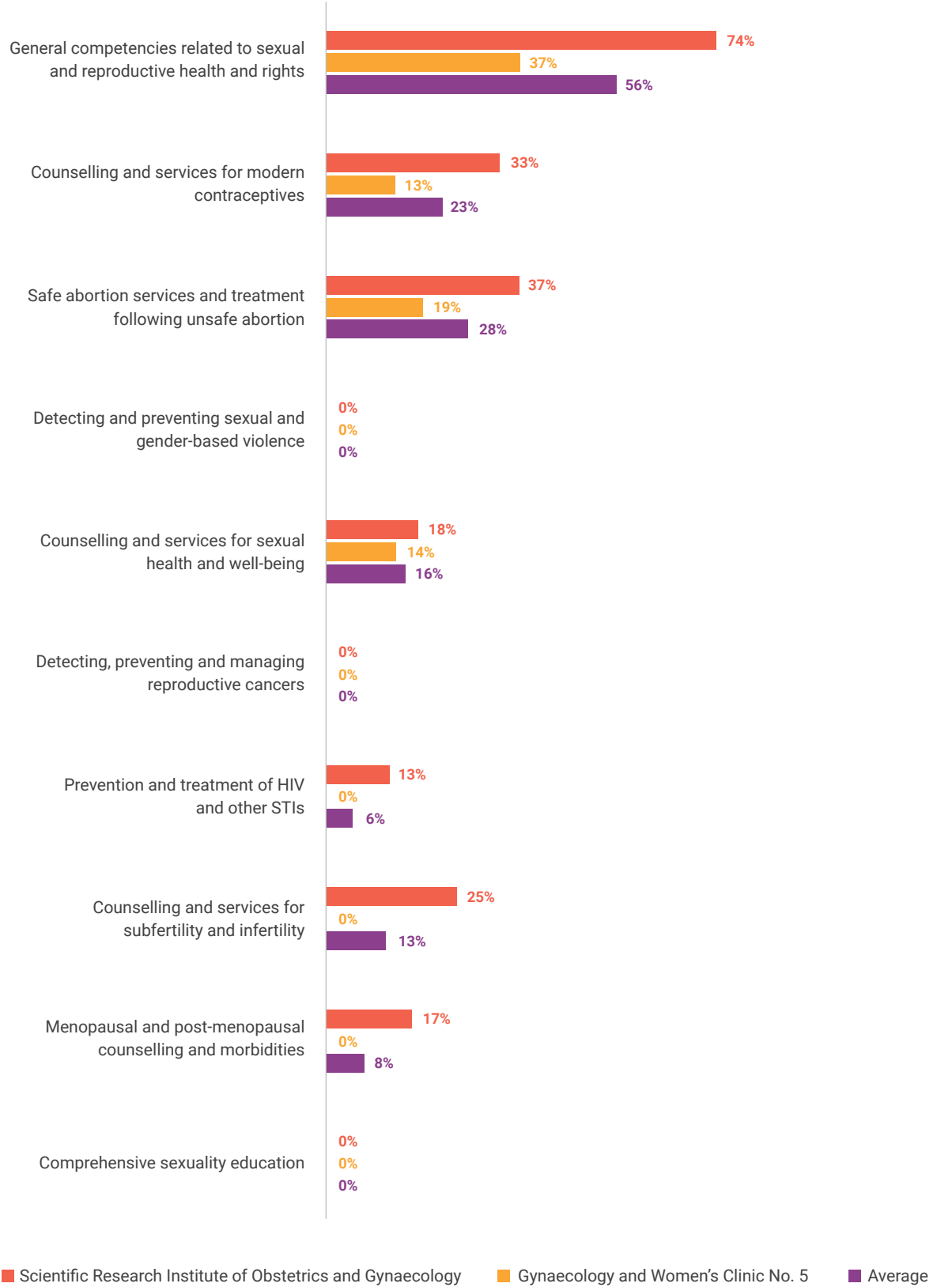
Azerbaijan reported that an average of 35 per cent of the SRHR competencies were included and 40 per cent partially included in its midwifery curriculum. The low inclusion rate is somewhat improved by the higher rate of partial inclusion, suggesting that the curriculum touches on many of the SRHR interventions, but at the same time recent midwife graduates are unlikely to be competent in the full package of essential SRHR interventions. The Scientific Research Institute includes twice as many competencies in its curriculum as Women's Clinic No. 5 does, but its 32 per cent inclusion rate is still one of the lowest rates among responding institutions in the region. Both institutions address some of the competencies relating to sexual and gender-based violence and reproductive cancer only partially in their curriculum, and sexuality education is not addressed at all. Women's Clinic No. 5 also reports that it does not include competencies relating to HIV and other STIs, infertility or menopause. Seventy-four per cent of the general SRHR competencies are covered at the Scientific Research Institute, but only 37 per cent are covered at Women's Clinic No. 5. The country did not provide data on the hours allocated to teaching on SRHR competencies.

Figure A3. Azerbaijan: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A4. Azerbaijan: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



Source: Compiled by the authors.

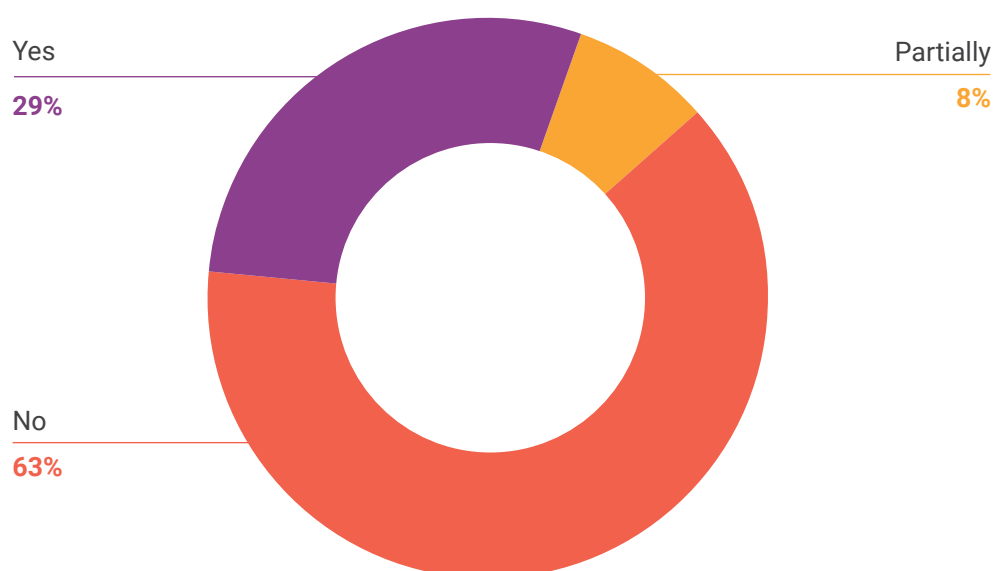
Georgia

Institutions providing midwifery education in Georgia

- Tbilisi State Medical University⁷⁰
- Association of Midwives of Georgia

Georgia reported that 28 per cent of the SRHR competencies are included in its midwifery curriculum, 63 per cent are not included, and 8 per cent are partially included. As a result, the country ranks among the lowest in the region. The Association of Midwives of Georgia reported that all competencies relating to HIV and other STIs are included, 75 per cent of competencies relating to reproductive cancers are included, and 64 per cent of competencies relating to sexual health are included. At the same time, it reported that none of the competencies relating to sexual and gender-based violence, infertility, menopause and sexuality education are included in the curriculum. Few of the competencies relating to general sexual and reproductive health and rights (15 per cent), contraceptives (13 per cent) and comprehensive abortion care (11 per cent) are included in the curriculum. Georgia reported that it allocates 300 hours for SRHR education, which is more than the reported average number of hours for the entire region, 246. Currently, 23 per cent of this time is spent on reproductive cancers, and 17 per cent on contraception as well as on HIV and other STIs.

