State of Asia's Midwifery 2024 Report

Assessing Progress, Celebrating Success

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Abbreviations and acronyms

ANC	antenatal care
AP	Asia and the Pacific
APRO	(UNFPA) Asia and the Pacific Regional Office
BEmONC	basic emergency obstetric and newborn care
CHW	community health worker
CO	(UNFPA) country office
CPD	continuing professional development
DPR Korea	Democratic People's Republic of Korea
EC	emergency contraception
EmONC	emergency obstetric and newborn care
EWENE	every woman, every newborn, everywhere
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
ISCO	International Standard Classification of Occupations
IUD	intrauterine device
Lao PDR	Lao People's Democratic Republic
mCPR	modern contraceptive prevalence rate
MMoC	midwifery model of care
MMR	maternal mortality ratio
MNH	maternal and newborn health
MoE	ministry of education
MoH	ministry of health
MPDSR	maternal and perinatal death surveillance and response
MRP	manual removal of the placenta
MVA	manual vacuum aspiration (to remove retained products of conception)
NMR	neonatal mortality rate
Ob/gyn	obstetrician and gynaecologist
PAC	post-abortion care
PNC	postnatal care
PNG	Papua New Guinea
PPH	postpartum haemorrhage
QoC	quality of care
SBA	skilled birth attendance
SDGs	Sustainable Development Goals
SoWMy	State of the World's Midwifery report
SRMNAH	sexual, reproductive, maternal, newborn and adolescent health
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAD	assisted instrumental delivery by vacuum extraction
WHO	World Health Organization

Foreword

The saying goes, you never truly appreciate something until you don't have it. So imagine being a pregnant woman without the guaranteed prospect of having a midwife by your side in your moment of joy, or worse - your hour of need. Neither scenario bears thinking about. And yet for many women, that is a reality.

Simply put, midwives save lives. They are the cornerstone of sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH) services. Their vital contributions are central to achieving the Sustainable Development Goals across the Asia-Pacific region. This report, *The State of Asia's Midwifery Workforce 2024*, marks a significant milestone in our collective efforts to strengthen midwifery workforce capabilities. Building on years of dedicated work and global insights—particularly the State of the World's Midwifery 2021—this publication offers a comprehensive and up-to-date assessment of the current landscape, challenges, and opportunities in midwifery across the region.

Drawing on data from 21 diverse countries, the report provides robust evidence on workforce availability, education, regulation, and leadership. It highlights both the progress made and the critical areas that require urgent attention. The findings reaffirm the transformative power of investing in midwives—to save lives, improve health outcomes, and ensure that every woman, newborn, and adolescent receives the quality care they deserve.

I have been privileged to meet many midwives across our diverse region, all of whom have inspired me with their dedication, professionalism, and leadership. This report, beyond statistics, tells the stories of the countless midwives working with diligence and resilience—from remote rural communities to densely populated urban centres. It reflects the strong commitments of governments, professional associations, and communities working together to advance midwifery. As a practical tool, it is intended to foster informed policy dialogue, guide strategic planning, and support national initiatives to strengthen the midwifery workforce and promote equitable, accessible healthcare for all.

I extend my heartfelt appreciation to the national stakeholders, researchers, and writers whose contributions made this report possible. It stands as a testament to our shared commitment to improving SRMNAH outcomes in the Asia-Pacific region. I hope it will inspire continued action and serve as a guide toward a future where every woman, newborn, and adolescent can not only survive, but thrive. Importantly, I hope it will reinforce our collective commitment to ensuring that the midwifery profession is properly funded and staffed, as well as valued and respected. Let's deliver for midwives!

Pio Smith, UNFPA Asia Pacific Regional Director

Executive summary

Photo credit: @UNFPA Myanmar / Benny Manser

Executive summary

Sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH) is an essential component of the Sustainable Development Goals (SDGs) and the Programme of Action of the International Conference on Population and Development (ICPD). Improving SRMNAH requires increased commitment to, and investment in, the health workforce. UNFPA's global and regional strategic plans recognise that investments in the midwifery workforce, in particular, are one of the key strategies for accelerating progress toward the transformative results of ending preventable maternal and newborn deaths and increasing access to sexual and reproductive health information and services.

This report includes information from **21 countries** in the UNFPA Asia-Pacific (AP) region: Afghanistan, Bangladesh, Bhutan, Cambodia, the Democratic People's Republic of Korea (DPRK), India, Indonesia, Iran, Lao People's Democratic Republic (Lao PDR), Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Papua New Guinea (PNG), Philippines, Sri Lanka, Thailand, Timor-Leste, and Viet Nam. Data were collected using a questionnaire survey, completed by national stakeholders, including representatives of ministries of health (MoHs), professional midwives' associations, regulatory bodies, and UNFPA country offices.

This report provides an up-to-date evidence base to highlight progress since the last global State of the World's Midwifery (SoWMy) report in 2021. It is intended to support ministry of health stakeholders, policymakers and legislators to engage in policy dialogue at national and regional levels, to assist countries in the region to meet the challenges of the health-related SDGs and the *Every Woman Every Newborn Everywhere* (EWENE) agenda. Understanding the current state of the midwifery workforce, midwifery education, policy and regulatory environment is necessary to identify specific challenges, gaps and bottlenecks which need to be addressed, and to consider suitable strategies for overcoming them.

The development of this report was led by UNFPA Asia and the Pacific Regional Office (APRO). The report builds on the approach used for the earlier regional midwifery workforce reports and the global *State of the World's Midwifery* (SoWMy) series of reports, led by UNFPA, the World Health Organization (WHO), and the International Confederation of Midwives (ICM). In this report, the word 'midwives' includes both midwives and nurse-midwives unless otherwise stated.

Availability of midwives

Of the 21 participating countries, 18 were able to provide data on the number of midwives and other SRMNAH workers (exceptions: Afghanistan, India, and Myanmar). There is considerable variation between countries in the availability of midwives. At least five countries are estimated to have a needs-based shortage of midwives (Lao PDR, Mongolia, Pakistan, PNG, and Timor-Leste), with the most severe shortages in Pakistan and PNG. If the participating countries continue to produce new graduate midwives at current rates, and are able to employ them all (which is known to be a challenge in many countries), at least two

countries in the region are projected to have a needs-based midwife shortage by 2030: Pakistan and PNG. In addition, it is likely that there are (and will continue to be) shortages in other countries, including Afghanistan, Myanmar, and Viet Nam, but there was insufficient data from these countries to quantify the shortage.

Measuring change over time in midwife availability is challenging, because data systems do not always distinguish clearly between midwives, nurse-midwives, and nurses. As a result, apparent changes over time may be due to a change in classification rather than a change in the size of the workforce. However, valid comparisons can be made for 15 countries in this report, of which nine show increased midwife availability since the last global SoWMy report in 2021: Bangladesh, Cambodia, Iran, Lao PDR, Maldives, Nepal, PNG, Sri Lanka, and Viet Nam. Four countries show decreased midwife availability (Indonesia, Malaysia, Pakistan, Philippines), and two show no significant change (Mongolia, Timor-Leste).

The World Health Organization (WHO) estimates that countries with fewer than 25 doctors, nurses, and midwives per 10,000 population will fail to achieve adequate coverage rates for important primary health care interventions. This threshold, while applying to primary healthcare interventions generally rather than SRMNAH needs specifically, can still give a sense of the minimum necessary health workforce density in any given country.

When looking at midwife density specifically, there is considerable variation in the region, with density ranging from 42.9 midwives per 10,000 population in DPRK to 1.4 per 10,000 population in PNG. At least four of the countries featured in this report have a midwife density below the 2021 global average of 4.4 per 10,000 population: Mongolia, Pakistan, PNG, and Viet Nam. Additionally, it is likely that midwife density is below the global average in Afghanistan, India, and Myanmar, but it was not possible to confirm this assumption based on the information submitted for the preparation of this report.

The likely reasons for issues with midwife density vary between and within countries, from deployment challenges to geographically dispersed populations and insufficient production of midwives. It should also be noted that efforts to compare midwife density between countries are potentially confounded by inconsistent definitions of who counts as a midwife.

There is also variety in terms of how countries configure their midwifery workforces. In seven countries the midwifery workforce is composed entirely, or almost entirely, of professional midwives (with few, if any, nurse-midwives). In six countries it is composed entirely, or almost entirely, of professional nurse-midwives. The remaining countries have considerable numbers of associate professional midwives and nurse-midwives, who have a relatively narrow scope of practice and can therefore safely provide only some essential SRMNAH interventions.

Of course, midwife headcounts tell only part of the story. This is illustrated by the fact that some countries have enough midwives to meet all of the needs for essential midwifery interventions, and yet their SRMNAH outcomes remain poor. It is therefore also important to focus on factors that enable midwives to provide good quality care, such as the regulatory environment and quality of education and training.

Workforce planning and management, regulation and work environment

Strategies to deploy midwives equitably, the creation and protection of sanctioned midwifery positions and transition to midwifery practice programmes are vital investments to increase the availability, acceptability and quality of midwives and the SRMNAH services they provide. Of the 21 participating countries, 20 were able to provide data on the enabling environment for midwifery (exception: Myanmar).

Of the 20 reporting countries, eight have a midwife-specific deployment strategy: Afghanistan,[1] Bangladesh, Cambodia, DPRK, India, Maldives, Philippines, and Sri Lanka. The strategy has been implemented in five of the eight countries (exceptions: Bangladesh, Cambodia, and Maldives). A further eight countries have a general health worker deployment strategy that applies to midwives without being specific to them, but only three of them have fully implemented their deployment strategy.

Only three countries reported the existence of sanctioned midwife positions in their country: Bangladesh, Lao PDR, and Philippines, where about 30 per cent, 70 per cent, and 90 per cent respectively of the sanctioned positions have been filled. Likewise, only six countries were able to report on the percentage of 2023 graduates who have been deployed at health facilities. Responses range from zero in Bangladesh (where graduates could not be deployed in 2024 due to the political instability in the country), through 70 per cent in Mongolia, to 100 per cent in Maldives and Nepal.[2]

Nine countries have a 'transition to practice' programme to support new graduate midwives as they start their careers: Afghanistan, Cambodia, India, Lao PDR, Malaysia, Maldives, Mongolia, Sri Lanka, and Thailand. However, in several countries the programme is not available to all new graduates.

All 20 responding countries have a regulatory body for midwifery. Ten countries have an independent council that performs this role, in nine countries the MoH does it, and six have a council that is a department within the MoH. Most countries have a separate regulator for midwifery education.

All 20 countries have a licensing system for midwives. In most cases, new graduate midwives must sit an additional licensing exam, but in seven countries a licence is granted automatically on graduation from an approved education programme. Most of the participating countries require their midwives to renew their licence every few years (exceptions: Afghanistan, Iran, Malaysia). Eleven of the responding countries require midwives periodically to provide evidence of continuing professional development (CPD) activities, and another three plan to introduce a CPD system in the near future.

Most of the responding countries restrict the midwife's scope of practice in a way that excludes one or more interventions that a midwife who is educated according to global

[1] During the preparation of this report, the Government of Afghanistan approved legislation which bans women and girls from education, including for midwifery. This will effectively interrupt the production of new midwifery graduates in the country, thus severely impacting the midwifery workforce. Information on Afghanistan is still included in different sections of this report, but recent developments since late 2024 must be taken into consideration.

[2] Not all of the Nepalese graduates are deployed as midwives, however.

standards should be able to provide. The interventions most commonly excluded from midwives' scope of practice are: medical abortion (if legal), assisted instrumental delivery by vacuum extraction, manual vacuum aspiration, obstetric fistula care and rehabilitation, and contraceptive implants.

The midwife's scope of practice is especially limited in: Bhutan, DPRK, Sri Lanka, and Thailand.

Lastly, there is anecdotal evidence from some countries that midwives' availability is adversely affected by poor coordination between education institutions and health service employers, and by international migration ('brain drain'). The survey attempted to collect data on these issues, but found that most national data systems did not have the capacity to measure them systematically, although plans are available in some countries (e.g. India) to improve data availability.

Education and training

Over the last decade, UNFPA has been supporting countries in the Asia-Pacific region to ensure that midwife education curricula are based on nationally agreed standards. Currently, all 20 reporting countries have national standards to guide curriculum content, although in three countries the standards are not used by all schools (Pakistan, Sri Lanka, and Timor-Leste). Nearly all of the participating countries have a national body with responsibility for accreditation of pre-service midwifery education programmes (exceptions: Mongolia and Viet Nam).

There are three basic types of pre-service midwifery education programme: direct entry, post-nursing, and combined nursing and midwifery. All three types exist in the Asia region: 12 countries have at least one direct entry programme, seven have at least one post-nursing programme, and six have at least one combined programme. Most countries have just one type of programme, but six countries have more than one type. Direct entry programmes range from 18 months in Sri Lanka to 60 months in Indonesia, and post-nursing programmes range from 12 months in Cambodia, Malaysia, and Maldives to 36 months in Nepal. Combined programmes are usually either 36 or 48 months in duration.

Although most of these midwife education programmes align with ICM Global Standards for Midwifery Education in terms of programme duration, alignment with other elements of the ICM standards is patchy. In the majority of responding countries, at least one element of the standards is not routinely met, indicating widespread challenges for the provision of high-quality midwifery education in the region. The elements of the global standards that are least likely to be met are: faculty, resources, and quality improvement.

Thirteen countries report having a national faculty development programme that is accessible to midwifery faculty, but in two of these countries the programme has yet to be implemented. Most faculty development programmes are coordinated by governments in partnership with midwifery associations (Nepal, Philippines), nursing/midwifery councils (India, Nepal, Pakistan), and UNFPA and development partners. Only two programmes (in Iran and Mongolia) are coordinated by educational institutions.

Other recent research indicates that the content of the existing programmes is not fully informed by the needs of midwifery faculty and the roles they are expected to perform.

Fourteen countries report having a national programme of in-service CPD for midwives in clinical practice (exceptions: Bangladesh, Bhutan, Maldives, Pakistan, Viet Nam, and possibly Malaysia). The reported objectives of the programmes were general and focused on improving quality of care, maintaining midwifery competencies and providing opportunities for midwives to complete CPD requirements for re-licensure. Many of the region's CPD programmes appear to be offered inconsistently or irregularly, and it is not always clear which midwives can access them.

Midwife-led improvements to service delivery

A midwife-led unit is one where midwives take primary professional responsibility for planning, organising and delivering services using a midwifery model of care. Under this model of care the main care providers are educated, licensed, regulated midwives who autonomously provide and coordinate care across their full scope of practice. Ten of the 20 responding countries report the existence of at least one midwife-led unit, and of these, eight countries have plans to open more within the next five years. In addition, four countries which currently do not have midwife-led units reported plans to introduce them within five years: Lao PDR, Mongolia, PNG, and Thailand. If these plans are implemented, by 2030 over half of Asian countries will offer care at midwife-led units.

Midwifery leadership and governance

The existence of midwives in leadership positions can improve the quality of decision-making on issues that affect midwives and their clients, and they may also facilitate the provision of effective midwife supervision and mentoring systems. In most countries with a professional association for midwives, a midwife leads the association. Twelve countries have a person responsible for setting the strategic direction for midwifery at a national level, but in nine of these countries the position is held by someone who is not a midwife. Fewer countries (n=9) have a midwife advisor within the MoH, and in four of those countries this position is held by a midwife. In seven countries the regulatory body for midwifery is led by a midwife. Afghanistan, Iran, and Malaysia stand out for having midwives in a wide variety of these national leadership roles.

It is also important to have midwives involved in key activities and structures that influence SRMNAH care, regulation and research. Most responding countries have midwives routinely involved in: MPDSR committees, quality improvement initiatives, defining and reviewing the midwife's scope of practice, production of national guidelines, obstetrician and gynaecologist education and training, and

monitoring and evaluation. Fewer countries have midwives routinely involved in other important activities such as research ethics committees, trialling of new drugs, and professional misconduct hearings. Bhutan, Indonesia, Iran, Thailand, and Timor-Leste stand out for having midwives involved in a wide variety of these activities.

Recommendations

As the findings presented in the different chapters of this report illustrate, the region has made considerable progress in advancing midwifery as a profession and establishing good quality educational pathways. However, more can be done to further strengthen the role, skills, and capacities of midwives, to ensure they can provide essential, high-quality SRMNAH services to mothers and newborns across the region.

UNFPA calls on governments, national stakeholders and partners to:

1. **Address needs-based shortages of midwives** through accelerating production and increasing educational pathways in line with ICM standards, and **develop equitable and updated deployment strategies**. This will require investments in midwifery faculty development and curriculum updates, as well as systems for the regulation of quality midwifery education to ensure adherence to ICM standards.
2. **Revise and update policies for practice and educational pathways**, to ensure that midwives are enabled, trained, and have the required competencies to perform to the full scope of practice as defined by ICM.
3. **Invest in data driven workforce planning, development of sanctioned midwifery posts in the public sector, and policies to guide equitable and sustainable recruitment,** deployment and retention of the midwifery workforce to meet the SRMNAH needs of the population in all parts of all countries, and to ensure maximum absorption of graduates into the workforce - in order to avoid future midwife shortages.
4. **Empower midwives through providing leadership opportunities** in key activities and structures that influence SRMNAH care, regulation, and research.