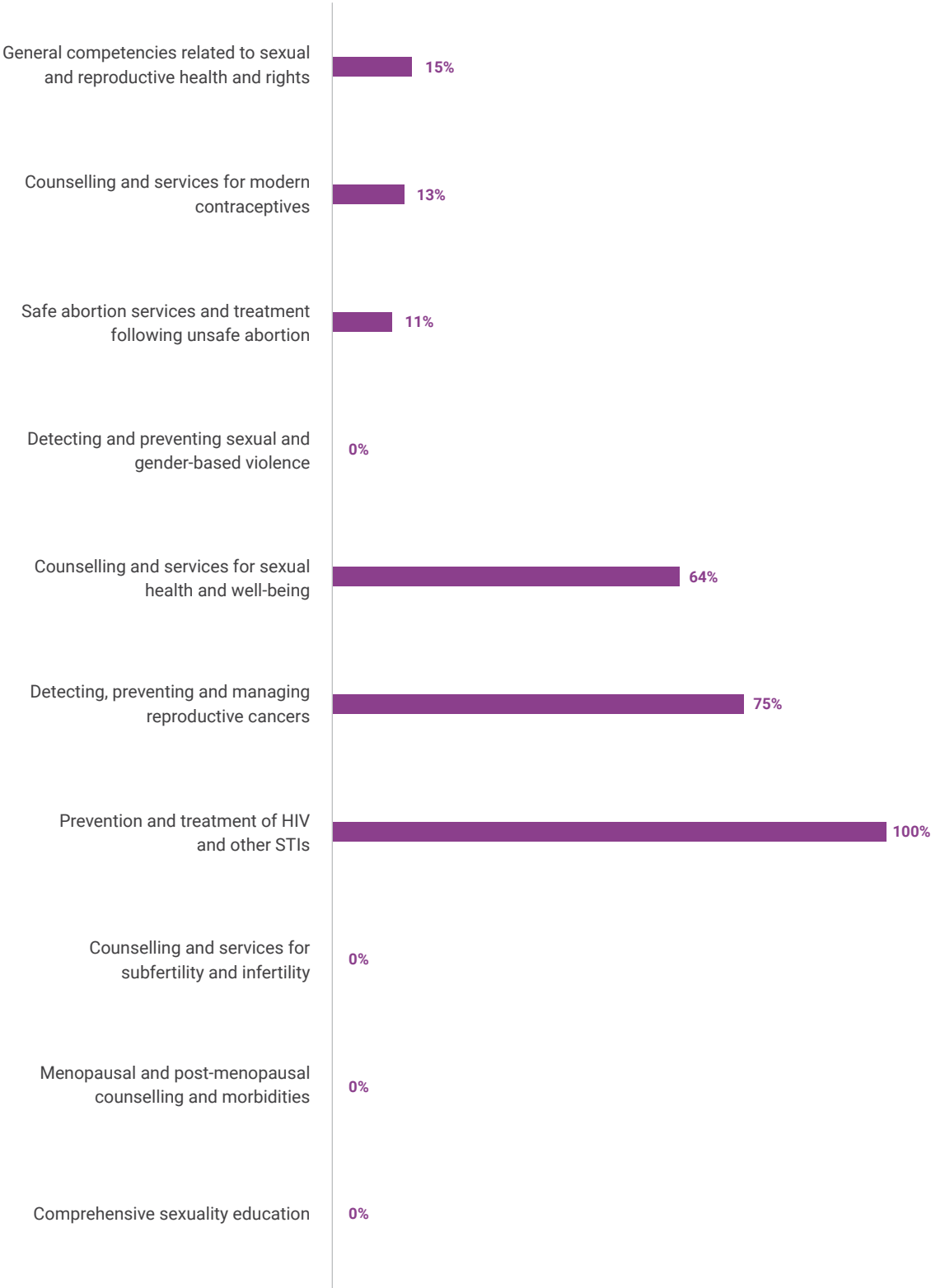
Figure A5. Georgia: rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

70. Although Tbilisi State Medical University does provide midwifery training, it did not submit any data for this study and is thus not included in the results for Georgia.

Figure A6. Georgia: rate of inclusion per SRHR intervention in midwifery curriculum



■ Association of Midwives of Georgia

Source: Compiled by the authors.

Kazakhstan

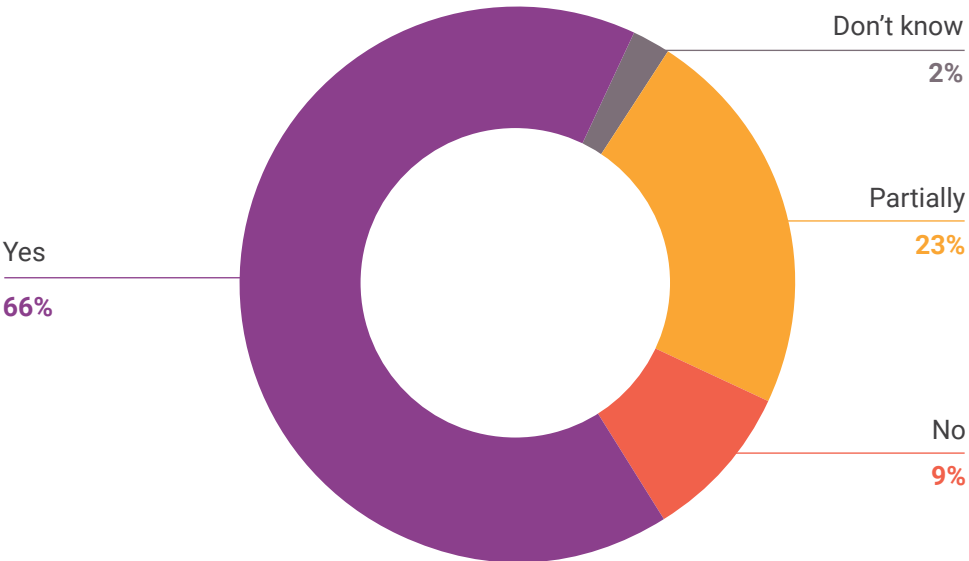
Institutions providing midwifery education in Kazakhstan
<ul style="list-style-type: none">• Kazakh–Russian Medical University• Republican Higher Medical College

On average, 66 per cent of the competency statements are included in the midwifery curriculum in Kazakhstan, 23 per cent are partially included, and 9 per cent are not included. A response of *I don't know* was provided regarding 2 per cent of the competency statements.

Both institutions in Kazakhstan score low when it comes to the inclusion of competencies on sexual and gender-based violence and sexuality education. Over 70 per cent of the general SRHR competencies and the competencies on HIV and STIs are included at both institutions.

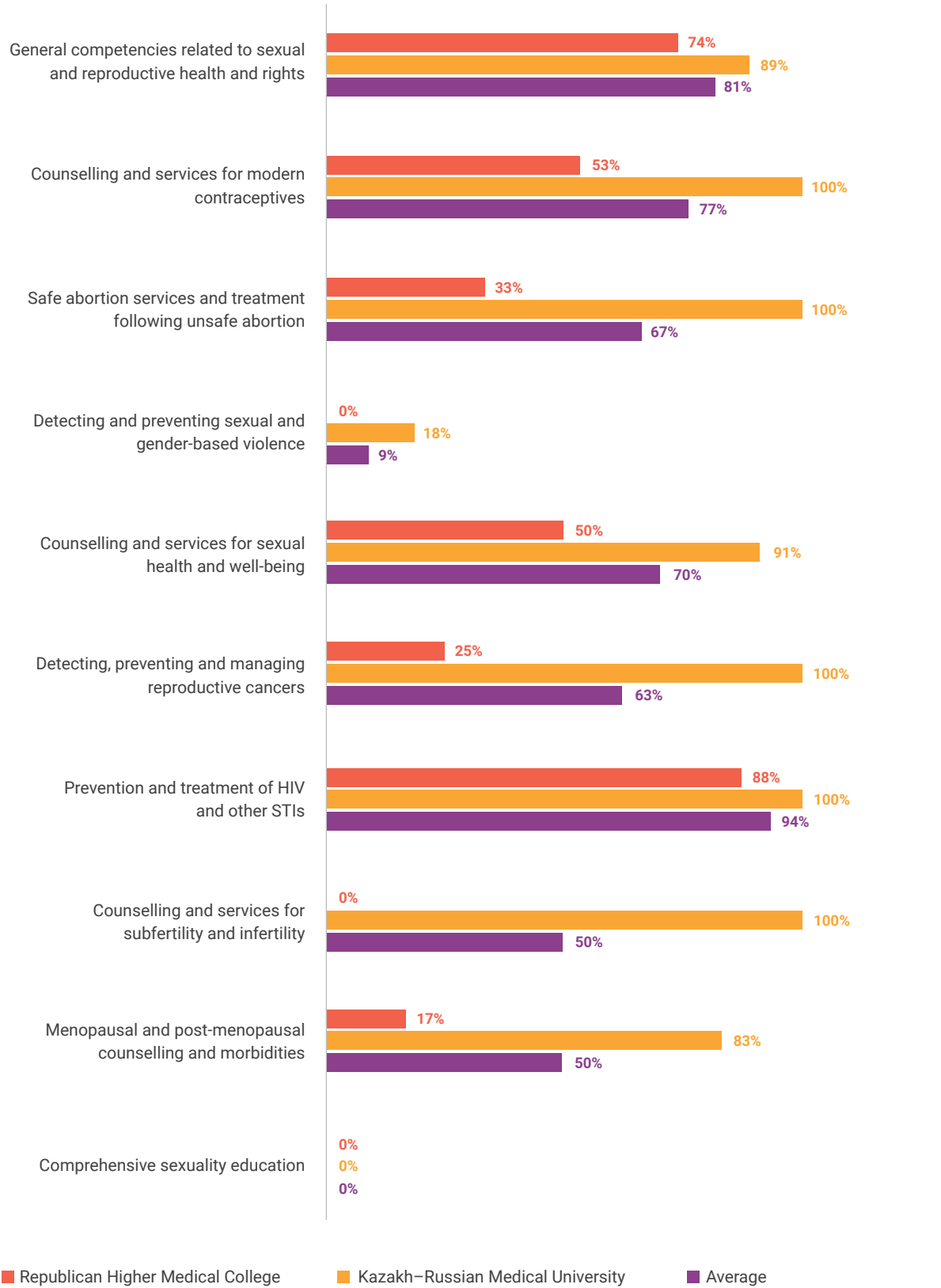
Kazakhstan did not report on the number of hours spent on SRHR interventions. On average, 65 per cent of the knowledge statements, 68 per cent of the skill/behaviour statements and 58 per cent of the combined statements were given a Yes response. It should be noted that the University's response was Yes to 61 per cent of the knowledge statements, 89 per cent of the skill/behaviour statements and 100 per cent of the combined statements, whereas the College responded Yes to 46 per cent, 47 per cent and 16 per cent of these statements, respectively.

Figure A7. Kazakhstan: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A8. Kazakhstan: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



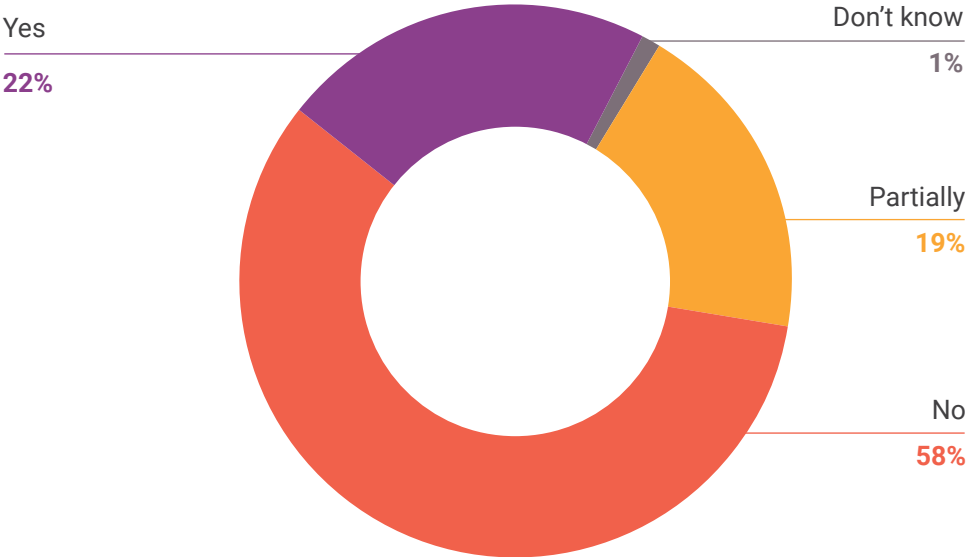
Source: Compiled by the authors.

Kyrgyzstan

Institutions providing midwifery education in Kyrgyzstan
<ul style="list-style-type: none">• Bishkek Medical College• Osh Medical College• Kara-Balta Medical College

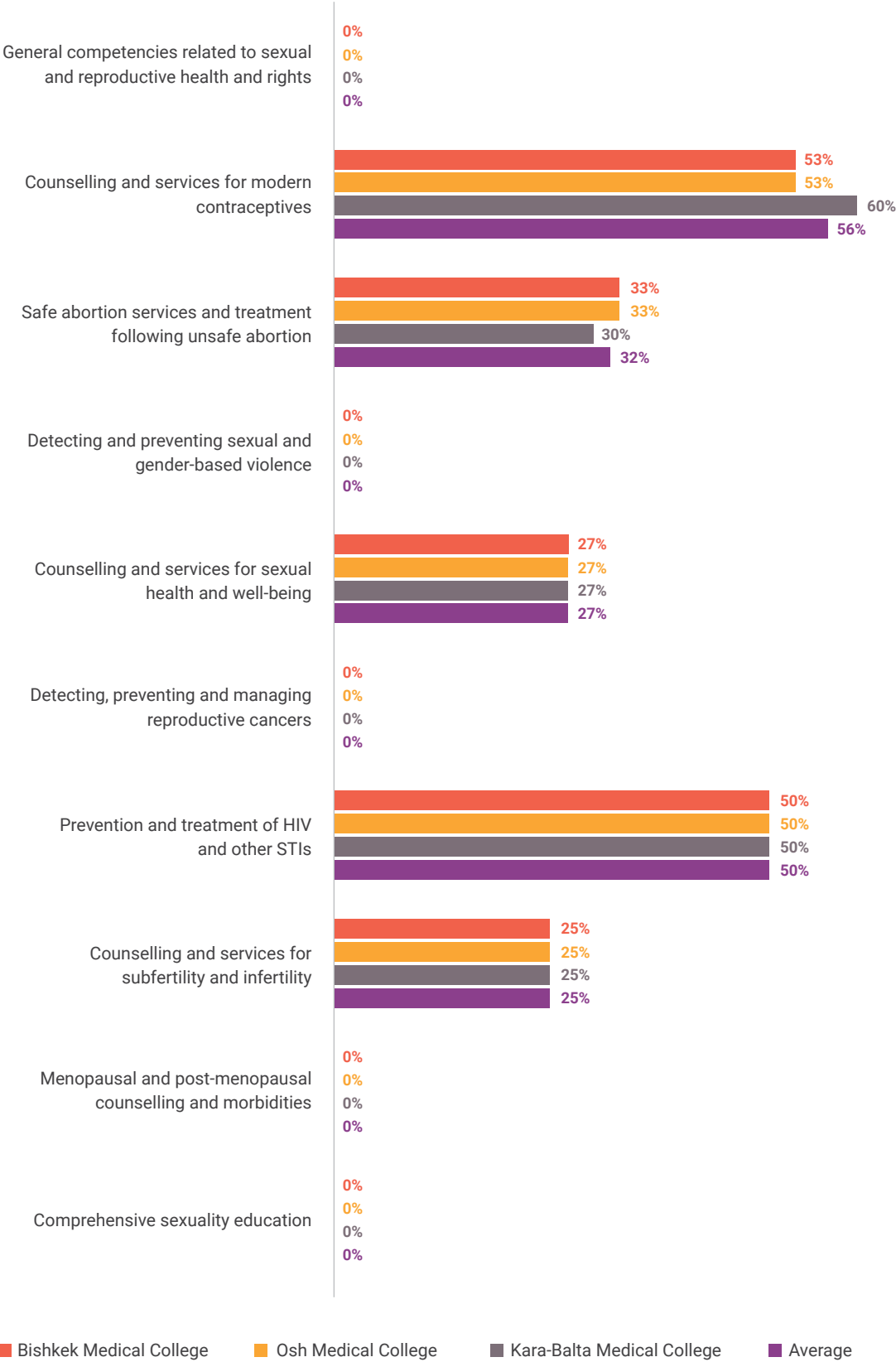
With the inclusion of only 22 per cent of the SRHR competencies in its midwifery curricula, on average, Kyrgyzstan is one of the lowest-scoring countries in the region. Fifty-eight per cent of the SRHR competencies were reported as not included, and 19 per cent are partially included, and 2 per cent are unknown. The three institutions had very similar scores for each of the SRHR interventions, with higher percentages of inclusion for general SRHR competencies, but lower scores for competencies on sexual and gender-based violence, infertility, menopause and sexuality education, and the competencies relating to sexual and gender-based violence are not fully included. The fact that all three institutions had similar scores suggests that a common curriculum may be applied. Kyrgyzstan reported that 736 hours is spent on SRHR interventions. This is much higher than the average regional number of 246. Twenty-two per cent of the knowledge statements received a Yes response, as did 19 per cent of the skill/behaviour statements and 31 per cent of the combined statements.

Figure A9. Kyrgyzstan: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A10. Kyrgyzstan: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



Source: Compiled by the authors.

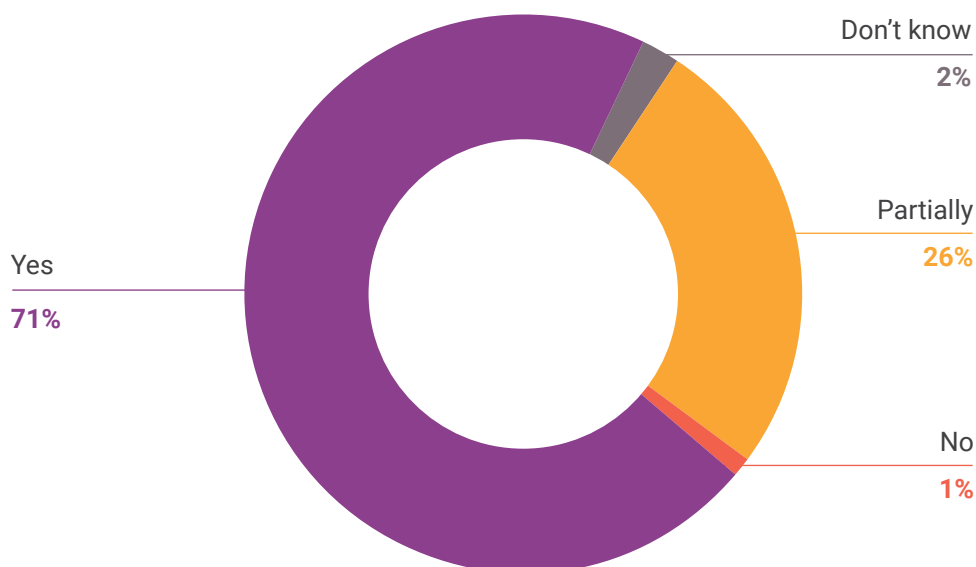
North Macedonia

Institutions providing midwifery education in North Macedonia

- Goce Delchev University
- University St. Kliment Ohridski
- Ss. Cyril and Methodius University