Chapter 1:

Introduction

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Background: why midwifery matters

The 1994 International Conference on Population and Development (ICPD) shone a light on the importance of sexual and reproductive health as a fundamental human right. It marked a shift in global thinking towards a focus on the needs, aspirations and rights of individual women and men. [1] In 2019, Kenya hosted a global summit to take stock of progress over the 25 years since the first ICPD conference. Here, it was agreed that the principles of the ICPD programme of action are essential to achieving the sustainable development goals (SDGs). The Nairobi Statement on ICPD25 made 12 global commitments to complete the ICPD agenda, including: (i) zero unmet need for family planning information and services, (ii) zero preventable maternal deaths, (iii) access for all adolescents and youth to comprehensive and age-responsive sexual and reproductive health information and services. [2]

The analysis later in this chapter shows that many countries in the Asia and the Pacific (AP) region have made – and continue to make – considerable efforts towards completing the ICPD agenda, achieving impressive results such as reduced maternal and neonatal mortality, and increased access to SRMNAH information and services. Further investment in the sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) workforce will help to ensure the completion of this ambitious agenda. Sustainable health systems based on primary health care are essential to the health and well-being of every woman, newborn, and adolescent. The Global Strategy on Human Resources for Health [3] stresses that without an effective health workforce no health system is viable and universal health coverage cannot be achieved. High-quality SRMNAH care requires a competent, educated, motivated and supported workforce.

Midwives are a vital element of the SRMNAH workforce. A 2020 study covering 88 countries that account for the vast majority of the world's maternal and neonatal deaths and stillbirths concluded that universal coverage of midwife-delivered interventions could avert two-thirds of these deaths and save 4.3 million lives per year by 2035. [4] The importance of midwives and midwifery is acknowledged by the *Every Woman Every Newborn Everywhere* (EWENE) initiative. [5] The fifth Global Midwifery Symposium in 2023 resulted in renewed commitments from global organisations to support, strengthen and promote midwifery models of care, and a call for all UN member states to do likewise. [6] In 2024, the World Health Organization (WHO) launched a global position paper that discusses how midwifery models of care represent a cost-effective strategy to optimise SRMNAH outcomes. [7]

Likewise, the UNFPA global strategic plan for 2022-2025 and its SRMNAH strategy for 2025-2030 recognise investment in the midwifery workforce as one of the key pathways for accelerating progress towards the transformative results of ending preventable maternal and newborn deaths and stillbirths. [8, 9] UNFPA with global partners recently launched a global midwifery acceleration road map to support these investments. [10] The 2022-2025 UNFPA strategic plan for the AP region identifies midwifery education, training and practice as a priority area for responding to gaps in access to high-quality SRMNAH care. [11]

UNFPA led the development of the State of the World's Midwifery 2021 report (SoWMy 2021), which highlighted the many and varied returns on investment in midwives. It called for "bold investments" in four areas: (i) health workforce planning, management, regulation and the work environment, (ii) high-quality education and training for midwives, (iii) midwife-led improvements to SRMNAH service delivery, and (iv) midwifery leadership

and governance. [12] This report addresses these four key areas as well as highlighting actions and changes over time, especially since SoWMy 2021.

Objectives of this report

In the context of the above global and regional policies and strategies, UNFPA's Asia Pacific Regional Office (APRO) commissioned this report, which is primarily intended to support policy dialogue at national and regional levels, to assist countries in the region to meet the challenges of the health-related SDGs and the EWENE agenda. The report has the following specific objectives:

i. Update estimates of the scale of regional and national shortages of midwives, taking into account the impact of COVID-19 and the growing population needs
ii. Address research priorities and policy and implementation gaps that are identified by stakeholders from the region, which may include international migration, need for faculty capacity development, and challenges with deployment and retention
iii. Show change over time in relation to midwifery workforce availability, midwifery services coverage and quality, and the education, regulation and status of midwives
iv. Showcase actions taken at regional and national levels in response to the recommendations of SoWMy 2021 and global strategic directions for nursing and midwifery
v. Provide data to support the EWENE health workforce milestone (EPMM Milestone 6) and the alignment of partners' support for midwifery

Where possible, this report describes change over time since the 2011, 2014 and 2021 global SoWMy reports, [12-14] or points out where progress has stalled and may require additional efforts. It thus contributes to the regional strategic objectives identified by UNFPA and other partners.

This report covers 21 countries in the UNFPA AP region: Afghanistan, Bangladesh, Bhutan, Cambodia, DPR Korea, India, Indonesia, Iran, Lao PDR, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Papua New Guinea (PNG), Philippines, Sri Lanka, Thailand, Timor-Leste and Viet Nam.

Methodology

The data presented in Chapter 1 of this report was collated from global data repositories. The data presented in Chapters 2 and 3 of this report were collected via a questionnaire survey, distributed to all UNFPA country offices (COs) in Asia in September 2024. A tailored version of the questionnaire was prepared for each country, showing the most recent published data (if any) for each indicator. The COs were invited to work in partnership with relevant national stakeholders to review the most recent data, and then to consult with relevant national stakeholders to provide updated data and fill data gaps.

On submission of a completed questionnaire, the data were reviewed for completeness and clarity, and queries resolved via discussion with the COs and other national stakeholders. A completed or partially completed questionnaire was received from all 22 countries in the Asia region with a UNFPA presence. The technical team reviewed the submitted data, and requested clarifications where gaps or inconsistencies existed, and some countries were then excluded from the full or partial analysis. The data were then collated into an initial draft of this report, which was shared with the UNFPA COs in all participating countries for review and validation with the relevant national authorities before the report was finalised. Most of the data were analysed descriptively. Midwife shortage estimates and projections

are made using statistical modelling, adapted from the methods used for SoWMy 2021. [15]

Locating and validating health workforce data is challenging. We appreciate the tremendous efforts of national stakeholders to provide data. One of the recommendations from previous SoWMy reports was to strengthen health workforce data systems to enable effective workforce planning. The fact that this report contains recent workforce numbers for most AP countries is evidence of real progress against this recommendation. Nevertheless, data system limitations mean that gaps remain in the data, including: lack of data on the private sector, inability to disaggregate data into sub-national administrative areas, and lack of clarity regarding how many registered health workers, including midwives, are active in clinical practice and where they are deployed.

Afghanistan, India, and Myanmar are excluded from the analyses in Chapter 2 (the state of the midwifery workforce). SRMNAH worker headcounts are available for these countries, but all three have undergone significant change since the data were submitted, to the extent that the available headcounts misrepresent the current reality. India is in the process of establishing a new cadre of professional midwives. [16] Afghanistan has seen a regime change which has severely impacted women's participation in education and the workplace, [17] thus affecting the female-dominated profession of midwifery. The protracted conflict in Myanmar has severely affected its health system, including the health workforce. [18] Afghanistan and India are included in the analyses in Chapter 3 (an enabling environment for midwives), but Myanmar is not. Instead, Myanmar is represented in this report via a short country case study in Chapter 4.

Sexual, reproductive, maternal and newborn health outcomes

The estimates presented in this chapter on health outcomes are drawn from global databases, often using United Nations Interagency estimates. These databases were selected on the basis that they use a standard methodology which allows for cross-country comparisons. National sources sometimes contain different estimates because they use a different methodology, or because they are based on more recent data. While we acknowledge the availability of national data and estimates that might differ from the ones presented in this chapter of the report, the need for comparability across countries in this report required the use of standardised methodologies and data sources.

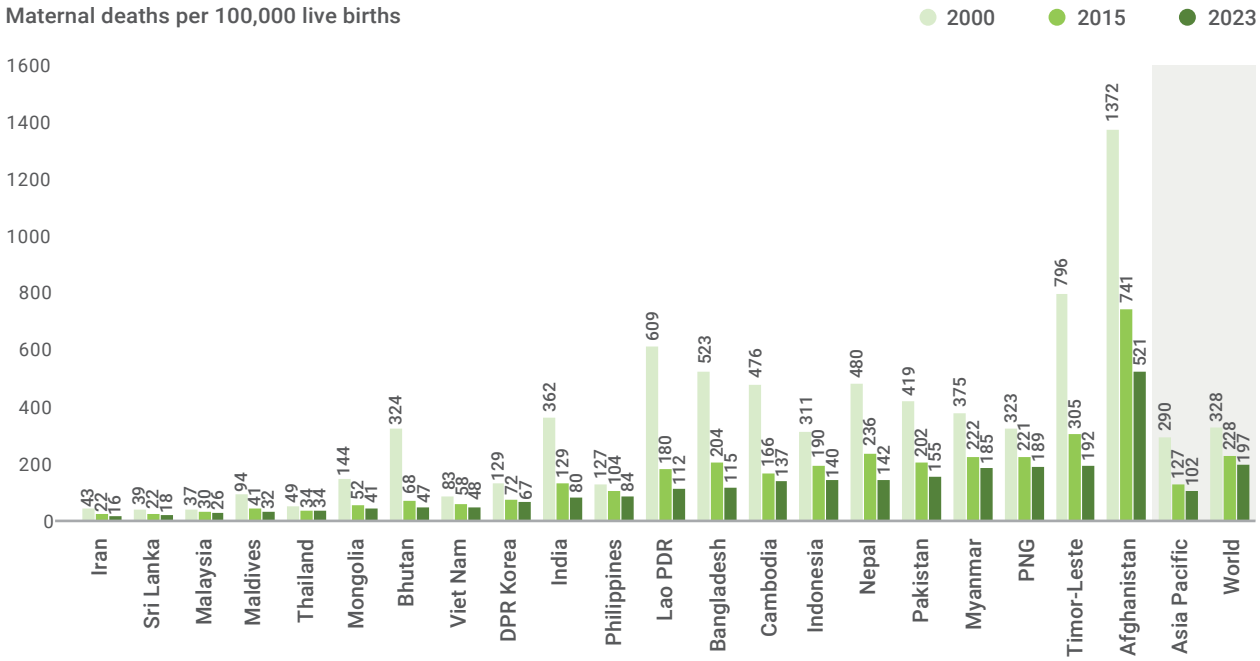
Since 2000, the world has made significant progress on improving the health and well-being of mothers, newborns and adolescents. Nevertheless, in recent years progress has slowed, and about 260,000 women died during and following pregnancy and childbirth in 2023. [19] Almost a quarter of these maternal deaths (22 per cent, or 58,000 deaths) occurred in the AP region, and most could have been prevented with high-quality maternal health care and services. [19] Additionally, 2.3 million of the world's children died in the first month of life in 2022, [20] and 42 per cent of those deaths (nearly a million newborns) occurred in the countries featured in this report.

The third SDG on "ensuring healthy lives and promoting well-being for all at all ages" calls for reducing the global maternal mortality ratio (MMR) to fewer than 70 maternal deaths per 100,000 live births by 2030, with no nation having an MMR higher than twice the global average. [21] Figure 1.1. shows that nine of the 21 countries featured in this report had an estimated MMR below 70 in 2023. Conversely, Afghanistan is the only one of the featured

countries with an MMR estimate that is above the global average: Afghanistan's MMR is 521 per 100,000 live births, 2.6 times the global average of 197.

Between 2000 and 2023, there was a reduction of 40 per cent in the global MMR. Over the same period, the AP region achieved a reduction of 65 per cent (the MMR declined from 290 maternal deaths per 100,000 live births in 2000 to 102 in 2023). [19] In common with other regions of the world, however, progress has slowed in recent years. AP countries with a particularly strong MMR reduction between 2015 and 2023 include: Bangladesh (43 per cent reduction), Nepal (40 per cent), Lao PDR (38 per cent), India (37 per cent), and Timor-Leste (37 per cent). However, some AP countries saw little or no improvement over that period, most notably DPRK and Thailand – although these countries' MMRs were already lower than the regional average in 2015.

Figure 1.1: Maternal mortality ratio: 2000, 2015 and 2023



Source: WHO et al 2025. [19]

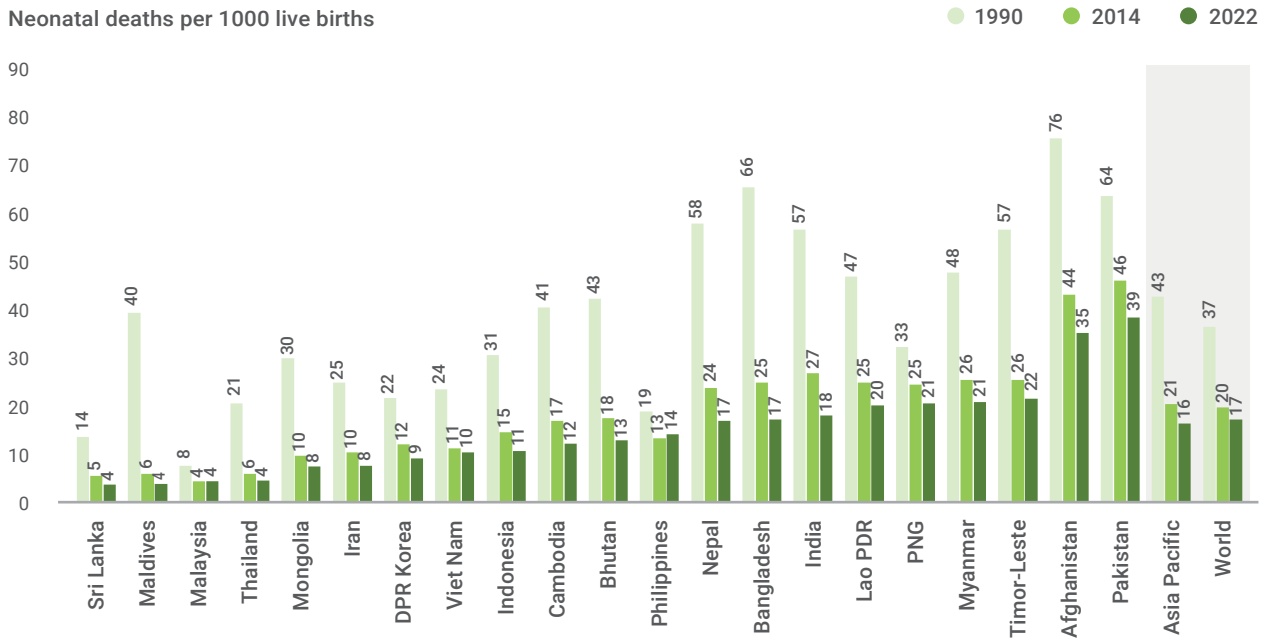
The SDG3 also includes a target to reduce the global neonatal mortality rate (NMR) to no more than 12 neonatal deaths per 1000 live births. [22] In 2022, half of AP countries had already met this target, but two countries (Afghanistan and Pakistan) had NMR estimates over 30. The average NMR for the region was 16 (Figure 1.2).

Between 1990 and 2022, the global NMR reduced by 53 per cent, and the NMR for the AP region reduced by more than the global average (62 per cent). Figure 1.2 shows that all 21 countries featured in this report made good progress over this 30-year period, most notably: Bangladesh, Maldives, Mongolia, and Thailand.

As with maternal mortality, progress on neonatal mortality has also slowed in more recent years. Between 2014 and 2022, the global NMR reduced by just 13 per cent, while

in the AP region it reduced by 20 per cent. The region's strongest performers on NMR reduction in recent years include: Bangladesh, India, Maldives, and Sri Lanka. Conversely, Malaysia, Philippines, and Viet Nam made little or no progress on neonatal mortality reduction between 2014 and 2022.

Figure 1.2: Neonatal mortality rate, 1990, 2014 and 2022

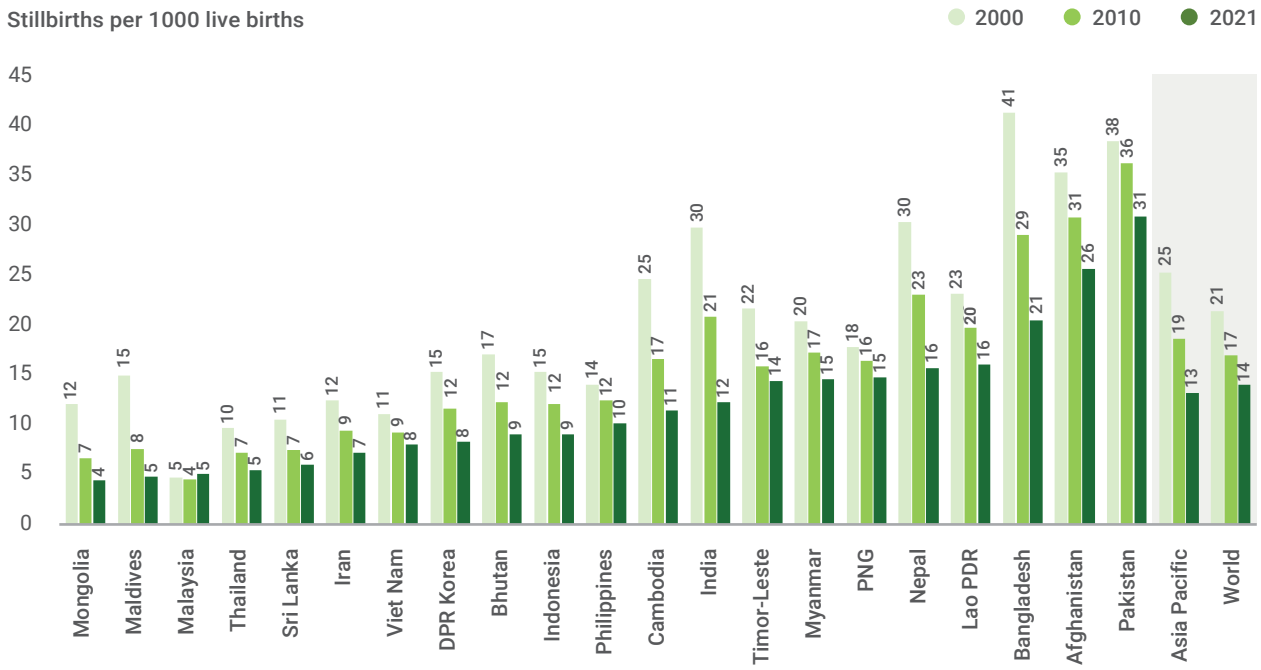


Source for country and world estimates: UN Inter-agency Group for Child Mortality Estimation 2024. [20] This source does not include an estimate for the UNFPA AP region. The regional estimate above was calculated for this report based on the estimated number of neonatal deaths in the above publication and UN population estimates.