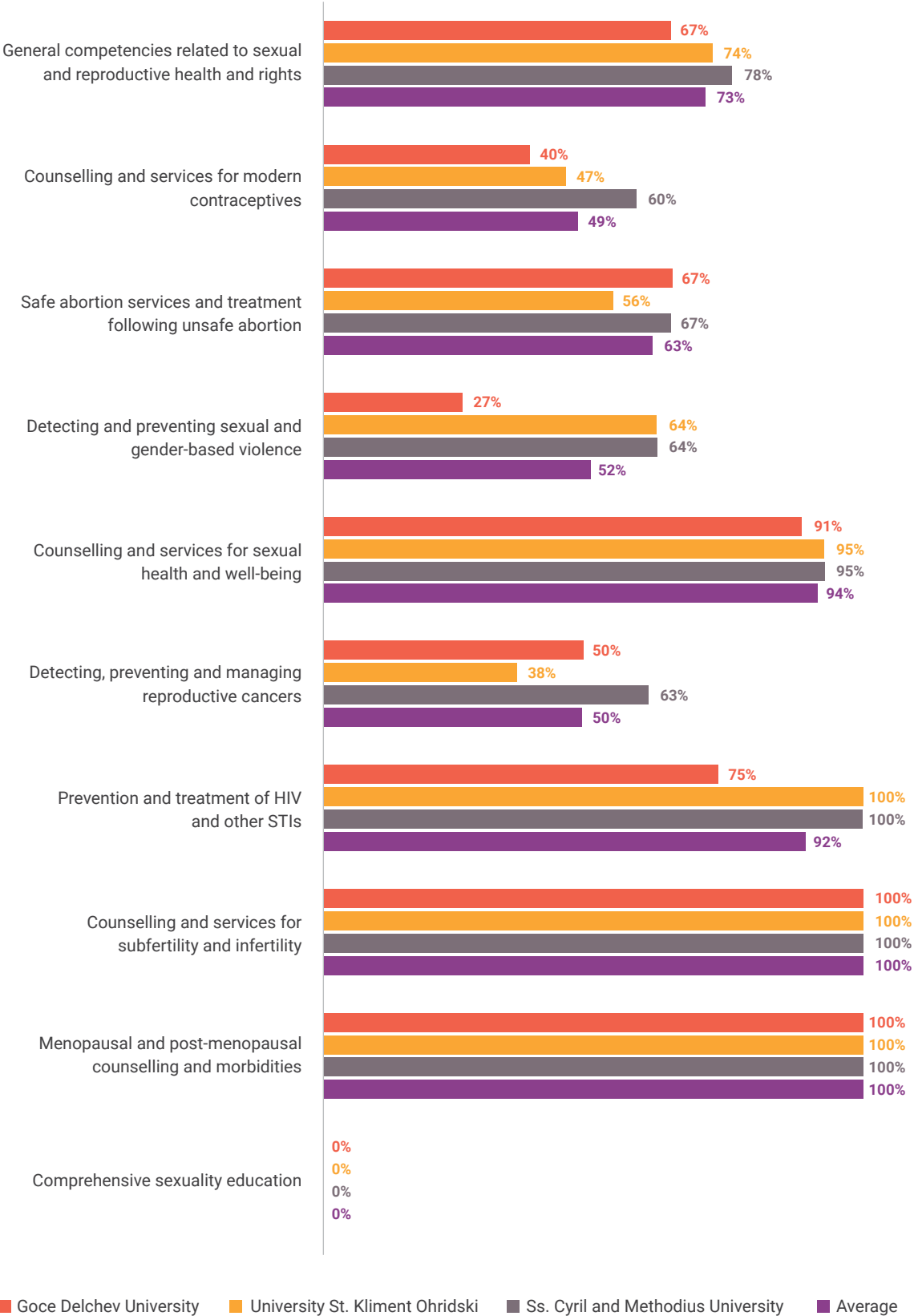
North Macedonia reported that, on average, 71 per cent of the SRHR competencies are included in the curriculum, 26 per cent are partially included, and 1 per cent are not included. A response of *I don't know* was provided regarding 2 per cent of the competency statements. The inclusion rate is higher than the regional average of 54 per cent, and the low percentage of *No* responses suggests that many of the SRHR interventions are somewhat addressed in the curriculum. With an average of 52 per cent of SGBV-related competencies included, North Macedonia is ahead of most other countries and territories in the region in this category. The same is true for menopause and infertility, with 100 per cent of the competencies in both categories included. On the other hand, with 49 per cent of the competencies relating to contraceptives included in the curriculum, on average, the country is below the regional average. North Macedonia did not provide complete information on the number of hours spent on SRHR interventions. Sixty-seven per cent of the knowledge statements, 70 per cent of the skill/behaviour statements, and 46 per cent of the combined competency statements were reported as included.

Figure A11. North Macedonia: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A12. North Macedonia: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



Source: Compiled by the authors.

Serbia

Institutions providing midwifery education in Serbia
<ul style="list-style-type: none">• Academy of Vocational Studies Belgrade• Dr. Miša Pantić Valjevo Medical School

Serbia reported that an average of 72 per cent of the SRHR competencies are included in its curriculum; this is higher than the regional average, which is 54 per cent. Twenty per cent of the competencies are partially included, and 8 per cent are not included, on average.

The Academy of Vocational Studies Belgrade includes more than 80 per cent of the competencies for each of the SRHR interventions, with the exception of those relating to menopause. Competencies on comprehensive abortion care, HIV and other STIs, reproductive cancers and sexuality education are all fully included in the curriculum of both institutions. While the inclusion rates are high in Serbia, the country did indicate that midwives are supervised by physicians and not recognized as independent professionals who are able to provide treatment or care at their own discretion.

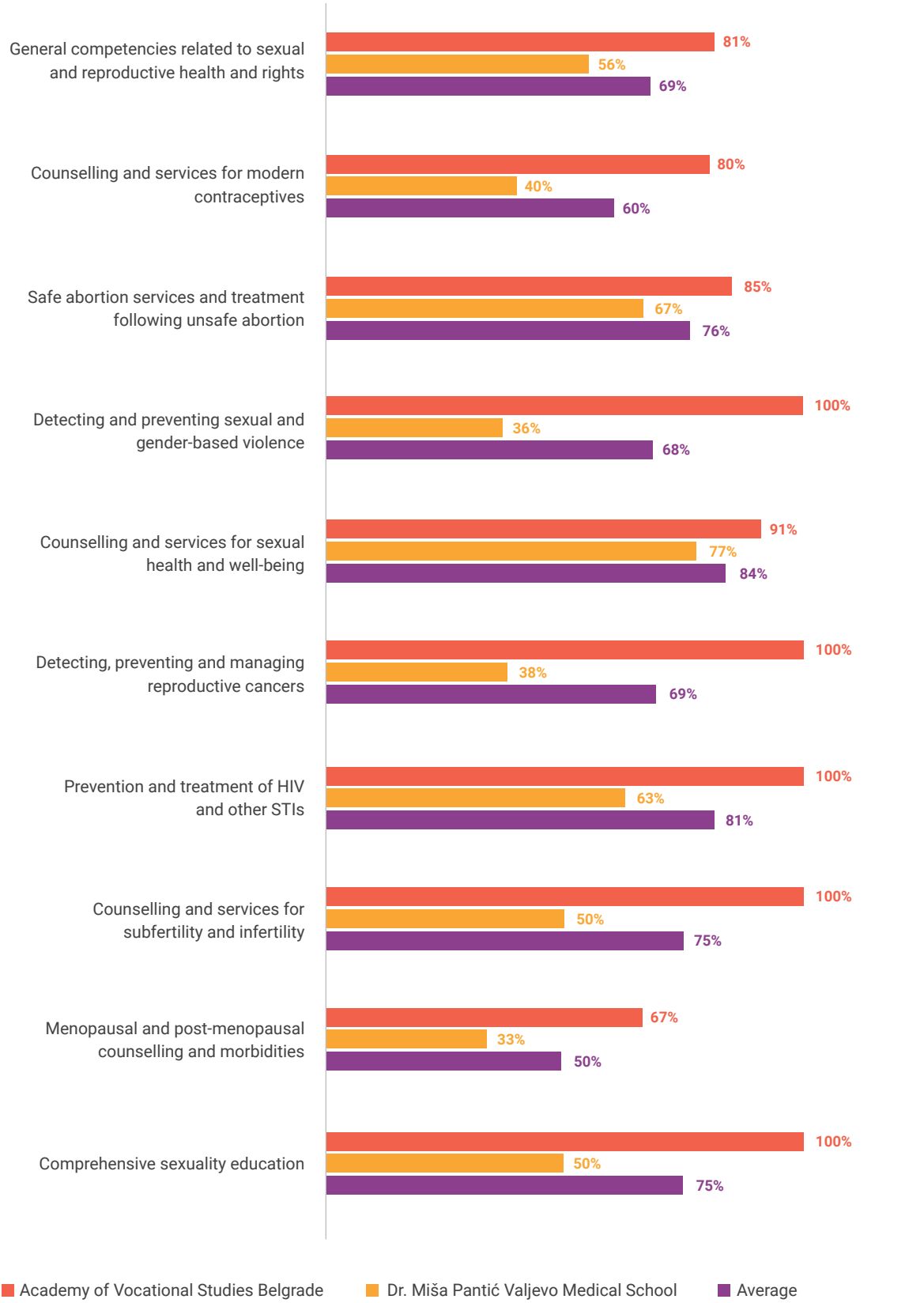
Serbia did not provide information on the number of hours allocated to teaching about SRHR interventions. The Academy of Vocational Studies Belgrade responded Yes to 85 per cent of the knowledge statements, 94 per cent of the skill/behaviour statements and 69 per cent of the combined statements. The Dr. Miša Pantić Valjevo Medical School responded Yes to 50 per cent, 63 per cent and 30 per cent of the statements, respectively.