In 2021, the estimated number of stillbirths per 1000 total births across the AP region was 13, broadly in line with the global average of 14 (Figure 1.3). Thirteen countries had stillbirth rate estimates below the global average, but two countries (Afghanistan and Pakistan) had estimates of over 25 stillbirths per 1000 births.

Between 2000 and 2021, the global stillbirth rate reduced by 35 per cent, with steady progress over the two decades. The AP region as a whole performed better than the global average, achieving a 48 per cent reduction over this period. Figure 1.3 shows that progress was particularly strong for Bangladesh, Cambodia, India, Maldives, and Mongolia.

Figure 1.3: Stillbirth rate, 2000, 2010 and 2021



Source for country and world estimates: UN Inter-agency Group for Child Mortality Estimation 2024. [23] This source does not include an estimate for the UNFPA AP region. The regional estimate above was calculated for this report based on the estimated number of stillbirths in the above publication and UN population estimates.

Several AP countries are doing relatively well on all three measures of mortality (maternal, neonatal, and stillbirth): Iran, Malaysia, Maldives, Mongolia, Sri Lanka, Thailand, and Viet Nam. By contrast, Afghanistan performs very poorly on all three measures, and Pakistan on neonatal mortality and stillbirth. Generally, the region's upper-middle-income countries have lower mortality estimates than its low- and lower-middle-income countries. The main exceptions are Sri Lanka and Viet Nam, which have low mortality relative to other lower-middle-income countries. Indonesia also performs worse than other upper-middle-income countries, especially on maternal mortality.

The global total fertility rate (average number of children per woman) in 2024 was estimated to be 2.2. The total fertility rate is above the global average in: Afghanistan (4.8), Pakistan (3.6), PNG (3.1), Cambodia (2.6), Mongolia (2.6), Timor-Leste (2.6), and Lao PDR (2.4), while it is very low in Thailand (1.2). [24] Similarly, many countries featured in this report have an adolescent birth rate below the global average of 38 births per 1000 girls aged 15-19, with the lowest rates in: Bhutan, DPRK, Malaysia, and Maldives. However, five countries recorded an adolescent birth rate of over 50: Afghanistan, Bangladesh, Lao PDR, Nepal, and PNG. [24]

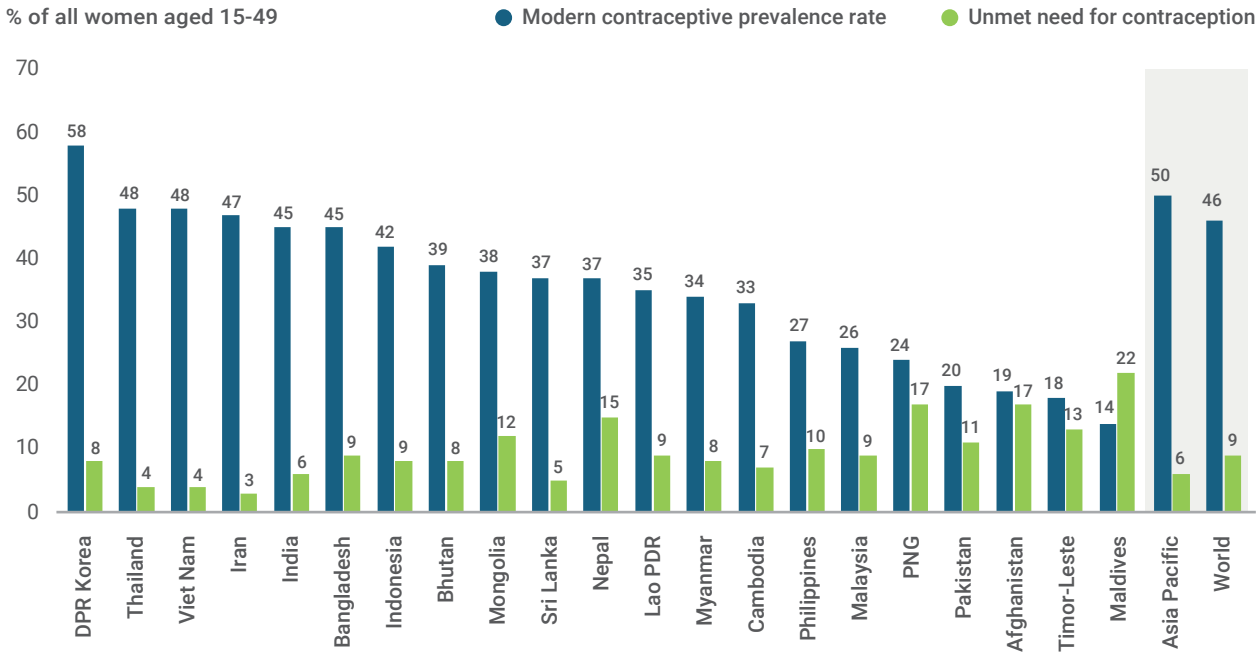
The "Survive, Thrive and Transform" objectives of the *Global Strategy for Women's, Children's and Adolescents' Health* aim not only to reduce preventable deaths, but also to transform societies so that women, children and adolescents everywhere can realise their rights to the highest attainable standards of health and well-being. [25] SRMNAH is an essential component of the SDGs, particularly SDG3 and SDG5: to "achieve gender equality and empower women and girls". [22]

Health and well-being are dependent on access to health services across the life course. In the case of SRMNAH, the life course includes adolescent sexual and

reproductive health, pre-pregnancy, antenatal, childbirth and postpartum care. Figure 1.4 shows that the global average modern contraceptive prevalence rate (mCPR) is 46 per cent. The average across the AP countries featured in this report is broadly in line with this global average. The mCPR is particularly high in DPRK. By contrast, the mCPR is extremely low in Afghanistan, Maldives, and Timor-Leste. This indicates a very high level of diversity within the region when it comes to access to, and use of, modern contraceptives.

AP countries with a relatively high mCPR also tend to have relatively low unmet need for contraception – below the global average of 9 per cent. The level of unmet need is also relatively low in Sri Lanka. Conversely, four countries have an unmet need of 15 per cent or higher: Afghanistan, Maldives, Nepal, and PNG.

Figure 1.4: Modern contraceptive prevalence rate and unmet need for contraception (all women aged 15-49), most recent available year



Source: UNFPA 2024. [26]

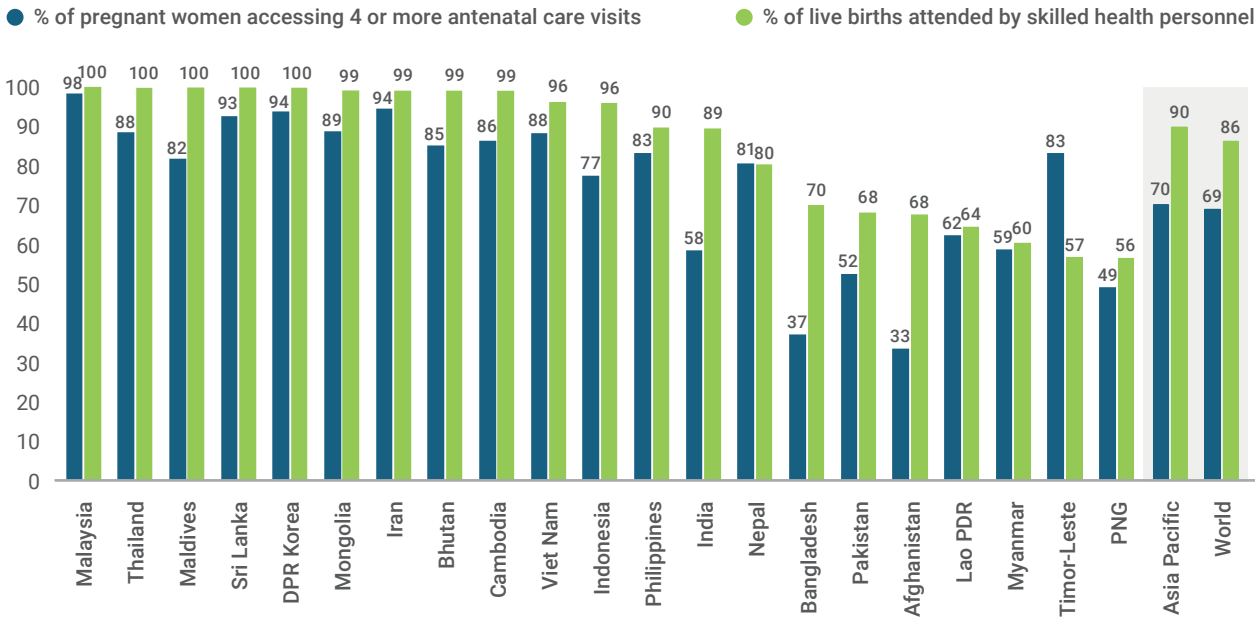
Another critical aspect of obtaining adequate SRMNAH care is access to comprehensive and high-quality antenatal, childbirth, and postnatal care for pregnant women and newborns. Figure 1.5 shows that the global average rate of skilled birth attendance (SBA) is 86 per cent, and the average for the region is very similar at 90 per cent. However, three countries report a rate of 60 per cent or below: Myanmar, PNG, and Timor-Leste.

In the AP region as a whole, 70 per cent of pregnant women access four or more antenatal care (ANC) visits, which is virtually identical to the global average of 69 per cent (Figure 1.5). However, ANC coverage is below 50 per cent in Afghanistan, Bangladesh, and PNG.

Rates of postnatal care (PNC) for mothers in the region are also similar to the global average of 69 per cent. [27] The lowest levels

of PNC coverage are in Afghanistan, Bhutan, and Timor-Leste, and also Myanmar for newborns. The highest levels (over 90 per cent) are in DPR Korea, Mongolia, and Sri Lanka. In most countries, PNC coverage rates for mothers are similar to coverage rates for newborns. The main exceptions are: Bhutan, Indonesia and Myanmar (where mothers are more likely than newborns to receive a postnatal check within two days) and India (where the opposite is true).

Figure 1.5: Accessing antenatal care and skilled birth attendance, most recent available year



Source: UNICEF 2024. [27]

As well as ensuring that all women and newborns who need high-quality care are able to access it, it is also important to avoid intervening when not clinically necessary. Birth by caesarean section is becoming increasingly common in many countries, and when medically necessary, this intervention saves lives. However, there is no evidence that a caesarean birth rate above 10 per cent reduces the rate of maternal and newborn death. [28] Rates much above 10 per cent may be indicative of unnecessary intervention, and rates below 10 per cent may be indicative of insufficient access. Within the AP region, there is huge variation in caesarean birth rates. For example, four of the countries featured in this report have a caesarean birth rate below 10 per cent (Afghanistan, Lao PDR, PNG, and Timor-Leste), and six have a rate above 30 per cent (Bangladesh, Iran, Maldives, Sri Lanka, Thailand, and Viet Nam). [27]

Chapter 2:

The state of the workforce

Photo credit: UNFPA Bangladesh / Allison Joyce

This chapter provides a situation analysis by describing and analysing workforce data from 18 of the 21 participating countries: Bangladesh, Bhutan, Cambodia, DPR Korea, Indonesia, Iran, Lao PDR, Malaysia, Maldives, Mongolia, Nepal, Pakistan, Papua New Guinea (PNG), Philippines, Sri Lanka, Thailand, Timor-Leste, and Viet Nam. At the time of data collection, it was not possible to obtain accurate data from Afghanistan, India, and Myanmar. Where feasible, comparisons are made against previous midwifery workforce reports, and future projections are made of the supply of midwives.

Defining midwives and other SRMNAH workers

The occupations considered to be part of the SRMNAH workforce in this report are: professional and associate professional midwives and nurses, 'SRMNAH doctors' (general medical practitioners, obstetricians/gynaecologists (ob/gyns), and paediatricians), paramedical practitioners, and community health workers (CHWs). Traditional birth attendants are not included because, although they attend a significant proportion of births in some countries and can play a role in community engagement and support, many are not formally educated, trained or regulated. Conversely, CHWs are included: although they are variously defined and have differing competencies, they play an important role in many countries in delivering a small number of essential SRMNAH interventions. The inclusion of workers such as CHWs and associate professionals is not meant to imply that they are all able to provide the same level of care as a professional midwife. It simply means that they can provide a limited range of essential interventions and can thus contribute to meeting population need for SRMNAH care.

This report focuses primarily on midwives, because – if available in sufficient numbers and if fully educated, regulated and integrated within an interdisciplinary team – midwives can meet about 90 per cent of the need for essential SRMNAH interventions. [12] To understand their pivotal role it is necessary also to define and consider their place within the wider SRMNAH workforce in a country. This report uses international definitions of health occupations to enable comparison between countries and the International Standard Classification of Occupations (ISCO) system [29] to classify the SRMNAH workforce into occupation groups based on their roles and responsibilities (see Annex and SoWMy 2021 webappendix 1 [15]). Not all of these occupations exist in every country, but where they do exist, and where data are available, they are included in the analysis.

The ISCO system classifies midwives as either "professionals" or "associate professionals". The definition of midwifery professionals is those who "*plan, manage, provide and evaluate midwifery care services before, during and after pregnancy and childbirth. They provide delivery care for reducing health risks to women and newborn children, working autonomously or in teams with other health care providers*." Midwifery associate professionals "*provide basic health care and advice before, during and after pregnancy and childbirth. They implement care, treatment and referral plans usually established by medical, midwifery and other health professionals*." [29]

The ISCO definition focuses on what the midwife does in her job, and does not take into account the midwife's competency to perform this role. This means that the definition of a midwife in this report is not fully aligned with the International Confederation of Midwives (ICM) definition of a midwife, which is: "*a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education, recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or*

legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the scope of practice of the midwife." [30] National human resources for health information systems do not generally yield counts of the number of midwives who meet the ICM definition.

In this report, 'nurses' are defined as those working in nursing roles with no midwifery component. Like midwives, nurses are sub-divided into professionals and associate professionals according to ISCO definitions relating to roles and responsibilities. In addition, many countries have nurse-midwives, who provide both nursing care and midwifery care. To avoid double-counting, in this report nurse-midwives are counted as midwives rather than nurses. **Throughout this report, therefore, the word 'midwives' includes both midwives and nurse-midwives, unless otherwise stated**.

Current workforce availability and composition

The main focus of this chapter is on midwives, nurses and doctors as the three main occupations involved in the provision of SRMNAH care. Numbers for CHWs, paramedical practitioners and medical assistants are shown in the individual country profiles for the countries where these occupations are relevant, in the final section of this report.

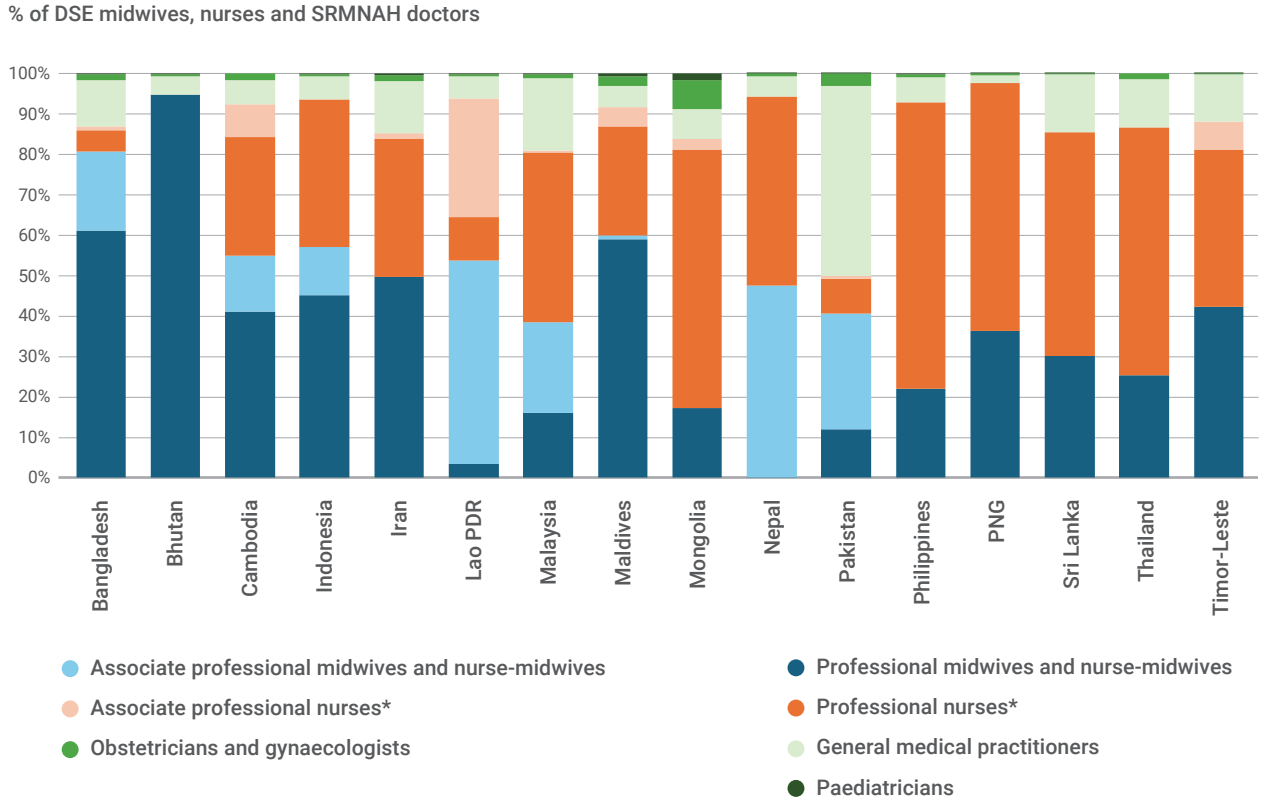
The survey on which this report is based included a section requesting a review of the most recent SRMNAH workforce headcounts contained within WHO's National Health Workforce Accounts (NHWA) platform. This platform uses ISCO definitions to classify health workers. Countries were asked either to confirm that the NHWA headcounts were the most recent and accurate available, or to provide updated headcounts and a data source. Several countries provided updated headcounts and sources, and for these countries the NHWA numbers were replaced by these new data. Subsequently (in December 2024), the NHWA platform published updated headcounts, so for countries who opted to use NHWA numbers, this report contains these updated NHWA headcounts.[3] The country profiles indicate which data source was used for each country.

SRMNAH workforce composition

Figure 2.1 illustrates the variation between countries in how they configure their SRMNAH workforces. Countries with large blue sections – such as Bangladesh and Bhutan – have large numbers of midwives/nurse-midwives in relation to the number of nurses, and those with large red sections – such as Mongolia and Philippines - have relatively large numbers of nurses. Pakistan stands out for its large number of medical doctors. DPRK and Viet Nam are excluded from Figure 2.1 because of missing data for one or more of the relevant occupations.

[3] Exception: Afghanistan.

Figure 2.1: SRMNAH workforce composition



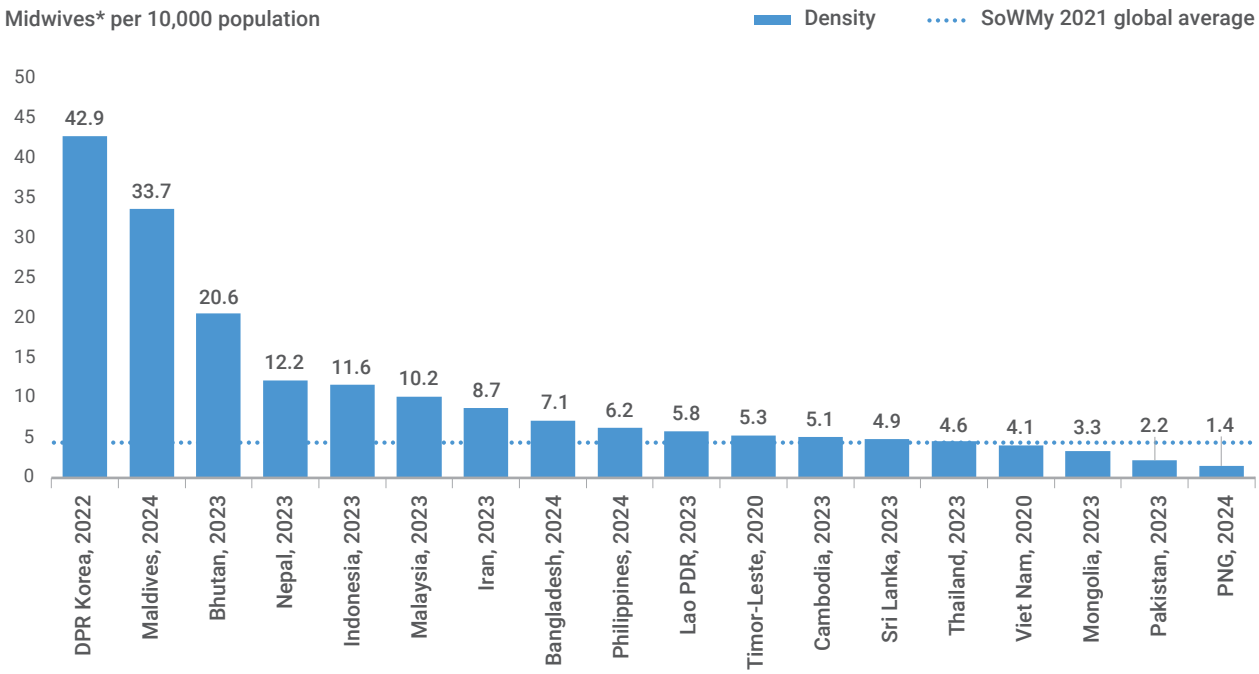
* Including professional and associate professional nurses, excluding nurse-midwives and associate nurse-midwives.
DSE = dedicated SRMNAH equivalent (headcounts adjusted for % of time spent on SRMNAH care).

Current availability of midwives

Figure 2.2 shows the considerable variation in midwife density across the responding countries, ranging from 42.9 midwives per 10,000 population in DPRK to 1.4 in PNG. The WHO estimates that countries with fewer than 25 doctors, nurses, and midwives per 10,000 population will fail to achieve adequate coverage rates for important primary health care interventions. [31] This threshold, while applying to primary healthcare interventions generally rather than SRMNAH needs specifically, can still give a sense of the minimum necessary health workforce density in any given country. Four of the participating countries have a midwife density below the 2021 global average of 4.4: Mongolia, Pakistan, PNG and Viet Nam.

In interpreting Figure 2.2, it should be noted that efforts to compare midwife density between countries are potentially confounded by inconsistent definitions of who counts as a midwife. Country classification systems have become more harmonised over time, but in some countries it remains difficult to provide headcounts according to the requested classifications. These definitional challenges may be the reason for some of the observed variation between countries.

Figure 2.2: Midwife density, most recent available year

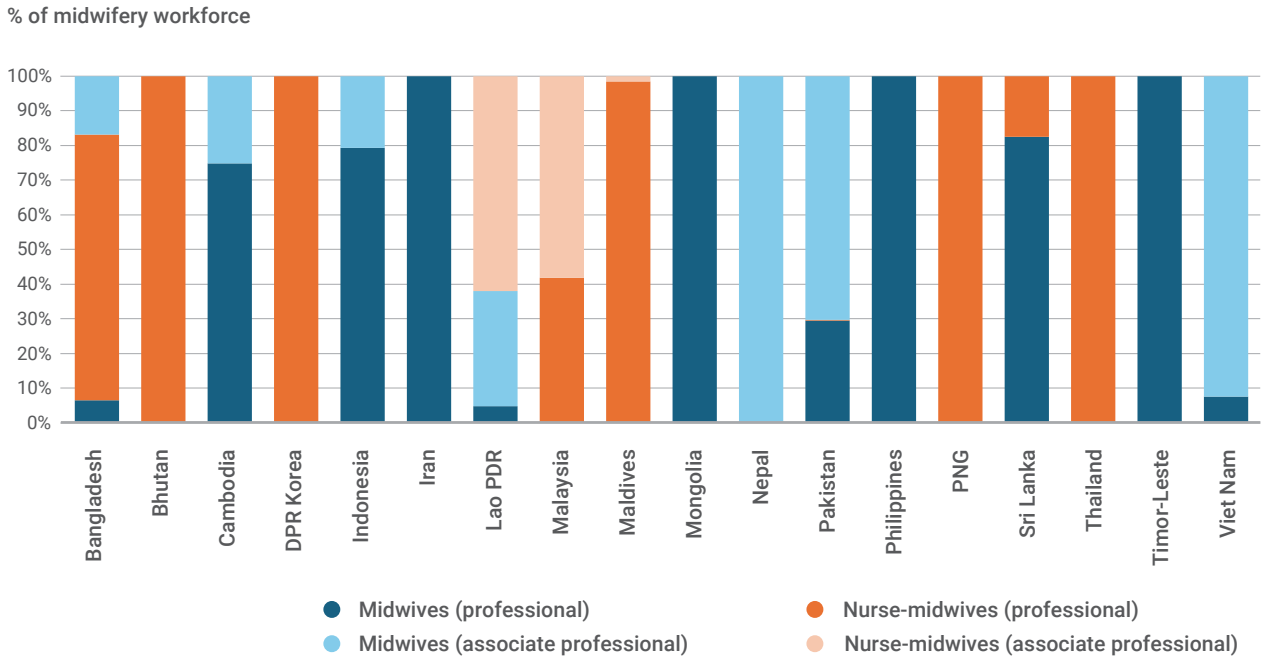


* Including professional and associate professional midwives and nurse-midwives. Note: For Lao PDR, the data for some types of midwife dates from 2023, and for other types from 2020.

Figure 2.3 shows the different types of midwives in the workforce in each participating country. In seven countries, the midwifery workforce is composed entirely, or almost entirely, of professional midwives: Cambodia,[4] Indonesia, Iran, Mongolia, Philippines, Sri Lanka, and Timor-Leste. In a further six countries (Bangladesh, Bhutan, DPRK, Maldives, PNG, and Thailand), the midwifery workforce consists entirely or almost entirely of professional nurse-midwives. The remaining five countries have a large number of associate professional midwives or nurse-midwives in the workforce: Nepal, Pakistan, and Viet Nam have associate professional midwives, Malaysia has associate professional nurse-midwives, and Lao PDR has both. Associate professionals have a relatively narrow scope of practice and can therefore safely provide only some of the essential SRMNAH interventions.

[4] Although Cambodia has a post-nursing education programme, all of the graduates of that programme are counted as professional midwives (as opposed to professional nurse-midwives).

Figure 2.3: Composition of the midwifery workforce



Analysis conducted for this report (see Annex) indicates that at least five countries have a needs-based shortage of midwives (Table 2.1), with a particularly large shortage in Pakistan. This means that in these countries, the current midwifery workforce is not sufficient to meet even the most basic population need for essential SRMNAH interventions. As noted in the table, the change over time for Pakistan is largely due to changes in the way the country chose to classify its midwives and nurses. For three of the other four countries, it is encouraging to note that the estimated shortage is smaller than it was in 2021 (exception: Timor-Leste, where the shortage estimate remains the same as in 2021). Nevertheless, the shortages in some countries remain severe. For example, to eliminate its shortage, PNG would need 2.6 times as many midwives as it currently has, and Pakistan would need 1.6 times as many midwives.[5]

[5] Workforce growth of this magnitude would eliminate the current shortage. In addition, future planning must account for growing need, for example due to population growth.

Table 2.1: Countries estimated to have a needs-based shortage of midwives, 2021 and 2024

Country	Midwife shortage 2021	Midwife shortage 2024	2024 shortage as a % of current headcount
PNG	4,300	3,900	261%
Pakistan*	3,100	81,900	158%
Mongolia	500	300	24%
Lao PDR	1,200	500	15%
Timor-Leste	100	100	8%

Notes: Shortage estimates are rounded to the nearest 100. Estimates take into account that nurse-midwives may not spend all of their clinical time on midwifery. * The increase since 2021 is mainly due to a change in classification – most of Pakistan's midwives used to be classed as professional, but now most are associate professional. Associate professionals are assumed to have a narrower range of competencies.

In addition to the countries shown in the table, it is highly likely that other countries in the region have significant midwife shortages, but the lack of recent headcount data makes them impossible to quantify. One example is India, which is in the early stages of implementation of a national Midwifery Services Initiative which includes the production of midwives who meet global standards, but it will take time to produce the desired number of midwives. Afghanistan, DPRK, Myanmar, and Viet Nam were also excluded from the shortage estimation due to insufficient data. Following the cessation of midwifery education in Afghanistan, the future scenario for the midwifery workforce is dire.

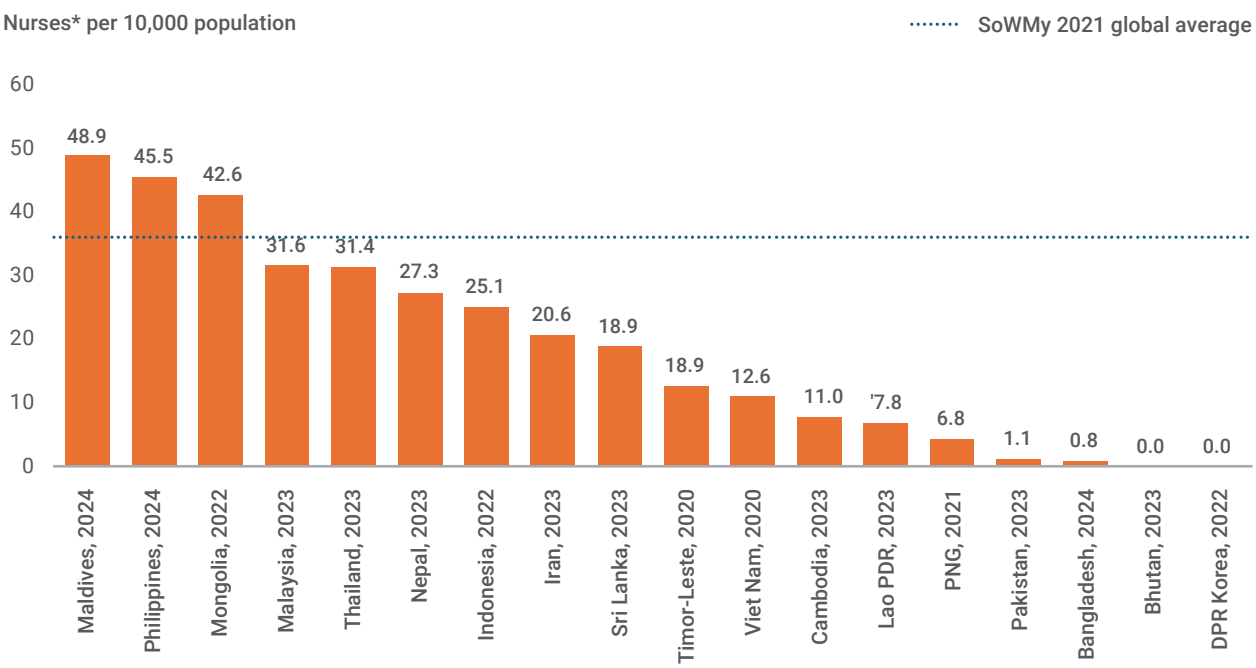
Other countries that are not shown in Table 2.1 are estimated to have no needs-based midwife shortage. In interpreting this finding, however, it is important to note the limitations of the methodology. The shortage estimates are calculated at a national level so do not take into account subnational shortages due to geographical maldistribution of midwives. A country with no overall shortage could, therefore, still have shortages in some parts of the country. The method for estimating the shortage also assumes that the country's midwives and nurse-midwives are competent to provide all the interventions within the ICM definition of the midwife's scope of practice. If this is not the case in a country, even if the midwife headcount is adequate, the workforce will not be able to meet all of the need for essential midwifery interventions.

Current availability of other SRMNAH workers

The health workforce is most effective when it operates within a fully enabled health system/work environment, with each person working to their full scope of practice, so the team collectively possesses all the competencies required to provide high-quality, respectful care. [32] The availability of midwives must therefore be considered in the context of availability of other key SRMNAH workers, especially nurses and SRMNAH doctors.

Figure 2.4 shows that most of the countries featured in this report have a nurse[6] density below the 2021 global average (exceptions: Maldives, Mongolia, Philippines). The lowest nurse densities (fewer than 5 per 10,000) are observed in: Bangladesh, Bhutan, DPRK, Pakistan, and PNG. However, in the cases of Bangladesh, Bhutan and DPRK this is because all (or nearly all) of their nurses have been counted in this report as nurse-midwives.