Figure A13. Serbia: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A14. Serbia: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



Source: Compiled by the authors.

Tajikistan

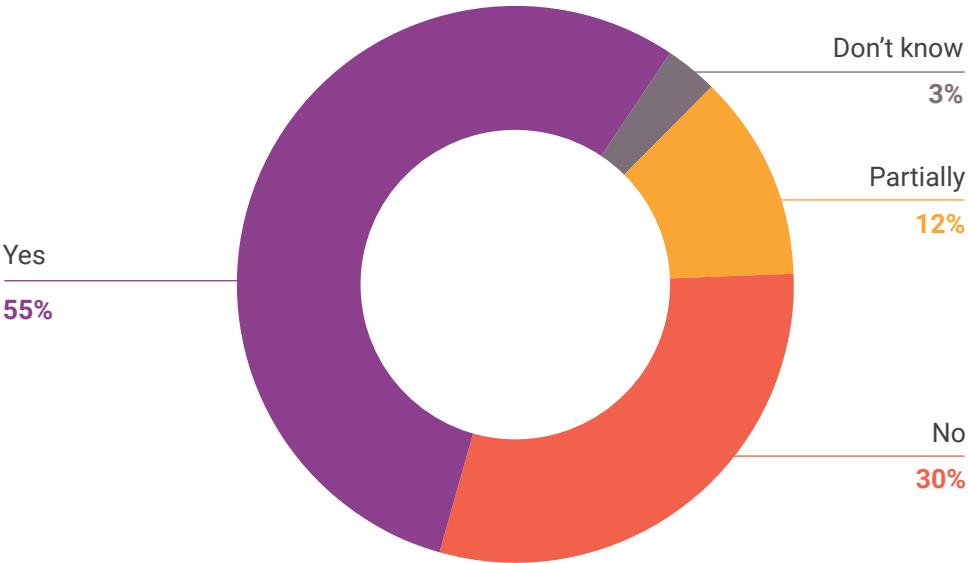
Institution providing midwifery education in Tajikistan
<ul style="list-style-type: none">Republican Medical College State Educational Institution

Tajikistan reported that 55 per cent of the SRHR competencies are included in its midwifery curriculum, 12 per cent are partially included, and 30 per cent are not included. A response of *I don't know* was reported regarding 3 per cent of the competencies. These scores put the country on par with the regional average.

As is the case in other countries in the region, a high percentage of the competencies relating to contraception (87 per cent) are included, while a much lower percentage of the competencies relating to sexual and gender-based violence (27 per cent), sexual health (23 per cent) and infertility (25 per cent) are included.

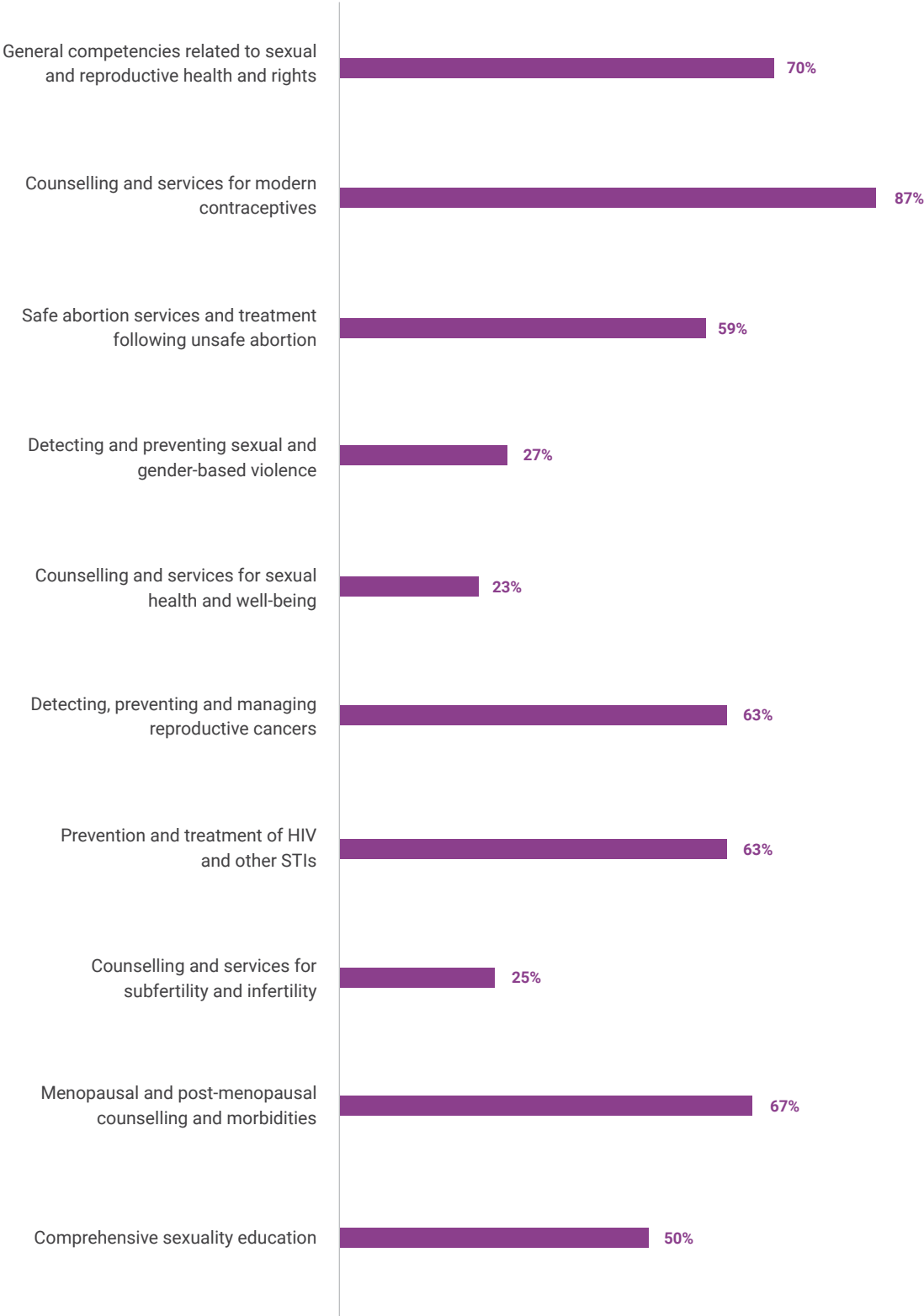
Tajikistan reported that the curriculum allocates 238 hours, close to the regional average, to teaching on SRHR interventions. Over half of this time is allocated to contraception; 10 per cent, to general SRHR competencies; and another 10 per cent, to HIV and other STIs. It also reported that 50 per cent of the knowledge statements, 31 per cent of the skill/behaviour statements and 39 per cent of the combined statements are included.

Figure A15. Tajikistan: rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A16. Tajikistan: rate of inclusion per SRHR intervention in midwifery curriculum



■ Republican Medical College State Educational Institution

Source: Compiled by the authors.