Figure 2.4: Nurse density, most recent available year

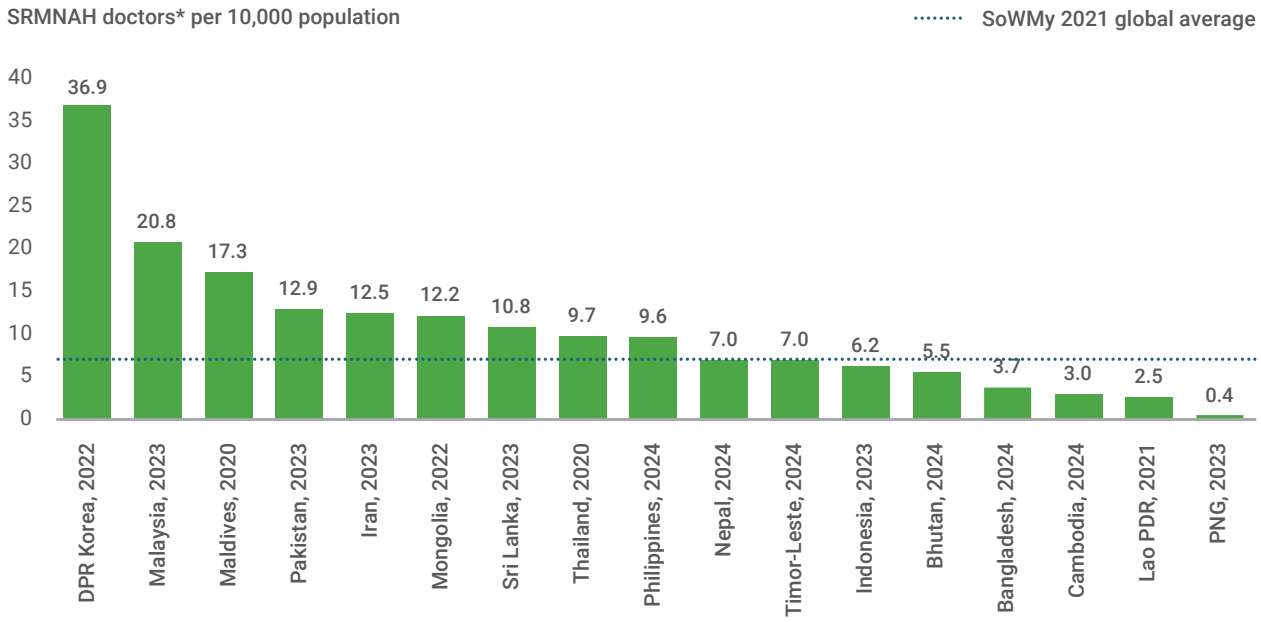


* Including professional and associate professional nurses, excluding nurse-midwives and associate nurse-midwives.

[6] Excluding nurse-midwives, who are counted as midwives in this report.

Figure 2.5 shows that nine of the participating countries have an SRMNAH doctor density above the 2021 global average, with an especially high figure in DPRK. Conversely, extremely low densities (3.0 or below) are reported in Cambodia, Lao PDR, and PNG. Viet Nam is excluded from Figure 2.5 due to lack of data on doctor numbers.

Figure 2.5: SRMNAH doctor density, most recent available year



* General medical practitioners, obstetricians and gynaecologists, and paediatricians.

Trends over time in SRMNAH worker availability

For some countries, the composition of the midwifery workforce as shown in Figure 2.3 is very different from that reported in SoWMy 2021. In particular:

- Bangladesh showed a mix of professional and associate professional midwives in 2021, but now it also reports a large number of nurse-midwives
- In 2021, Bhutan and Thailand reported no midwives or nurse-midwives at all, but now they do report nurse-midwives in the workforce
- In 2021, DPRK, Mongolia and Viet Nam declared midwives in their workforce without specifying whether they were professionals or associate professionals. Now DRPK reports nurse-midwives rather than midwives, Mongolia reports that all its midwives are professionals, and Viet Nam reports a mix of professional and associate professional midwives (mostly associate professional)
- In 2021, Indonesia's midwifery workforce was nearly all midwifery associate professionals, but now it consists mostly of midwifery professionals
- Pakistan reported a mix of professional midwives and professional nurse-midwives in 2021, whereas now its midwifery workforce consists mostly of associate professional midwives

However, it is important to note that it is unlikely that the midwifery workforces of these countries have changed so completely in just a few years. It is more likely that their approach to health worker classification has

changed, hopefully towards a more accurate reflection of the composition of the midwifery workforce in each country.

Out of the participating countries, 15 provided midwife headcounts for both SoWMy 2021 and this regional report, and do not appear to have made any major changes to the way they distinguish between midwives and nurses. For these 15 countries, therefore, it is possible to assess the extent to which midwife availability has changed over the last few years. In nine countries, midwife density has increased (indicated by green shading in Table 2.2), and in four countries it has decreased (indicated by red shading in Table 2.2). In Mongolia and Timor-Leste, midwife density has barely changed.

Table 2.2: Change over time in midwife* density

Country	2021	2024	Per cent change 2021-2024
Maldives	31.7	33.7	+6
Nepal	11.8	12.2	+4
Indonesia	16.7	11.6	-30
Malaysia	11.8	10.2	-14
Iran	4.4	8.7	+100
Bangladesh	3.9	7.1	+82
Philippines	7.0	6.2	-11
Lao PDR	3.9	5.8	+48
Timor-Leste	5.2	5.3	+2
Cambodia	4.3	5.1	+18
Sri Lanka	4.6	4.9	+5
Viet Nam	3.0	4.1	+36
Mongolia	3.3	3.3	+1
Pakistan	3.6	2.2	-40
PNG	0.8	1.4	+87

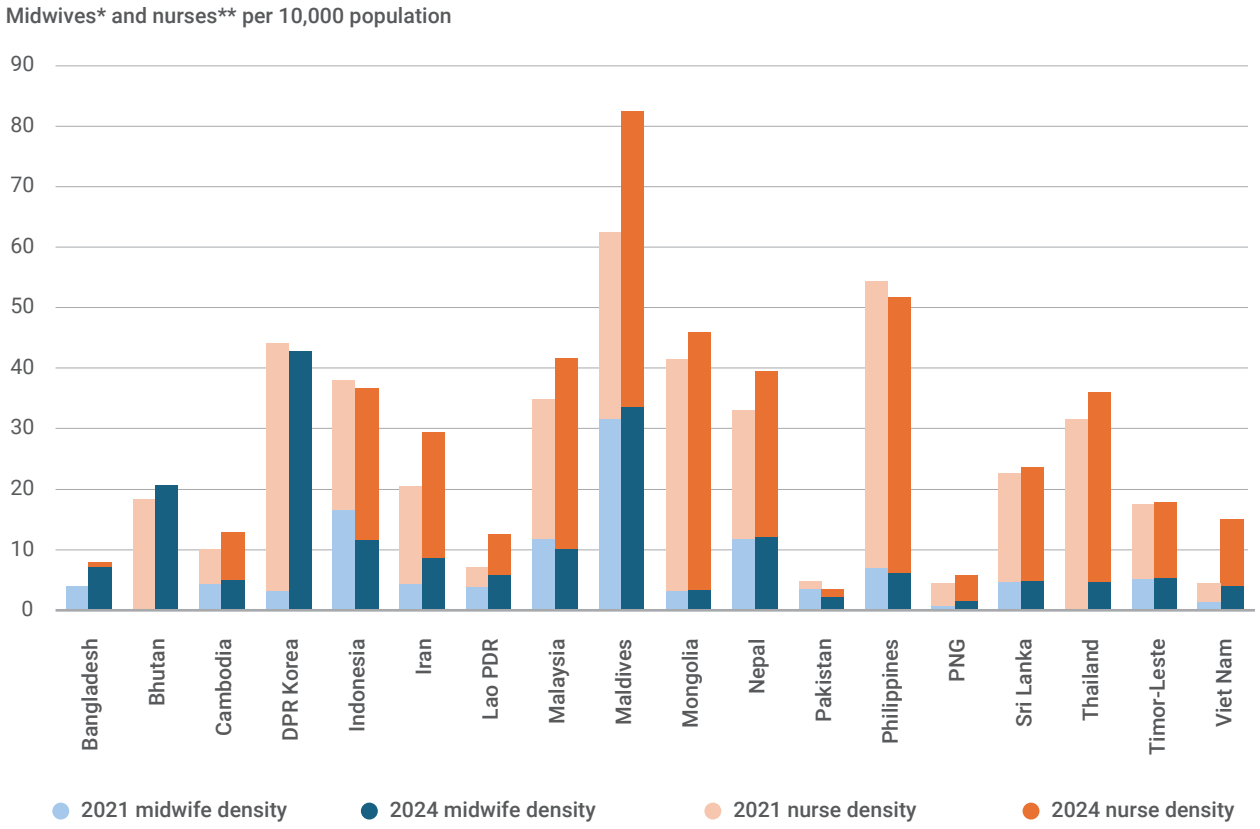
* Including professional and associate professional midwives and nurse-midwives.

Country-level estimates of nurse density changed relatively little between SoWMy 2021 and this regional report. The main exceptions are Bhutan and DPRK, whose nurse density estimates are lower in 2024 than they were in 2021 because of changes in how these countries have chosen to classify their nurses and midwives. All of Bhutan's and DPRK's nurses have been classed this report as nurse-midwives, whereas in 2021 they were classified as nurses.

Given that some countries have changed the way they classify midwives and nurses since 2021, Figure 2.6 helps to interpret the observed changes in midwife and nurse density. The bars show the total midwife and nurse density, sub-divided into midwives (blue sections) and nurses (red sections). This

confirms that the current total density of nurses and midwives in Bhutan and DPRK is very similar to that reported in 2021. This chart also provides evidence that the growth in midwife density in the countries shaded green in Table 2.2 is real, and not simply an artifact of changing methods of occupation classification.

Figure 2.6: Total midwife and nurse density, 2021 and 2024



* Including professional and associate professional midwives and nurse-midwives.
** Including professional and associate professional nurses, excluding nurse-midwives and associate nurse-midwives.

More countries were able to provide headcounts for the three types of medical doctor that are classified as 'SRMNAH doctors' than was the case in SoWMy 2021. At that time, a large number of countries provided data only for the total number of medical doctors, which included doctors working in other branches of medicine. Among those countries providing the requested data in both 2021 and 2024, six report growth in SRMNAH doctor density (Bhutan, Indonesia, Iran, Maldives, Nepal, and Sri Lanka) and two report reduced SRMNAH doctor density (Mongolia and Philippines).

Future workforce availability

Domestic production of new graduate midwives

Most of the participating countries provided estimates of the number of new graduate midwives in 2023 (Table 2.3). The largest numbers of new graduate midwives were produced in Bangladesh, Iran, and the Philippines. Lao PDR and Timor-Leste also produced large numbers of new graduates, relative to the size of their current midwifery workforce. Large numbers of nurse-midwives were also produced in Bangladesh and

Malaysia. Many countries with associate professional midwives and associate professional nurse-midwives in the workforce - such as Bangladesh and Nepal - have stopped producing them, in a move towards professionalisation of midwifery.

Table 2.3: New midwife graduates in 2023, by type of midwife

	Midwifery professionals		Midwifery associate professionals		Nurse-midwife professionals	
	n	% of current headcount	n	% of current headcount	n	% of current headcount
Bangladesh	3,000	38	na	na	15,000	16
Bhutan	na	na	na	na	201	12
Cambodia	498	8	na	na	na	na
DPR Korea	na	na	na	na	-	-
Indonesia	-	-	-	-	na	na
Iran	3,000	4	na	na	na	na
Lao PDR	174	84	na	na	na	na
Malaysia	na	na	na	na	789	5
Maldives	na	na	na	na	8	0.5
Mongolia	52	5	na	na	na	na
Nepal	35	38	na	na	na	na
Pakistan	0	0	-	-	19	19
PNG	na	na	na	na	84	6
Philippines	6,000	8	na	na	na	na
Sri Lanka	997	11	na	na	-	-
Thailand	na	na	na	na	240	1
Timor-Leste	359	53	na	na	na	na
Viet Nam	-	-	-	-	na	na

na = country is not producing graduates in this occupation group. - = no data.

Future projections of midwife shortages

If the participating countries continue to produce new graduate midwives and nurse-midwives at current rates, and are able to employ them all (which is known to be a major challenge in many countries), only two of the participating countries are projected to have a needs-based midwife shortage by 2030: Pakistan (75,700) and PNG (3,700). In addition, as noted above, several other countries are likely to have a midwife shortage in 2030, but without more detailed data on current midwife availability, the predicted shortage cannot be quantified.

Countries with a shortage will need to accelerate current production - and all countries will need to ensure maximum absorption of graduates into the workforce - in order to avoid midwife shortages in 2030.

It is notable that several countries were not able to provide graduate numbers (see Table 2.3). For these countries, it was necessary to make assumptions about graduate numbers in order to make future projections. All projections are based on assumptions and should be treated with caution, but a greater degree of caution is advised for countries with missing graduate numbers.

Chapter 3:

An enabling environment for midwives

Photo credit: © UNFPA Myanmar / Nowai Linn

SoWMy 2021 recommended bold investments in midwifery in four key areas: (i) health workforce planning, management and regulation and the work environment, (ii) high-quality education and training for midwives, (iii) midwife-led improvements to service delivery, and (iv) midwifery leadership and governance. This chapter assesses the current state of the work environment for midwives in these four areas.

This chapter includes data from 20 of the 21 participating countries: Afghanistan, Bangladesh, Bhutan, Cambodia, DPR Korea, India, Indonesia, Iran, Lao PDR, Malaysia, Maldives, Mongolia, Nepal, Pakistan, Papua New Guinea (PNG), Philippines, Sri Lanka, Thailand, Timor-Leste, and Viet Nam. At the time of data collection, it was not possible to obtain data from Myanmar.

Workforce planning, management, regulation and work environment

Midwife 'brain drain'

Despite improvements in the availability of workforce data as reported in Chapter 2, some gaps remain - including data on midwife recruitment, deployment and retention. Anecdotal evidence suggests that international out-migration ('brain drain') and geographical maldistribution are important challenges for some countries in the region. However, in the survey on which is report is based, just three countries identified midwife 'brain drain' as a "big problem": Afghanistan, Bhutan, and PNG. Of these three countries, only Bhutan stated that the government has officially acknowledged the problem. Furthermore, two countries (Cambodia and Viet Nam) stated that they have more in-migration of midwives than out-migration. No respondents indicated that their country deliberately over-produces midwives for export to other countries.

Some of the countries that did not identify midwife brain drain as a big problem indicated that this is largely because not enough is known about international migration to make a judgement. The survey responses from Indonesia, Nepal, and PNG acknowledged that there is no established mechanism for monitoring out-migration, which makes it difficult to establish the extent to which it is a problem. The responses from Malaysia and Philippines mentioned a concerted effort to collect more comprehensive data so as to better understand international migration patterns. Malaysia is doing this through WHO's NHWA platform, and in the Philippines a request has been made to the Department of Migrant Workers to collect additional data to aid understanding of out-migration.

Responses from a few countries suggest that brain drain is a bigger issue for nurses than for midwives. For example, the response from Pakistan noted that there are fewer opportunities for its midwives to seek work abroad, because its midwifery programme does not produce midwives educated according to global standards.

Rural midwife retention efforts

Rural and remote communities face particular challenges in accessing health facilities and health workers. It is therefore vital to encourage midwives to take up rural positions, and to support them to remain in post. The story in Box 3.1 emphasises the vital work that midwives perform in rural parts of Mongolia.

Box 3.1: The life of a rural midwife in Mongolia

Batkhuu Jigjidsuren has been working as a midwife for 38 years and is based in Erdenesant Soum of Tuv Province, 216km from the capital city Ulanbaatar. She explains that there is a great need for midwives in soums. By living and working at the soum, the midwife can provide emergency care. "*When a woman comes to the health centre to give birth, other staff do not know how to treat the patient. This is why midwives are essential to mothers, and babies. That is why it is impossible to imagine a soum without a midwife*."

The work of a midwife is significantly influenced by climate and natural phenomena. "*There are blizzards in the winter, and in summer there can be rains and floods. Some nights are freezing cold. We work tirelessly to deliver a healthcare service to a person in some way, regardless of the cold. Especially this winter, we had a lot of snowfall. We travelled some 12 hours to get to see a patient. The car would break down on the way, or we would run out of gasoline, we would get lost without finding our destination as the road vanishes under the snow. Sometimes, we followed the bulldozer that was used to clear a path to a household. On occasions, I would ask for a horse from a patient's home, and I would go there on horseback to deliver the assistance. In summer, the rivers flood and it becomes very difficult to cross the river. You can see your patient across the river, but you can't go there because of the flood*."

Batkhuu tells of a family whose three children she has delivered. "*I went to Yanjmaa's home to pick her up because it was her due date, but the ambulance was stuck in the snow, and I could not come. Then the next day, I travelled again, and she also rode for us to meet in the middle*." Purevkhishig. S, husband of Yanjmaa and a herder in the area, says: "*This winter was very cold and snowy. When my wife was about to give birth, I cleared the path to my home by digging 1-2 meters deep snow in the ravine. But the next wind will bring more snow, so I dug again. After lots of digging, we finally met the midwife. We are very grateful to Batkhuu*."

Recently, midwives are in short supply - there are only 4 or 5 soums with midwives in Tuv Province. Batkhuu sees many advertisements for hiring midwives and hears that some are daunted by the responsibility of a midwife for the lives of two people. "*Also, I think midwives do not want to come to work in rural areas. I think there are several reasons, including issues such as salary, housing and unemployment of a partner*." She also identifies a gap in training the next generation of midwives - her health centre is training up the next midwife to serve there.

"*I feel very grateful and satisfied when the baby is delivered safely, and the mother has no complications. I think my job is the best because it brings happiness to a family*."

Photo credit: © UNFPA Mongolia

In 2021, WHO published updated guidance on health workforce recruitment and retention in rural and remote areas, which included recommendations in four spheres of influence: education, regulation, incentives, and support. [33] Figure 3.1 shows that just over half of the responding countries featured in this report are currently trying to improve the availability of midwives in rural areas by implementing at least one of these types of recommendations. The reported actions focus primarily on midwife education, but a few countries are implementing interventions relating to regulation, incentives and support.

Figure 3.1: Actions on rural recruitment and retention

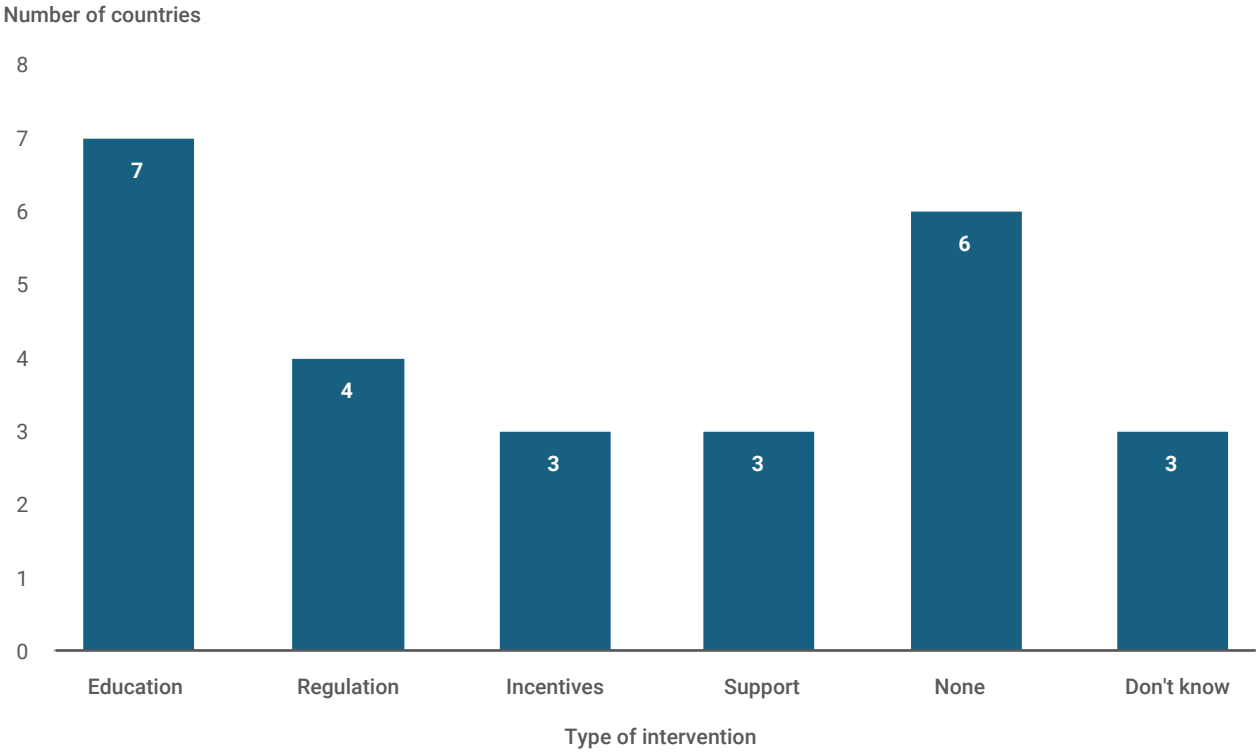


Table 3.1 provides more detail on some of the specific actions taken by participating countries to improve the availability of midwives in rural and remote areas. Bangladesh and Cambodia stand out as the only countries to take action in more than two of the four spheres of influence, indicating awareness of the importance of taking a multi-faceted approach to addressing the complex range of causes of rural midwife shortages.

Table 3.1: Actions on rural recruitment and retention of midwives

Type of action	Country/ies implementing	Examples
Education / training interventions	Afghanistan, Bangladesh, Cambodia, Maldives, Pakistan, PNG, Philippines	In **Afghanistan*** and **Pakistan**, women from remote areas are selected to be trained as community midwives. **Afghanistan** also introduced a 3-month refresher and competency-based training for unemployed midwives and deployed them to remote locations. **Bangladesh** has quotas and scholarships to encourage rural women to train as midwives. In **PNG**, rural applicants are given priority for admission to midwife education programmes. Nurses based on smaller islands in **Maldives** are given paid study leave to attend a post-nursing midwifery education programme.
Regulation interventions	Bangladesh, Cambodia, Nepal, Thailand	In **Bangladesh**, new graduate midwives are required to work in rural health facilities for at least two years before they may apply for an urban posting. **Cambodia** sets quotas for the number of midwives deployed to rural health centres.
Financial and non-financial incentives	Bangladesh, Cambodia, Malaysia	Midwives working in remote parts of **Bangladesh** and **Malaysia** are eligible for a hardship allowance, and in some areas of Bangladesh housing is provided. **Cambodia** offers a 'live birth incentive' for midwives.
Support interventions	Cambodia, Malaysia, Philippines	In **Malaysia**, funding is available to support an annual visit to the midwife's home town, including spouse and children. The **Philippines** has an infrastructure development programme to support rural midwives' practice.

* This was true at the time of data collection, but in November 2024 all education of women and girls was stopped, and the current situation is not clear.

Policy environment

The SoWMy 2021 report found that globally, three-quarters of countries had legislation recognising midwifery as distinct from nursing. In 2024, all responding countries in this report had such legislation, except Bhutan where midwifery is still practiced under the nursing qualification. This is a positive change since the global SoWMy report in 2014, when most of the participating AP countries did not have such legislation (Table 3.2). Three countries report the introduction of legislation since the 2021 global SoWMy report: Bangladesh, India, and Thailand.

Table 3.2: Legislation recognising midwifery as a profession distinct from nursing

Country	2014	2021	2024	Explanatory notes
Afghanistan	×	✓	✓	
Bangladesh	×	×	✓	First midwives were licensed in 2016
Bhutan		×	×	
Cambodia	*	✓	✓	
DPR Korea	×		✓	
India	×	×	✓	National Nursing and Midwifery Act 2023
Indonesia	×	✓	✓	
Iran		✓	✓	
Lao PDR	×	✓	✓	Health Care Law 2023 reinforced the distinction
Malaysia			✓	
Maldives			✓	
Mongolia		✓	✓	A new midwife job description was approved in 2024, and a midwifery development strategy is awaiting MoH approval
Nepal	×	✓	✓	
Pakistan	✓		✓	Nursing and Midwifery Act 1973, updated 2023
Philippines		✓	✓	Nursing and Midwifery Act 1960, updated 1992
PNG	×	✓	✓	In addition, the country's first midwifery policy is awaiting endorsement
Sri Lanka			✓	
Thailand		×	✓	
Timor-Leste		✓	✓	
Viet Nam	×	✓	✓	

Grey shading indicates no data for that year. * Cambodia responded 'no' to the SoWMy 2014 survey, but the 2006 Royal Decree on Establishing Cambodian Midwives Council was in place at that time.

Scope of practice

A midwife who is educated and regulated according to ICM global standards should be able to provide all modern methods of contraception, all seven basic emergency obstetric and newborn care (BEmONC) signal functions, and a range of other essential interventions including post-abortion care (PAC), and care after obstetric fistula surgery. In the survey, respondents were asked to state which of a list of 15 interventions midwives are authorised to provide in their country, and the results are summarised in Figure 3.2.

In all 20 responding countries midwives are authorised to provide contraceptive pills and newborn 'bag and mask' resuscitation, and in nearly all responding countries they are authorised to provide oxytocics as a uterotonic (exception: Sri Lanka[7]), emergency contraception (exception: Thailand), and post-abortion care (exception: DPRK). The interventions most commonly excluded from the midwife's scope of practice are: medical abortion, assisted instrumental delivery by vacuum extraction (VAD), manual vacuum aspiration (MVA), obstetric fistula care/ rehabilitation, and contraceptive implants.

[7] The respondent(s) from Sri Lanka did not answer the question about oxytocics, so it is possible that Sri Lankan midwives can provide this intervention.

Figure 3.2: Number of countries where midwives are authorised to provide essential interventions

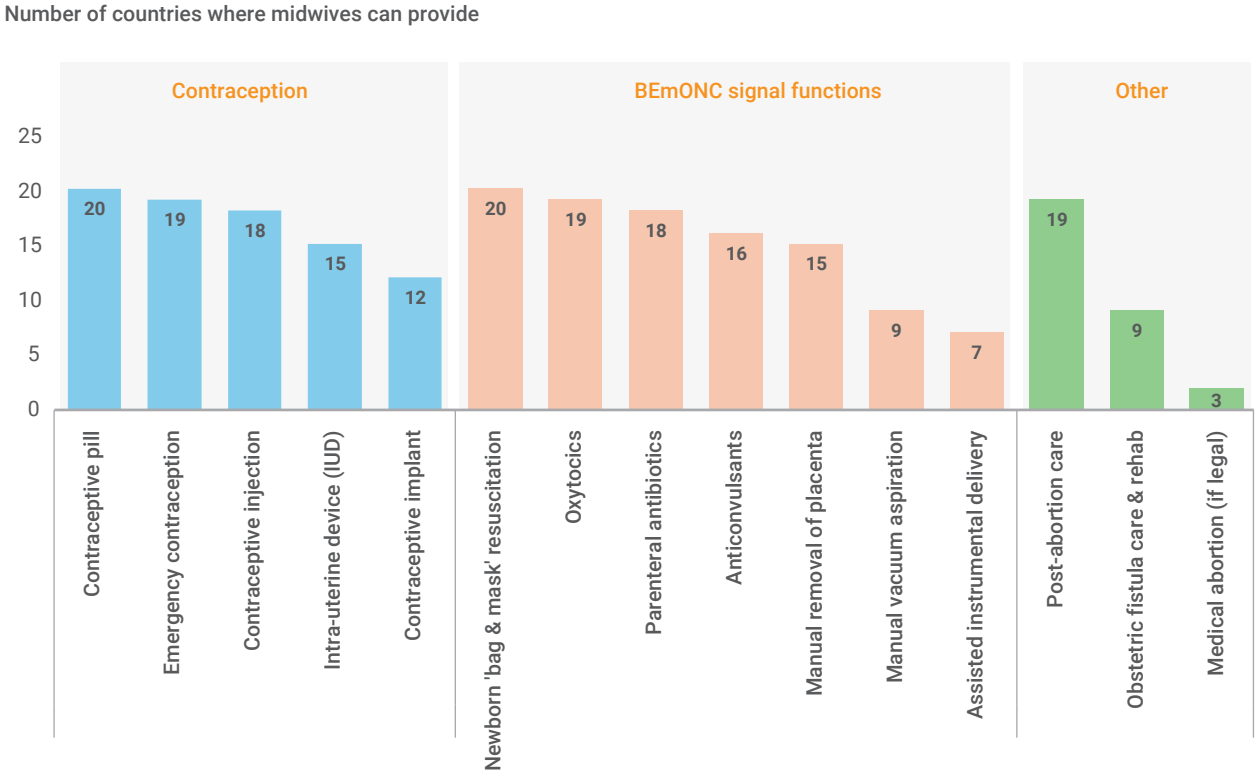


Table 3.3 provides detail about individual countries' restrictions to the midwife's scope of practice, and how this has changed since 2014. No country authorises midwives to provide all 15 of the listed interventions, but the scope of practice is relatively broad in Cambodia and Lao PDR, where it includes 14 of the 15 interventions. The scope of practice is relatively narrow in Sri Lanka and Thailand, where midwives are authorised to provide only 5 of the 15.

Just two countries authorise midwives to provide medical abortion: Cambodia and Lao PDR. Lao PDR has restrictive abortion laws, yet in the circumstances under which abortion is permitted (e.g. to save the life of the mother), midwives are authorised to provide this intervention. By contrast, in several countries abortion is available on request [34] and yet midwives are not authorised to provide it: DPRK, Maldives, Mongolia, Nepal, Thailand, and Viet Nam. In Bangladesh, midwives are authorised to perform a procedure known as "menstrual regulation".

In four countries the midwife's scope of practice appears to have broadened since 2021: (i) Bangladesh now permits midwives to provide antibiotics and anticonvulsants (see Box 3.2), (ii) Lao PDR now permits midwives to provide MVA, (iii) Philippines now permits midwives to provide emergency contraception and manual removal of placenta, and (iv) Viet Nam now permits midwives to provide antibiotics, anticonvulsants, MVA, and oxytocics as a uterotonic.

Table 3.3: Number of interventions midwives are authorised to provide

Country	2014 (/9)	2021 (/12)	2024 (/15)	Interventions that midwives are not authorised to provide
Cambodia	9	12	14	Care after obstetric fistula*
Lao PDR	9	11	14	Care after obstetric fistula
Afghanistan	9	12	13	Abortion, care after obstetric fistula
PNG	9	12	13	Abortion, care after obstetric fistula*
Timor-Leste		12	13	Abortion, care after obstetric fistula*
Viet Nam	9	7	13	Abortion, VAD
Bangladesh	8	8	12	Abortion**, contraceptive implant, VAD
Maldives			12	Abortion, MVA, VAD
Nepal	2	12	12	Abortion, contraceptive implant, IUD
India	5	12	11	Abortion, contraceptive implant, MVA, VAD
Indonesia	7	10	11	Abortion, care after obstetric fistula, MVA, VAD
Mongolia		10	11	Abortion, care after obstetric fistula, MVA, VAD
Pakistan	3		11	Abortion, anticonvulsants, MRP, VAD
Philippines		8	11	Abortion, care after obstetric fistula, MVA, VAD
Iran		12	10	Abortion, anticonvulsants, care after obstetric fistula, MVA, VAD
Malaysia			10	Abortion, contraceptive implant, IUD, MRP, MVA
Bhutan		9	9	Abortion, care after obstetric fistula, contraceptive implant, MRP, MVA, VAD
DPR Korea	2		8	Abortion, contraceptive implants and injections, IUD, MVA, PAC, VAD
Sri Lanka			5	Abortion, antibiotics, anticonvulsants*, care after obstetric fistula, contraceptive implants, IUD, MRP, MVA, oxytocics*, VAD
Thailand		4	5	Abortion, antibiotics, anticonvulsants, contraceptive implants and injections, EC, IUD, MRP, MVA, VAD

Grey shading indicates no data for that year. * Survey respondents did not know whether or not midwives are authorised to do this. ** Midwives in Bangladesh are authorised to perform "menstrual regulation", but not abortion. EC = emergency contraception. IUD = intrauterine device. MRP = manual removal of placenta. MVA = manual vacuum aspiration to remove retained products of conception. PAC = post-abortion care. VAD = assisted instrumental delivery by vacuum extraction.

Box 3.2: A scope of practice that enables midwife-led care - Bangladesh

Midwifery was introduced in Bangladesh in 2008 and midwifery education, matched to ICM standards, commenced in 2013. This required student midwives to participate in midwife-led models of care. As an interim measure, UNFPA supported the Government of Bangladesh in upgrading 1,600 existing nurse-midwives to become Certified Midwives, to provide respectful, evidence-based midwife-led care in health facilities and to support students' practice learning. At least one midwife-led care centre was established for each of the public midwifery education institutions, to provide a primary clinical practice site for midwifery students. Other organisations also supported the development of midwife-led models of care in private midwifery education institutions. Concurrently, UNFPA worked with international universities to prepare and mentor nurse-midwife teachers to deliver the new midwifery curriculum.

The midwife's scope of practice was developed in 2016 and UNFPA initiated a mentorship programme in the midwife-led care centres where midwives would be deployed, utilising female medical graduates to help the newly qualified midwives transition into their new roles, and to orient health service managers and existing staff to midwives' scope of practice. [35] At the same time, UNFPA and its partners worked with the Bangladesh Midwifery Society to build midwives' leadership capacity. The scope of practice was revised in 2023 to provide more clarity on midwives' role in independently administering medications, especially in rural areas where midwives must stabilise complications in midwife-led care centres, prior to transfer to higher-level facilities.

Photo credit: © UNFPA Bangladesh

A recent study found that, since midwives were introduced, 892 additional neonatal lives and 151 additional maternal lives were saved between 2019 to 2023 in just eight of Bangladesh's 64 districts; an additional 31,335 lives of mothers and newborns could be saved by 2035 if midwifery was significantly scaled up in Bangladesh. [36]

Midwife deployment

Recruiting and deploying midwives into the workforce is critical to mobilise and equitably distribute midwifery graduates into positions within the health system to meet workforce and population health needs. [3] National policies that guide the implementation of SRMNAH workforce recruitment and deployment are important mechanisms to strengthen maternal health services and systems. [37] It is vital that the midwifery profession is included in such policies to ensure that SRMNAH services are staffed with the appropriate personnel and that midwives are enabled to work to their full scope of practice. [38]

Timely deployment is particularly important when midwifery is a recently recognised profession that requires integration within the existing health system. If deployment strategies for midwives or sanctioned midwifery positions do not exist, there is a risk that new graduate midwives will be deployed to non-midwifery positions, return to nursing positions or remain unemployed following graduation. Deployment policies and strategies are also important to guide equitable mobilisation and distribution of midwives to rural, remote and underserved areas. [3]

Of the 20 participating countries, eight report the existence of a midwife-specific deployment strategy: Afghanistan, Bangladesh, Cambodia, DPRK, India, Maldives, Philippines and Sri Lanka. Five of these countries report that the midwife deployment strategy has been fully implemented (exceptions: Bangladesh, Cambodia, and Maldives[8]).

When professional midwives were first introduced in Bangladesh, the government published a midwife deployment strategy in 2018 to oversee the deployment of new graduate midwives. The strategy included guidance on priority areas for midwife deployment with a focus on rural and remote public facilities, in addition to the rules and regulations surrounding conditions of employment and service. The Ministry of Health and Family Welfare continues to set standards on midwifery staffing levels and priority areas for deployment, including approving midwifery positions, however the extent to which these standards have been implemented remains unclear. The draft national workforce strategy that will likely address ongoing midwife deployment is due for publication in 2025. Box 3.3 details the history of midwife deployment in the country.