Türkiye

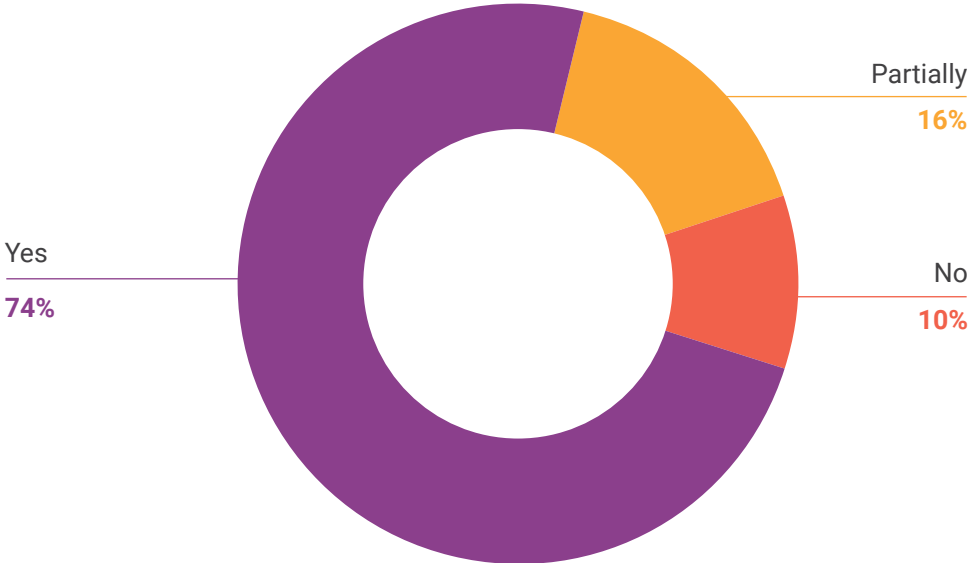
Institutions providing midwifery education in Türkiye
<ul style="list-style-type: none">• Pre-graduation National Core Education Framework Programme (by the Council of National Higher Education)• Izmir Tinaztepe University• Ege University

Türkiye reported that 74 per cent of the SRHR competencies were included in its curriculum, on average, compared with the regional average of 54 per cent. This score ranks the country among the highest in the region. Ten per cent of the competencies are not included, and 16 per cent are partially included.

Türkiye is one of the few countries in the region with a high score (91 per cent) when it comes to the inclusion of SGBV-related competencies; the remaining 9 per cent are partially included. Türkiye also scores higher than the regional average in terms of competencies on infertility and menopause. On the other hand, 38% of competencies relating to reproductive cancers are included, compared with the regional average of 44 per cent.

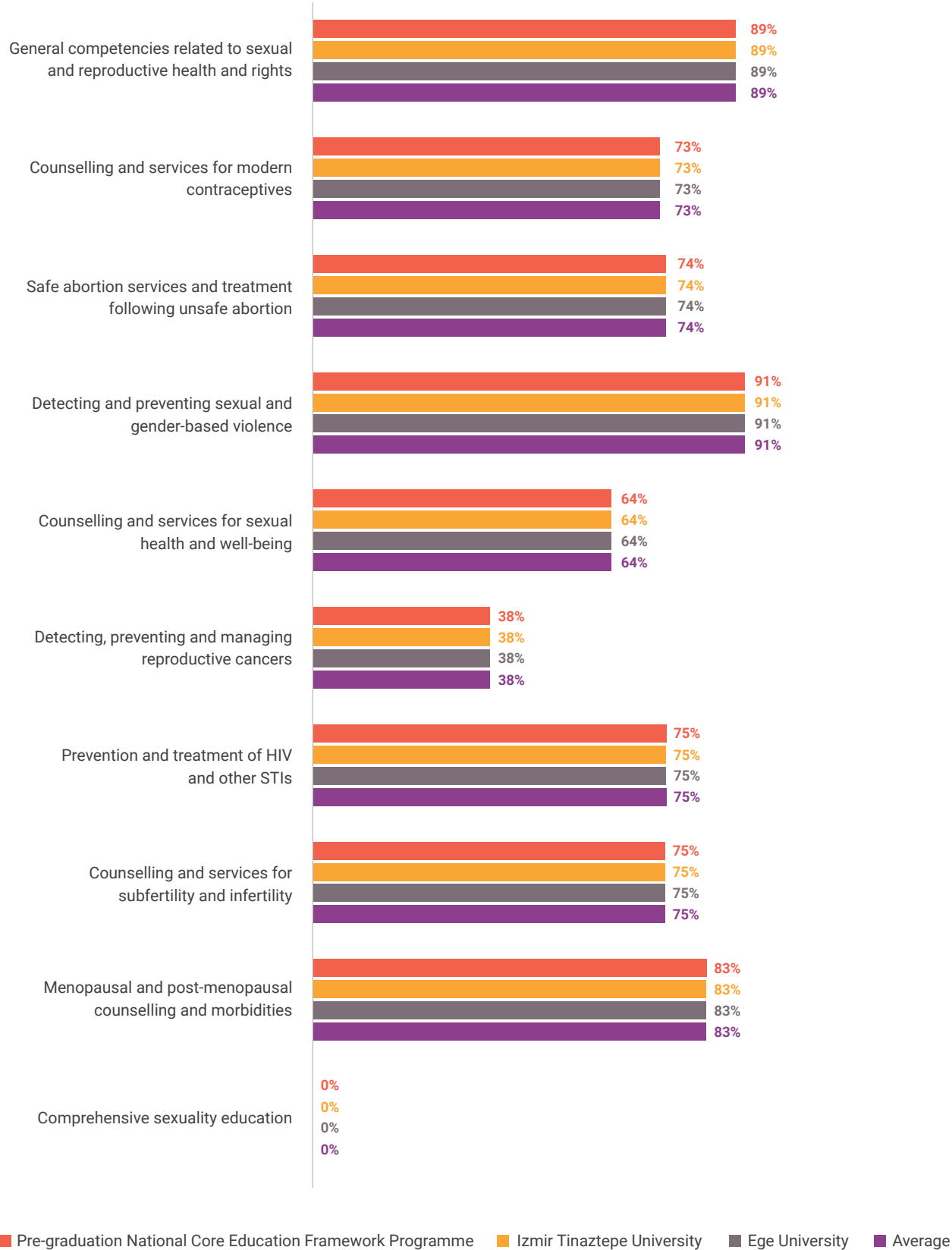
Türkiye reported that an average of 510 hours is spent teaching on SRHR interventions, which is twice the regional average. Twenty-seven per cent of this time is allocated to general SRHR competencies; 20 per cent, to both contraception and comprehensive abortion care; and 14 per cent, to sexual health. The three institutions reported very similar inclusion rates, suggesting a shared curriculum. Türkiye answered Yes to 78 per cent of the knowledge statements, 77 per cent of the skill/behaviour statements and 38 per cent of the combined statements.

Figure A17. Türkiye: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A18. Türkiye: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



Source: Compiled by the authors.

Ukraine

Institutions providing midwifery education in Ukraine

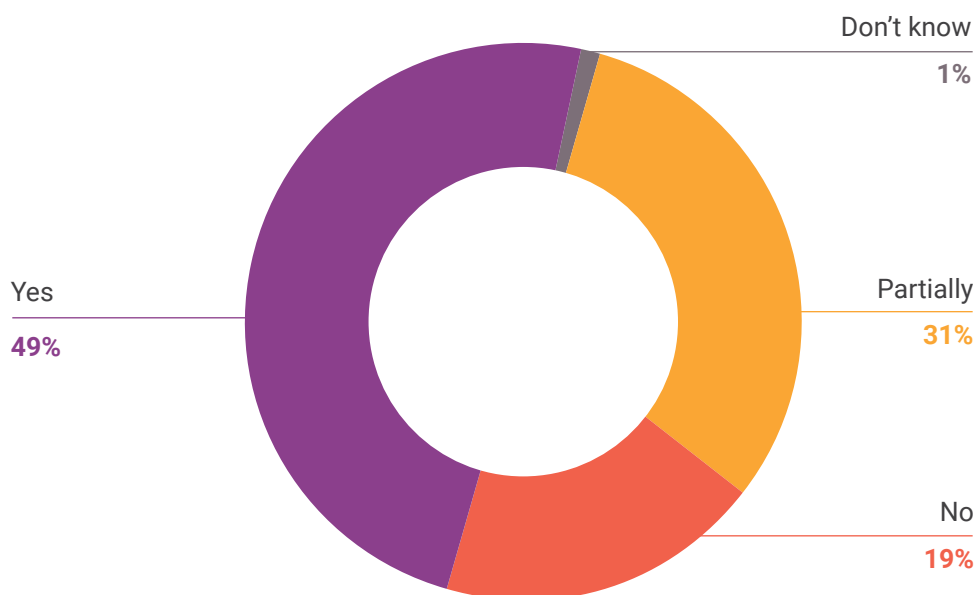
- Kremenchu Medical College
- Kyiv Professional Medical College No. 4
- Ivano-Frankivsk Medical Vocational College

Ukraine reported that 49 per cent of the SRHR competencies, on average, are included in its midwifery curriculum, slightly less than the regional average. Nineteen per cent of the competencies are not included, and 31 per cent are partially included. A response of *I don't know* was provided regarding 1 per cent of the competencies.

Seventy-three per cent of the competencies relating to comprehensive abortion care and 71 per cent relating to reproductive cancers are included, on average. As is the case in other countries in the region, competencies relating to sexual and gender-based violence, infertility and sexuality education scored lower. Ukraine also reported a lower inclusion rate for competencies on HIV and other STIs than the regional average. The three institutions reported similar rates of inclusion of most SRHR interventions, with the notable exception of Kremenchu Medical College, which includes more SGBV-related competencies (45 per cent) than the other two institutions (9 per cent each).

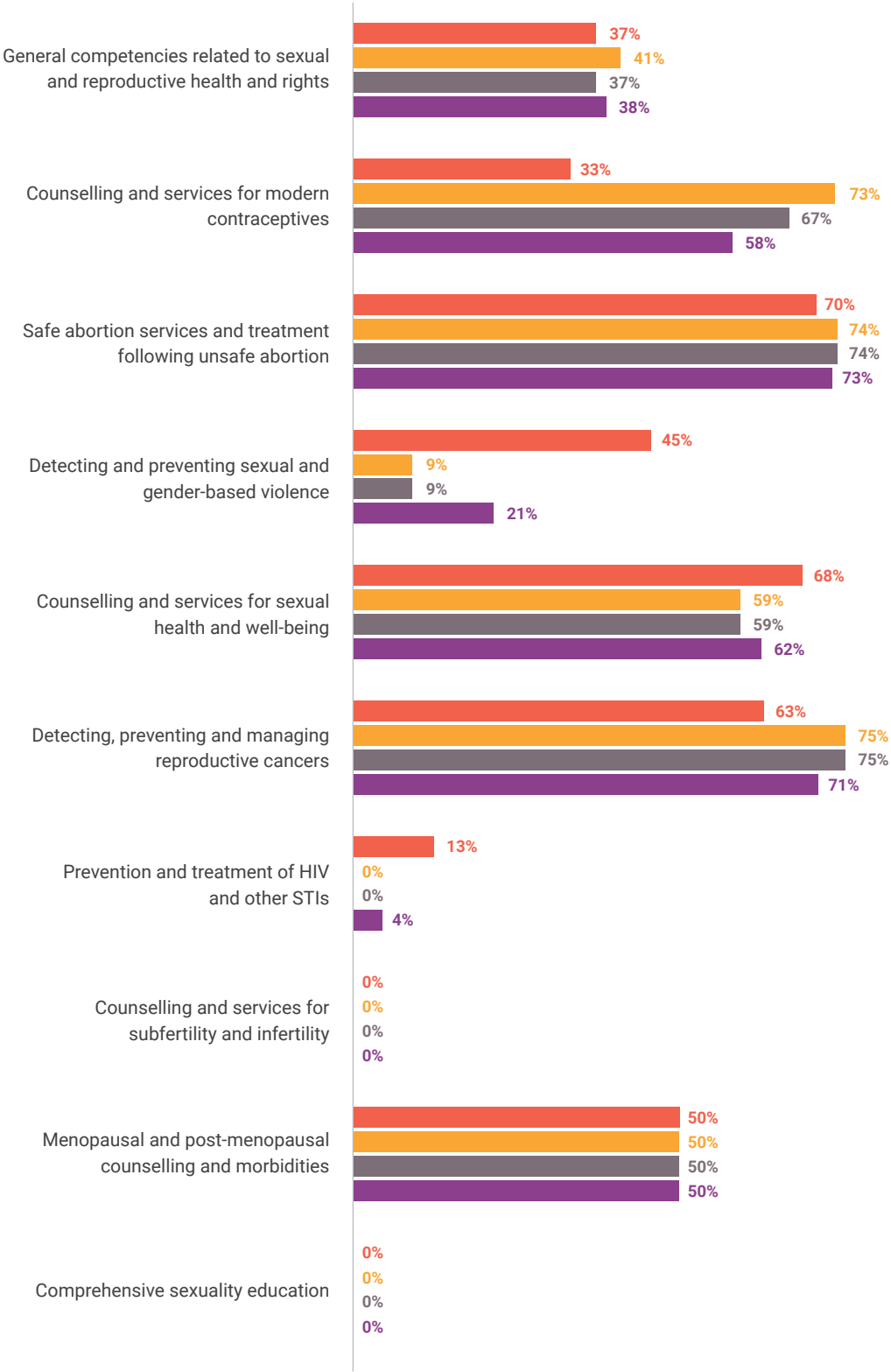
The three institutions all responded that 32 per cent of the knowledge statements, 49 per cent of the skill/behaviour statements and 33 per cent of the combined statements are included. Ukraine did not provide information on the hours taught on SRHR interventions.

Figure A19. Ukraine: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A20. Ukraine: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



■ Kremenchu Medical College ■ Kyiv Professional Medical College No. 4 ■ Ivano-Frankivsk Medical Vocational College ■ Average

Source: Compiled by the authors.

Uzbekistan

Institution providing midwifery education in Uzbekistan

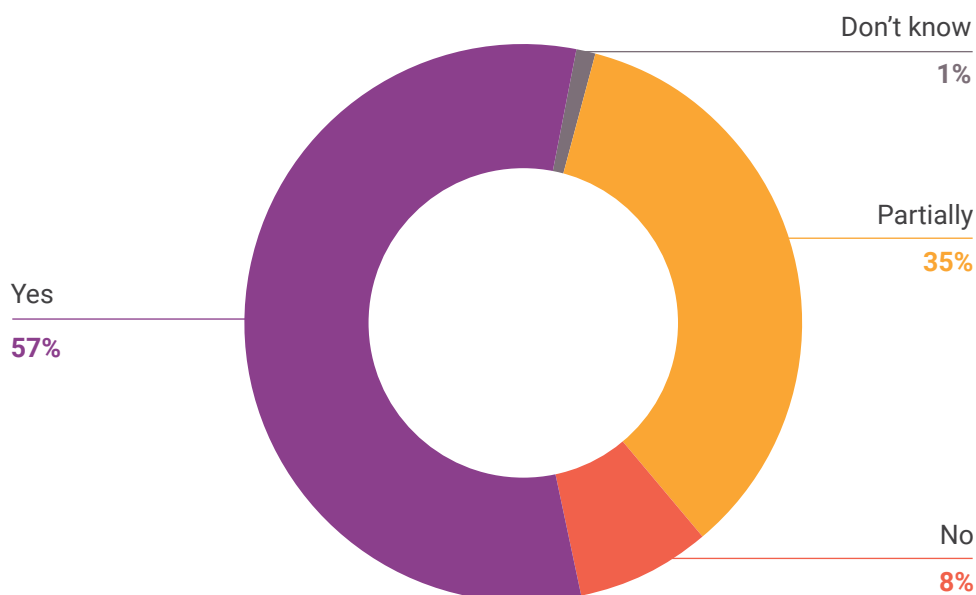
- Tashkent Paediatric Medical Institute

Uzbekistan reported that 57 per cent of the SRHR competencies are included in its midwifery curriculum, which is similar to the regional average. Thirty-five per cent of the competencies are partially included, and 8 per cent are not included. A response of *I don't know* was reported regarding 1 per cent of the competencies.

The Tashkent Paediatric Medical Institute includes all of the competencies on HIV and other STIs as well as 88 per cent of the competencies relating to reproductive cancers. In line with the regional trend, the percentages of competencies included on sexual and gender-based violence, menopause, infertility and sexuality education are lower.

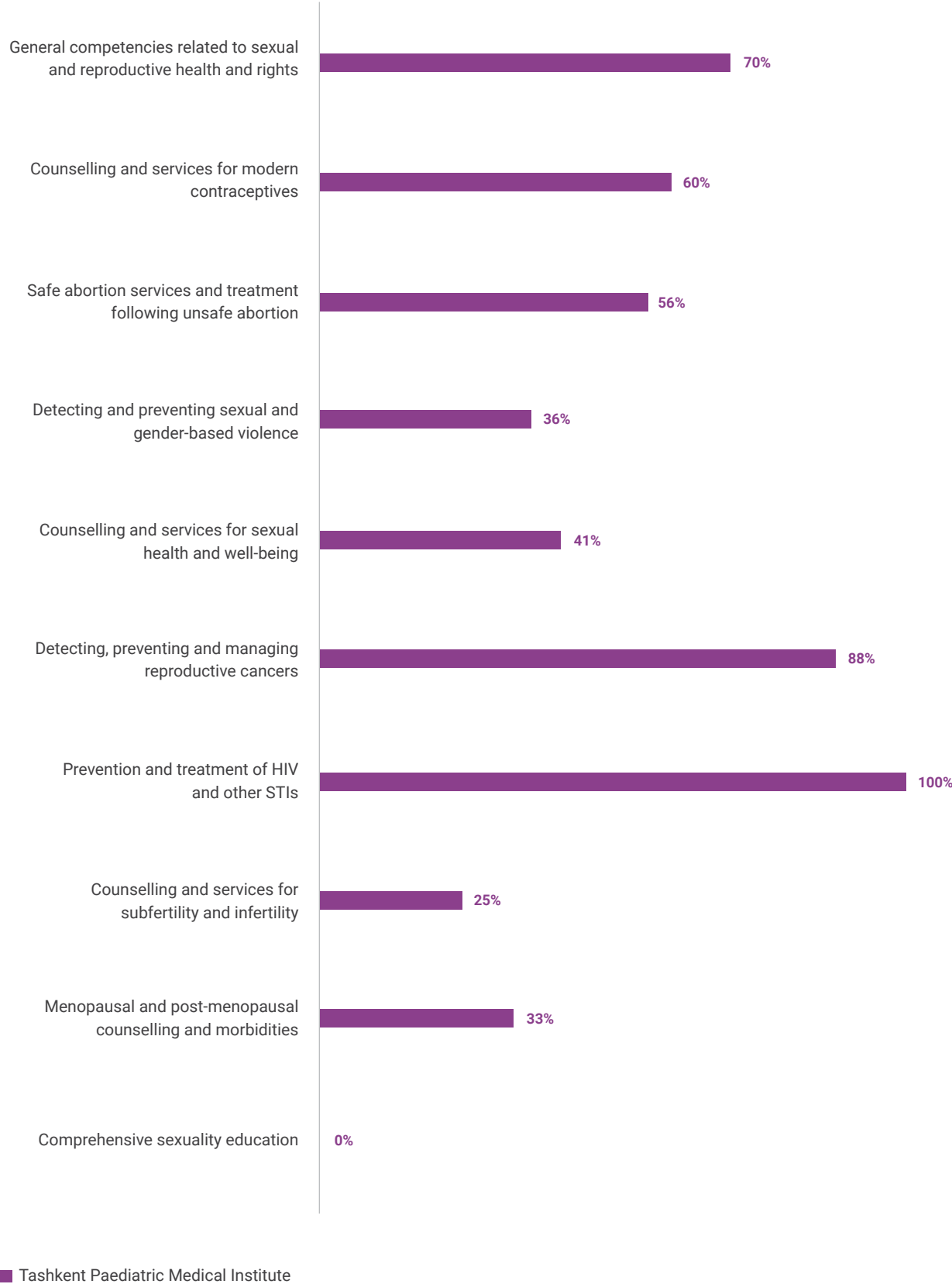
Fifty-five per cent of the knowledge statements, 67 per cent of the skill/behaviour statements and 23 per cent of the combined statements are reported to be included in the curriculum. Uzbekistan did not report how much time is allocated to SRHR interventions in the curriculum.