[8] The midwife deployment strategy in Maldives is currently partly implemented within individual facilities.

Box 3.3: Previous and planned deployment of midwives in Bangladesh

Midwifery education in Bangladesh commenced in 2013, with the first midwives educated using international standards graduating in 2016. The public sector midwife deployment strategy was still under development at that time. UNFPA played a critical role in advocating for the deployment of these midwives and subsequently deployed midwives to the humanitarian sector – the Tea Gardens of Bangladesh, flood- and cyclone-affected areas, and the Rohingya refugee camps and host communities. These deployments provided these new graduate midwives with invaluable professional experiences, especially when later deployed to government positions. The midwives have since used their experiences from these deployments to inform the ongoing strengthening of midwifery education. [39]

Following this, the government's initial national midwife deployment strategy saw the creation of 3,000 sanctioned midwife positions. The strategy determined that four midwives were to be assigned to each government sub-district hospital (serving a population of 300,000–500,000) and one midwife to selected rural community facilities (serving a population of 30,000–50,000).

In 2018, the first wave of public-sector deployment placed 1,149 midwives in 342 sub-district hospitals. By 2021, a second deployment wave increased this number to 2,556 midwives across 667 sub-district hospitals and health centres. During the COVID-19 pandemic, an additional 200 'surge-project' midwives were deployed to public hospitals, and a midwife-led telemedicine intervention was implemented across five districts. [40]

Midwife deployment must be supported by efforts to create an enabling environment for midwifery practice, [41] especially where midwifery is a new profession. UNFPA supported midwives by implementing a clinical mentoring programme in health facilities to build acceptance of midwives and their model of care among doctors, nurses, and facility managers. This programme also supported midwives' clinical competence and confidence to provide quality care. This mentoring strategy was highly effective compared to midwifery deployment without mentorship. [35] Social media has also proved helpful in raising awareness of the role of midwives in communities.

Photo credit: © UNFPA Bangladesh/Fahima Tajrin

Where midwives are deployed in Bangladesh, they provide a wide range of SRMNAH services. These include antenatal, childbirth, and postnatal care (with a high vaginal birth rate), adolescent health, menstrual regulation and post-abortion care, cervical cancer screening, and health-sector response to sexual and gender-

based violence including post-rape clinical care. Midwives also play a critical role in the prevention of child and early marriage and adolescent pregnancy.

Still, further deployment of midwives is urgently needed. In 2022, 5,000 new midwife positions were created with the goal of filling these positions in phases until 2026. This planned expansion will enable the deployment of midwives to all levels of healthcare facilities, including tertiary-level medical colleges and district hospitals. However, at the time of writing in November 2024, this deployment had not yet started. A further 20,000 public sector midwife positions were announced in 2024, but these have not yet been created. Midwives are also urgently needed in the private sector, where 37 per cent of births take place, and 89 per cent of these are by caesarean section. [42]

Photo credit: © UNFPA Bangladesh / Fahim Tajrin

Eight countries report the existence of a general health worker deployment strategy that is not specific to midwives but includes midwives. Of these countries, only Iran, Malaysia, and Thailand report full implementation of the deployment strategy, while Bhutan, Lao PDR, Timor-Leste, and Viet Nam report partial implementation. Four countries currently do not have a deployment strategy that specifically addresses the midwifery workforce: Indonesia, Mongolia, Pakistan, and PNG (Table 3.4).

The absence of a midwife deployment strategy in Pakistan has resulted in a disconnect between midwife education and employment. A new occupation group (known as community midwives) has been created, but is not yet recognised in the health service structure. This means that new community midwife graduates are available but are not yet employed within the health system. This loss of educated midwives is a missed opportunity to strengthen the workforce. However, the existence of a midwifery deployment strategy is not sufficient if investments have not been made to realise the implementation of the strategy. As another example, Nepal has a strategy to deploy midwives throughout the health system, yet this strategy has not been implemented, and currently there are no sanctioned positions for midwives within the public health system, and the few available midwives are employed as nurses.

Sanctioned midwife positions are jobs within the health system that are created and protected specifically for midwives. These positions enable midwives to focus solely on

providing midwifery care in accordance with their scope of practice. Most countries were not able to report on the existence or number of sanctioned midwife positions in the public or private sectors.

Similarly, only three countries (Bangladesh, Lao PDR, and the Philippines) were able to provide estimated numbers of filled and vacant sanctioned midwifery positions. In Lao PDR, there are currently 2,770 sanctioned midwife positions, of which 1,928 are reported as currently filled, leaving 842 positions vacant at the time of preparation of this report. Between 2024 and 2026, Lao PDR expects 483 new midwife graduates, i.e. just half the number needed to fill the vacancies. In Bangladesh, there are 10,506 sanctioned midwife positions in the public and non-governmental organisation sectors, of which 3,060 are currently reported as filled, leaving almost 7,500 vacant. With moderate numbers of new graduates expected over the coming three years, there is potential to fill these public-sector vacancies if the new graduates are deployed appropriately. At the time of data collection in late 2024, none of the midwives who graduated in 2023 had been recruited and deployed due to political instability around the time these graduates had completed their pre-licensure internship. However, midwives in Bangladesh are also deployed to the private sector, the humanitarian response sector and within non-governmental organisations.

The remaining countries were not able to report on the existence of sanctioned midwifery positions, indicating either that information on such positions is not readily available, or that sanctioned midwifery positions do not exist, as is the case in Nepal. Sanctioned midwifery positions are currently under development for both public and private sector positions in Mongolia. It is critical that all countries have sanctioned midwifery posts, otherwise this is a major barrier to ensuring deployment of new graduates, skill retention, and subsequent coverage of midwives.

Similarly, only six countries were able to report on the employment status of recent graduate midwives. Of these six countries, percentages of graduates from 2023 recruited into midwifery positions varied from 0 per cent in Bangladesh (due to critical security issues experienced in 2024) to 100 per cent in Maldives. All newly graduated midwives in Nepal have been recruited by government and non-governmental organisations and employed in nursing roles as no midwifery positions exist in the public sector. It is uncertain if these graduates are working as midwives.

Many countries indicated that there is no system to track recruitment and deployment of graduates into the health system. Policy alignment between the education and health sectors is critical to ensure congruence between the number of graduates and the number of positions available in the workforce. Policy mismatch between these sectors can lead to either insufficient production of midwives and a workforce shortage, or a paradoxical oversupply and underemployment of health workers. [43]

Table 3.4: Midwifery deployment and sanctioned midwifery posts

Country	Midwife deployment strategy?	Deployment strategy implemented?	Number of sanctioned midwife positions	Sanctioned midwife positions filled / (vacant)	Per cent of 2023 graduates recruited and deployed
Afghanistan	Yes	Fully	DK	DK / (DK)	DK
Bangladesh	Yes**	Partly	10,506***	3,060 / (7,446)***	0%
Bhutan	Partial*	Partly	DK	DK / (DK)	DK
Cambodia	Yes	Partly	6	DK / (DK)	DK
DPR Korea	Yes	Fully	-	-	DK
India	Yes	Fully	DK	DK / (DK)	-
Indonesia	No	na	DK	-	DK
Iran	Partial*	Fully	DK	DK / (DK)	DK
Lao PDR	Partial*	Partly	2,770**	1,928 / (842)**	DK
Malaysia	Partial*	Fully	0	0	DK
Maldives	Yes	Partly	DK	DK / (DK)	100%
Mongolia	No	na	0	0	70%
Nepal	Partial*	No	0	0	100%^^
Pakistan	No	na	DK	DK / (DK)	DK
PNG	No	na	DK	DK / (DK)	90%
Philippines	Yes	Fully	2,533^	2,272 / (261)^	DK
Sri Lanka	Yes	Fully	DK	DK / (DK)	81%
Thailand	Partial*	Fully	-	DK / (DK)	DK
Timor-Leste	Partial*	Partly	DK	DK / (DK)	DK
Viet Nam	Partial*	Partly	DK	DK / (DK)	DK

Notes: DK = don't know. na = not applicable. - = no data. * Partial deployment strategy = a general health workforce deployment strategy that includes midwives. ** No current deployment strategy exists, however the Health Workforce Strategy 2023 is currently drafted which covers deployment. The previous Midwifery Deployment Guidelines (2018) guided the initial phases of midwifery deployment. *** Public and non-governmental organisation sectors only. ^ Department of Health positions only – does not include midwifery positions in local government units (province, city, municipality). ^^ Midwife graduates have been recruited; however, not always into midwifery positions.

Transition to practice

Investing in the continuum of midwifery education, recruitment and deployment, and workforce retention is critical to scale up and maintain the midwifery workforce. [3] Once new graduate midwives have been recruited into the workforce and deployed to midwifery positions, it is essential that they are supported in their transition into practice. Providing structured mentoring and support for them helps to build confidence and competence in clinical practice. [44] New graduate midwives need to be deployed to appropriate midwifery positions and should be supported to consolidate their clinical competence and confidence as new practitioners as they transition from student to midwife. [44] Strategies to deploy midwives

equitably, the creation and protection of sanctioned midwifery positions and transition to practice programmes are vital investments to increase the availability, acceptability and quality of midwives and SRMNAH services. [35, 45]

Nine countries report the existence of a transition to practice programme to support new graduate midwives, which vary in scope and duration (Table 3.5). Since 2011 and until midwife education was stopped in 2024, Afghanistan ran a mentorship programme for new graduates, coordinated by the Afghan Midwives Association and other non-governmental organisations. UNFPA Afghanistan has also supported an internship programme for community midwife graduates, covering the period immediately before and after their deployment. In Malaysia, a mandatory transition to practice programme supports graduate midwives and nurses to develop their competence, foster support and promote professional development. Transition to practice programmes in Cambodia, Thailand, and Viet Nam exist but are not universally available to all new graduates. In 2024, Lao PDR commenced a 6-month transition to practice programme with the aim to support all new graduate midwives to develop competence and confidence across antenatal, labour and birth, postnatal, newborn care and family planning. In 2024, Mongolia also commenced a 6-month midwifery orientation programme for new graduate midwives, at the National Centre for Maternal-Child Health. In India, a mentoring programme is offered to midwifery educators and nurse practitioner midwives, which is supported by national mentoring guidelines; however, it is unclear if this programme is also offered to new graduate midwives.

Newly graduated midwives in Bangladesh and Sri Lanka undertake a pre-licensure internship programme for six months, but no specific programmes for new midwives exist once they receive their licence and enter the workforce. When professional midwifery was first introduced into the Bangladesh health system, a mentoring programme was implemented to support the new midwives to integrate into public hospitals and health centres. Evaluations of this mentoring programme were very positive, identifying that midwives supported by mentors followed evidence-based care practices and were more prepared for maternal and newborn emergencies compared to midwives who received no mentoring. [35] This mentoring programme also supported the midwives and their non-midwifery colleagues to adapt to a change in service structure, suggesting that mentorship programmes can also facilitate change within often rigid hospital systems (see also Box 3.3).

Table 3.5: Transition to practice programmes to support new graduate midwives

Country	Transition to practice programme?	Name of programme	Programme objectives and explanatory notes
Afghanistan	yes*	Mentorship programme, internship programme	To improve the health of women and newborns.
Bangladesh	no	NA	Newly graduated midwives enter an internship programme before licensure (pre-service). No TTP graduate programme.
Bhutan	no	NA	Midwifery graduates join a general 2-week orientation programme for all health workers.
Cambodia	yes	Mentorship programme	To build confidence and competency during TTP. Run by Provincial Health Departments, National Maternal and Child Health Centre and UNFPA. Partially implemented.
DPR Korea	no	NA	
India	yes	Mentoring programme	For Midwifery Educators and Nurse Practitioner Midwives. Mentoring guidelines covers all states.
Indonesia	no	NA	
Iran	no	NA	
Lao PDR	yes	Not stated	TTP programme for all graduate midwives commenced 2024. 6-month programme covering ANC, delivery, PNC, FP, newborn care.
Malaysia	yes	Transition to practice programme	To ensure competency, foster support and promote professional development. Mandatory TTP programme for all graduate nurses and midwives.
Maldives	yes	Not stated	Carried out in individual health facilities.
Mongolia	yes	Midwifery orientation	6-month midwifery orientation programme commenced in 2024 at the National Centre for Maternal-Child Health.
Nepal	no	NA	
Pakistan	no	NA	
PNG	no	NA	
Philippines	no	NA	
Sri Lanka	yes**	NA	Graduates are screened for a 'good conduct' certificate, required to practice in midwifery, by completing 6-months of work experience.
Thailand	yes	Residency	To develop competencies. 3-year residency programme for new graduate nurse-midwives. Yet to be fully implemented.
Timor-Leste	no	NA	
Viet Nam	yes	Transition to practice programme	Partial implementation of TTP programmes as some private and public hospitals, not a national or mandatory programme.

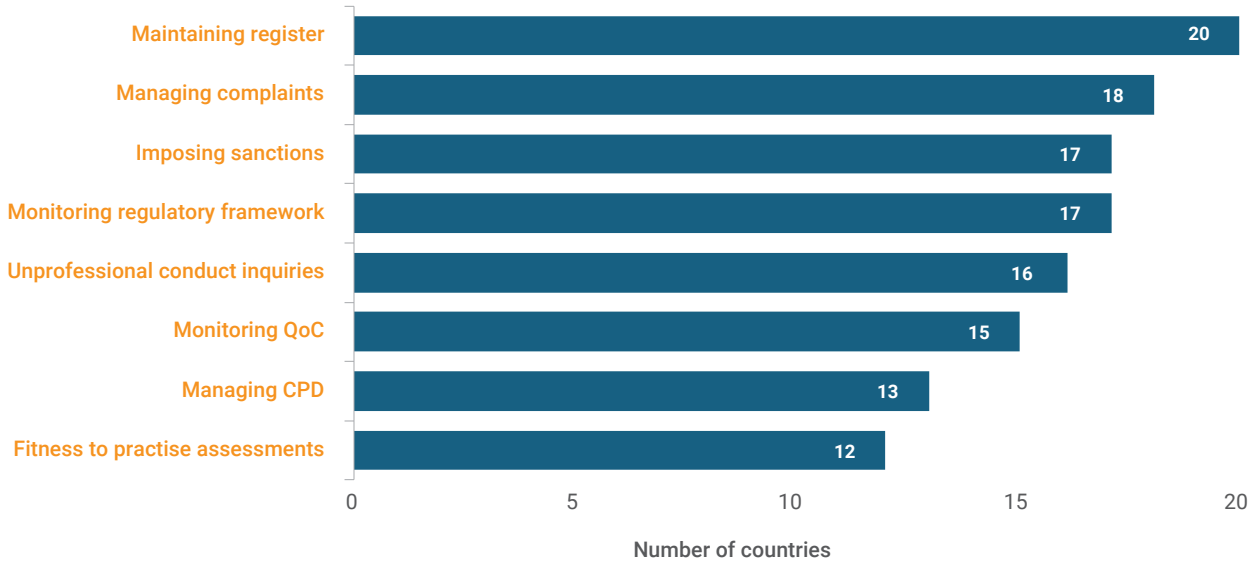
NA = not applicable. TTP = transition to practice. * The programme existed until education for women and girls was banned in Afghanistan in late 2024. ** The survey respondent(s) counted this as a transition to practice programme, but it seems more like an internship.

Nature and role of regulatory bodies

All 20 responding countries have organisations responsible for regulation of midwifery practice. In ten countries (Afghanistan, Cambodia, India, Indonesia, Maldives, Nepal, PNG, Philippines, Sri Lanka, and Thailand) an independent midwifery or nursing council has a role, in eight countries (DPRK, India, Indonesia, Iran, Malaysia, Mongolia, Timor-Leste, and Viet Nam) the national ministry of health (MoH) has a role, and in six countries (Bangladesh, Bhutan, Iran, Lao PDR, Mongolia, and Pakistan) the regulator is a nursing and/or midwifery council that sits within the MoH. Some countries appear more than once in the above list because more than one organisation is involved in regulation of midwifery practice.

In ten of the participating countries, the regulator's role includes all eight of the functions shown in Figure 3.3. The only function that is performed by the regulatory body in all 20 countries is keeping an up-to-date register of licensed midwives. The two functions most commonly excluded from the regulator's role are managing CPD (perhaps linked to the finding that many countries do not yet have a formal CPD system for midwives – see Table 3.7) and assessing midwives' fitness to practise.

Figure 3.3: Functions performed by the regulatory body/ies for midwifery practice



CPD = continuing professional development. QoC = quality of care.

Table 3.6 shows how each country responded to the questions about the nature and role of the regulatory body/ies for midwifery practice. There is no clear relationship between the type of regulator and the number of functions it performs: the ten countries where the regulator performs all eight functions cover the whole range of organisational types.