Figure A21. Uzbekistan: rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A22. Uzbekistan: rate of inclusion per SRHR intervention in midwifery curriculum



Source: Compiled by the authors.

Kosovo

Institutions providing midwifery education in Kosovo

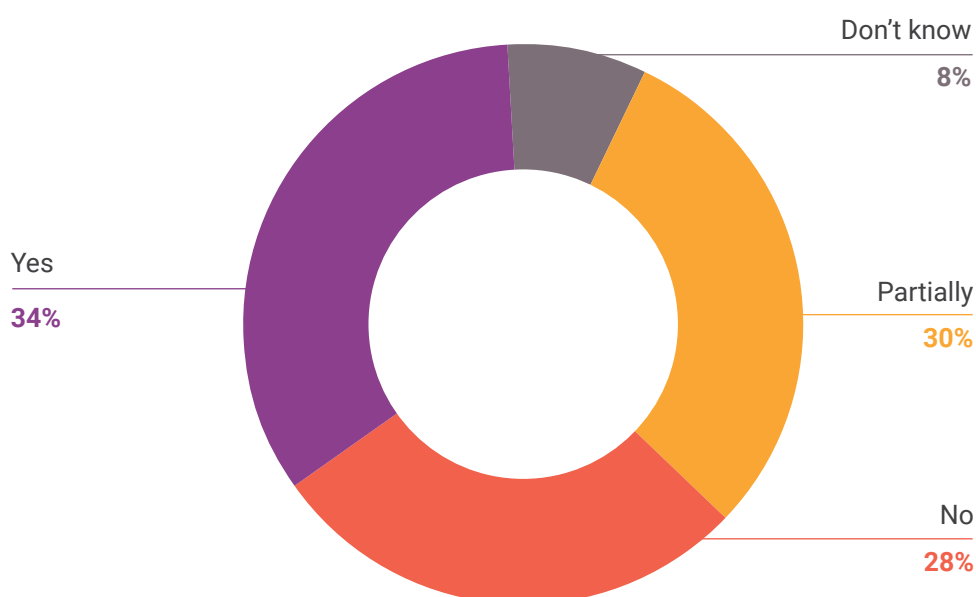
- Elena Gjika Ferizaj Upper Middle School of Medicine
- Kolegji Rezonanca

Kosovo reported that an average of 34 per cent of the SRHR competencies are included, 30 per cent are partially included, and 28 per cent are not included in its midwifery curriculum. A response of *I don't know* was given regarding 8 per cent of the statements.

On average, the two institutions scored low on the inclusion of SGBV-related competencies, with only 9 per cent included, and even lower for competencies on infertility and sexuality education, at 0 per cent. Kolegji Rezonanca includes 44 per cent of SRHR competencies, versus 26 per cent at the Upper Middle School of Medicine, 60 per cent versus 33 per cent, respectively, for competencies on contraceptives, and 59 per cent versus 26 per cent, respectively, for competencies on comprehensive abortion care. Both schools score lower on HIV and other STIs than the regional average, with 18 per cent for the Upper Middle School of Medicine and 50 per cent for Kolegji Rezonanca.

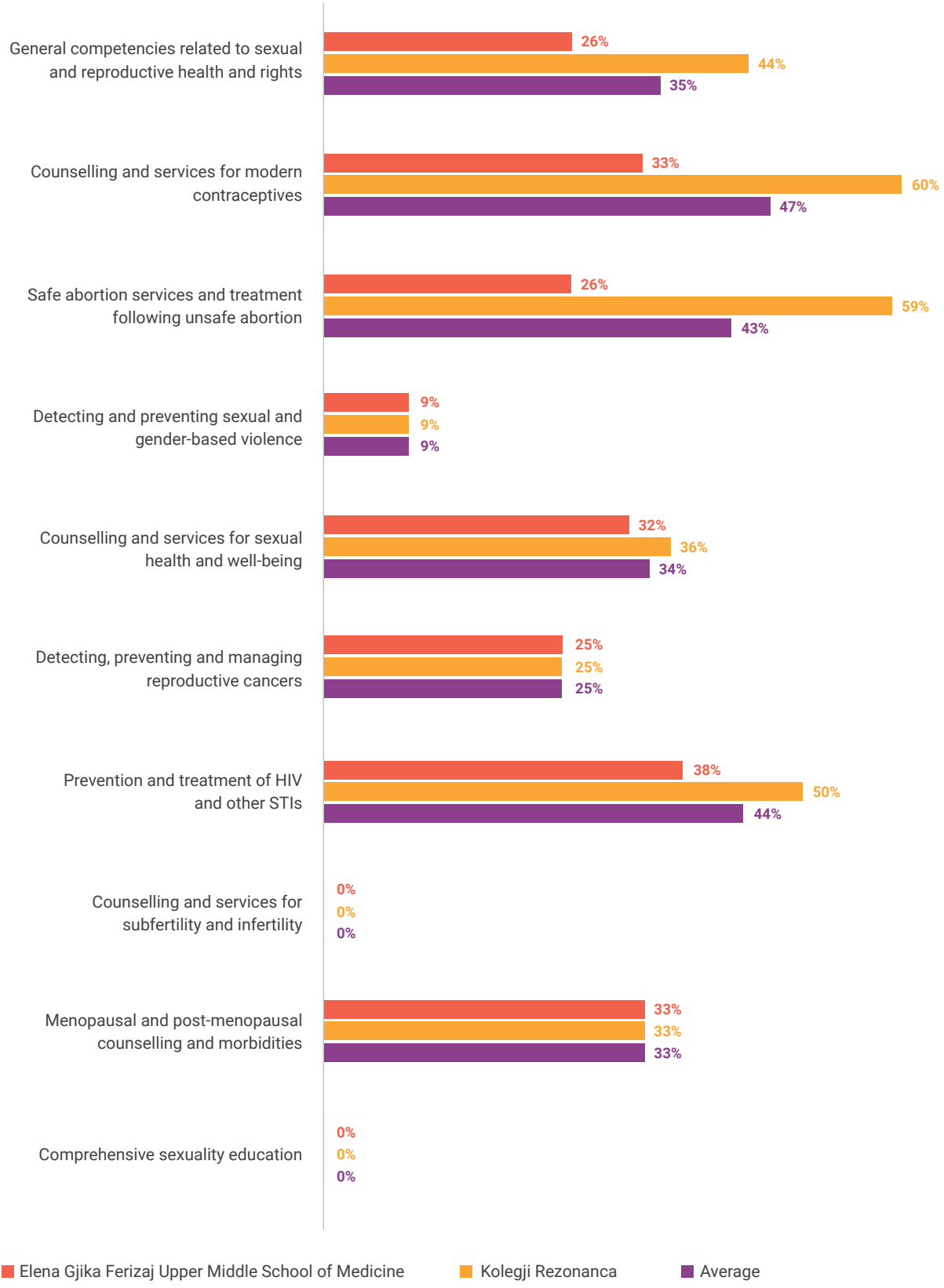
Kosovo reported that an average of 30 hours is spent on SRHR interventions, with no considerable differences between the two institutions. This is much lower than the regional average of 246 hours. On average, 42 per cent of the knowledge statements, 25 per cent of the skill/behaviour statements and 35 per cent of the combined statements are included in the curriculum.

Figure A23. Kosovo: average rate of inclusion of SRHR competencies in midwifery curriculum



Source: Compiled by the authors.

Figure A24. Kosovo: responses per institution and average rate of inclusion per SRHR intervention in midwifery curriculum



Source: Compiled by the authors.