Functions excluded from the regulators' role in the remaining countries are as follows:

- Bangladesh: Monitoring QoC, unprofessional conduct inquiries, imposing sanctions, fitness to practise assessments, managing CPD
- Bhutan: Unprofessional conduct inquiries, fitness to practise assessments*, managing CPD*
- Indonesia: Monitoring regulatory framework, monitoring QoC, fitness to practise assessments, managing CPD
- India: Managing complaints, unprofessional conduct inquiries, imposing sanctions, fitness to practise assessments, managing CPD
- Maldives: fitness to practise assessments, managing CPD
- Mongolia: unprofessional conduct inquiries
- PNG: Fitness to practise assessments*, managing CPD*
- Sri Lanka: Monitoring regulatory framework*, monitoring QoC*, fitness to practise assessments
- Timor-Leste: Monitoring regulatory framework*, monitoring QoC*, managing complaints, imposing sanctions*, fitness to practise assessments*, managing CPD*
- Viet Nam: Monitoring QoC*

* For these functions, the response was 'don't know', rather than 'excluded'.

Of the 20 responding countries, just two have exactly the same regulatory body/ies for both practice and education: Bhutan and Iran. In the remaining 18 countries, a separate regulatory body exists for education. In seven countries (Bangladesh, DPRK, Lao PDR, Malaysia, Pakistan, PNG, Thailand), the separate body works in parallel with the regulatory body/ies for midwifery practice. In the remaining 11 countries, regulation of education is a separate function. Table 3.6 shows that, in most countries, regulation of midwifery education is the responsibility of a government department, usually within the MoH or ministry of education (MoE).

Table 3.6: Nature and roles of regulatory bodies for midwifery practice and education

	Regulator (practice)				Regulator (education)				
Country	Council (independent)	Council (not independent)	MoH	No. of functions performed (/8)	Council (independent)	Council (not independent)	MoH	MoE	Other
Afghanistan	✓			8			✓		
Cambodia	✓			8			✓		✓
DPR Korea			✓	8			✓	✓	
Iran		✓	✓	8		✓	✓		
Lao PDR		✓		8		✓	✓		
Malaysia			✓	8			✓		
Nepal	✓			8					✓
Pakistan		✓		8		✓	✓	✓	
Philippines	✓			8				✓	
Thailand	✓			8	✓				
Mongolia		✓	✓	7			✓	✓	
Viet Nam			✓	7			✓	✓	✓
Maldives	✓			6					✓
PNG	✓			6	✓			✓	
Bhutan		✓		5		✓			
Sri Lanka	✓			5					✓
Indonesia	✓		✓	4			✓	✓	
Bangladesh		✓		3		✓	✓		
India	✓		✓	3	✓				
Timor-Leste			✓	2				✓	

MoH = ministry of health. MoE = ministry of education.

Licensing systems

All 20 reporting countries have some kind of professional licensing system for midwives, but the process for obtaining a licence varies (Table 3.7). In 11 countries, new graduate midwives are required to pass a licensing exam before they can apply for a practice licence. In seven countries, a licence is granted automatically on graduation from an approved education programme. In Cambodia, student midwives must pass a national exit exam before they can graduate and apply for a licence. In Sri Lanka, new graduate midwives must complete six months of work experience in a health facility and obtain a recommendation in order to obtain a licence.

In 17 of the 20 countries, midwives are required to renew their licence periodically (exceptions: Afghanistan, Iran, and Malaysia). Usually this is done every 4-5 years, but in seven countries it is done every 2-3 years. In 11 countries, midwives are periodically required to provide evidence of CPD. In most of these countries this is a condition of re-licensing, but in two countries (Iran and Malaysia) it is not linked to the process of licence renewal. Of the nine countries which do not currently require their midwives to provide evidence of CPD, three (Bangladesh, Maldives, and Pakistan) reported that a compulsory CPD system for midwives will be introduced in the near future.

Table 3.7: Characteristics of midwife licensing systems

Country	Initial licensing process	Compulsory licence renewal?	Compulsory CPD?	Notes
Afghanistan	Licensure exam	no	no	CPD is recommended
Bangladesh	Licensure exam	Every 4-5 years	no	Compulsory CPD is due to be introduced in 2025
Bhutan	Automatic on graduation	Every 4-5 years	yes	
Cambodia	National exit exam	Every 2-3 years	yes	60 active learning hours are required every 3 years
DPR Korea	Licensure exam	Every 2-3 years	yes	
India	Automatic on graduation	Every 4-5 years	no	CPD is recommended
Indonesia	Automatic on graduation	Every 4-5 years	yes	50 credits are required every 5 years
Iran	Automatic on graduation	no	yes	CPD not linked to licence renewal
Lao PDR	Licensure exam	Every 4-5 years	yes	
Malaysia	Licensure exam	no	yes	CPD not linked to licence renewal
Maldives	Licensure exam	Every 2-3 years	no	Compulsory CPD is planned for 2025
Mongolia	Licensure exam	Every 2-3 years	yes	
Nepal	Licensure exam	Less than every 5 years	no	CPD is recommended
Pakistan	Automatic on graduation	Every 4-5 years	no	CPD is recommended. The regulator is planning to introduce compulsory CPD
PNG	Automatic on graduation	Every 2-3 years	no	
Philippines	Licensure exam	Every 2-3 years	yes	As per Continuing Professional Development Law (RA 10912)
Sri Lanka	Recommendation after internship	Every 4-5 years	no	
Thailand	Licensure exam	Every 4-5 years	yes	
Timor-Leste	Automatic on graduation	Every 2-3 years	no	
Viet Nam	Licensure exam	Every 4-5 years	yes	120 learning hours are required every 5 years

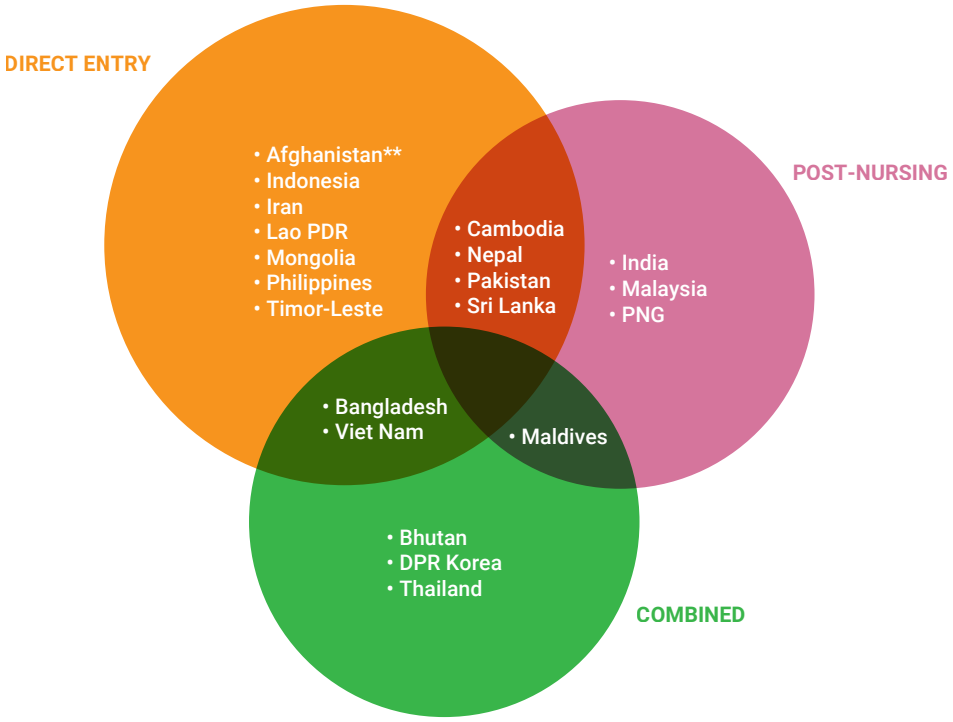
Education and training

Types of pre-service education programmes

There are three basic types of pre-service midwifery education programme: (i) direct entry, which focuses specifically on midwifery and produces professional or associate professional midwives, (ii) post-nursing, which provides qualified nurses with an additional qualification in midwifery (usually after spending some time working as a nurse) and produces nurse-midwives, and (iii) combined nursing and midwifery, which teaches nursing and midwifery concurrently and produces nurse-midwives. Figure 3.4 shows that all three types exist in the countries featured in this report: twelve countries have at least one direct entry programme, seven have at least

one post-nursing programme, and six have at least one combined nursing and midwifery programme. Most countries have just one type of midwife education programme, but six countries have more than one type, e.g. Cambodia and Nepal have both direct entry and post-nursing programmes.

Figure 3.4: Types of pre-service education programme available in each country



** Afghanistan is included here because a direct entry programme existed at the time of data collection; however, the programme was stopped in November 2024.

Table 3.8 provides more detail at country level. It shows that eleven countries have more than one educational pathway into midwifery. This includes eight countries with multiple pathways even within one type (e.g. more than one direct entry programme), producing midwives with different levels of qualifications. This presents a rather different picture than that shown in previous SoWMy reports. This is because the questions were asked in a different way, to capture more detail about the range of programmes available in each country. In Nepal and the Philippines, the multiple pathways are part of a gradual change to a new system of midwife education that is more in line with global recommendations.

Table 3.8 also shows a range of programme durations in the region. Direct entry programmes range from 18 months in Sri Lanka to 60 months in Indonesia, and post-nursing programmes range from 12 months in Cambodia, Malaysia, and Maldives to 36 months in Nepal. ICM recommends that direct entry programmes consist of at least 4,600 hours of study and clinical practice over 36 months, and that post-nursing programmes should be at least 18 months. [46] ICM does not make an equivalent recommendation for combined programmes.

Of the countries that offer direct entry and/or post-nursing pathways, most offer at least one programme of the recommended duration

(shaded green in Table 3.8). The exceptions are Malaysia and Sri Lanka, where there are no programmes of the recommended duration. Three of the countries that offer at least one programme of the recommended duration also offer shorter programmes: Cambodia, Pakistan, and Viet Nam. These shorter programmes are designed to prepare associate professional midwives rather than professional midwives. This approach may be appropriate for the context, but it requires careful management, because previous research found that midwives with lower-level qualifications are sometimes deployed to positions that require them to provide a level of clinical care for which they are not qualified. [47]

Table 3.8: Number and duration of pre-service education programmes

Country	No. of pathways	Type of programme	Duration (months)*	Explanatory notes
Afghanistan	1**	Direct entry	36	Diploma in midwifery
Bangladesh	2	Direct entry	36	Diploma in midwifery
		Combined	36	Diploma in nursing science and midwifery (curriculum does not meet ICM standards)
Bhutan	2	Combined	48	BSc in nursing and midwifery
		Combined	36	Diploma in general nursing and midwifery
Cambodia	3	Direct entry	48	BSc in midwifery (includes some nursing content)
		Direct entry	36	Associate degree in midwifery
		Post-nursing	12	Associate degree in nursing and midwifery
DPR Korea	1	Combined	36	
India	1	Post-nursing	18	Post-basic diploma: nurse practitioner in midwifery
Indonesia	2	Direct entry	60	Professional midwife
		Direct entry	36	Vocational midwife
Iran	1	Direct entry	48	BSc in midwifery
Lao PDR	1	Direct entry	36	High level diploma
Malaysia	1	Post-nursing	12	Advanced diploma in midwifery
Maldives	2	Post-nursing	12	Advanced diploma in midwifery
		Combined	48	BSc in nursing and midwifery
Mongolia	1	Direct entry	48	Bachelor's degree
Nepal	3	Direct entry	48	BSc midwifery. First cohort will graduate in 2028
		Direct entry	36	PCL midwifery (diploma). First cohort will graduate in 2026
		Post-nursing	36	Bachelor of midwifery science
Pakistan	5	Direct entry	48	BSc midwifery. First cohort will graduate in 2026
		Direct entry	24	Community midwife
		Direct entry	24	Lady health visitor***
		Direct entry	24	Family welfare worker***
		Post-nursing	24	BSc midwifery (post-nursing)
PNG	1	Post-nursing	18	BSc midwifery

Country	No. of pathways	Type of programme	Duration (months)*	Explanatory notes
Philippines	3	Direct entry	48	BSc midwifery. First cohort will graduate in 2027
		Direct entry	24	Diploma. Final cohort graduated in 2024
		Direct entry	48	Bridging course to upskill diploma midwives to BSc. Final cohort will graduate in 2026.
Sri Lanka	2	Direct entry	18	Diploma
		Post-nursing	12	Diploma. 6 months theory + 6 months placement
Thailand	1	Combined	48	Bachelor of nursing science
Timor-Leste	2	Direct entry	48	BSc midwifery
		Direct entry	36	Diploma
Viet Nam	4	Direct entry	48	BSc
		Direct entry	36	Vocational training, mostly offered at provincial secondary medical schools
		Direct entry	24	Vocational training, mostly offered in remote regions
		Combined	48	Nursing with midwifery concentration

Notes: The colours in the table represent whether the programme duration is aligned with ICM recommendations (green) or not (red). Neutral colour is for programmes without a specific ICM recommendation (combined programmes).* For post-nursing programmes, this is the number of months studying midwifery after qualification as a nurse. ** Afghanistan is included here because a direct entry programme existed at the time of data collection; however, the programme was stopped in November 2024, and at the time of going to press, there is no midwifery education in Afghanistan. *** These two groups are counted as associate professional midwives in Chapter 2 on the basis that their scope of work matches the ISCO definition.

Quality of pre-service education programmes

High-quality pre-service education depends on factors such as curriculum content and faculty development, skills labs and clinical training sites, as well as programme duration. Over the last decade, UNFPA has been supporting most AP countries to ensure that midwife education curricula are based on nationally agreed standards. Currently, all 20 of the countries included in this chapter have national standards to guide curriculum content (Table 3.9), but in three countries (Pakistan, Sri Lanka, and Timor-Leste) the standards are not used by all midwifery schools.

Most countries stated that the standards have been reviewed within the last five years, and most of the rest stated that they have been reviewed in the last ten years. Iran is the only reporting country in which the midwifery education standards date from before 2014. However, only six countries reported that the next revision is scheduled to take place within five years of the previous one: Afghanistan, Cambodia, Lao PDR, Maldives, Mongolia, and Philippines. Several countries could not provide a date for the next revision, which implies that there is no standard cycle for updating education curricula in these countries.

Table 3.9: Existence and recency of national standards to guide education curricula

Country	National standards to guide curriculum content?	Year of last revision	Year of next revision	Notes
Afghanistan**	Yes, used by all schools	2021	2025	
Bangladesh	Yes, used by all schools	2019	2026	COVID-19 delayed implementation of the 2019 revision until 2022
Bhutan	Yes, used by all schools	2018	2024	
Cambodia	Yes, used by all schools	2020	2025	The 2020 revision was implemented in 2022
DPR Korea	Yes, used by all schools	2019	DK	
India	Yes, used by all schools	2022	DK	
Indonesia	Yes, used by all schools	2017	2024	
Iran	Yes, used by all schools	2012	DK	
Lao PDR	Yes, used by all schools	2021	2025	
Malaysia	Yes, used by all schools	2018	2025	
Maldives	Yes, used by all schools	2022	2025	
Mongolia	Yes, used by all schools	2024	2029	
Nepal	Yes, used by all schools	2023	DK	Initial standards were developed in 2016 by the Nursing Council, then reformed in 2023 by the Medical Education Commission
Pakistan	Yes, used by some schools	2021	DK	Standards guide the BSc midwifery programme, but not other programmes
PNG	Yes, used by all schools	2020	DK	
Philippines	Yes, used by all schools	2023	2028	
Sri Lanka	Yes, used by some schools	2016	2025	National standards exist for health professionals, but are not specific to midwifery. It is planned to adapt the standards for midwifery in 2025
Thailand	Yes, used by all schools	2019	DK	
Timor-Leste	Yes, used by some schools	DK	DK	National standard does not align with ICM standards
Viet Nam	Yes, used by all schools	2015	DK	

DK = don't know. **Afghanistan is included here because a midwifery education programme existed at the time of data collection; however, the programme was stopped in November 2024, and at the time of going to press, there is no midwifery education in Afghanistan.

Four of the responding countries reported that their pre-service education programmes are fully aligned with all six elements of ICM Global Standards for Midwifery Education: [46] India, Iran, Malaysia, and Thailand (Table 3.10), despite some apparent discrepancies in areas including programme duration. For all other responding countries, at least one element of the standards is not routinely met.

The strongest element of the standards is 'programme and curriculum' – 11 countries reported that all of their programmes adhere to this standard. Nine countries reported that all their programmes adhere fully to the standard on 'students', and eight that all programmes adhere fully to the standard on 'programme governance'. For the remaining three elements ('faculty', 'resources' and 'quality improvement') only five or six

countries reported full adherence across all programmes. This indicates significant challenges to high-quality education in many of the participating countries. Box 3.4 explains how Bhutan is trying to address some of these.

Table 3.10: Reported adherence of pre-service education programmes to ICM global standards

Country	Governance	Faculty	Students	Programme and curriculum	Resources	Quality improvement
Afghanistan**	All	DK	All	All	All	All
Bangladesh	Some	Some	Some	All	Some	Some
Bhutan	None	None	None	None	None	None
Cambodia	Some	Some	Some	Some***	Some	Some
DPR Korea	-	-	-	All	-	All
India	All	All	All	All	All	All
Indonesia	Some	Some	Some	Some	Some	Some
Iran	All	All	All	All	All	All
Lao PDR	Some	Some	Some	All	Some	Some
Malaysia	All	All	All	All^	All	All
Maldives	None	None	None	None	None	None
Mongolia	All	Some	Some	Some	Some	Some
Nepal	None	None	All	All	Some	Some
Pakistan	Some	Some	Some	Some	Some	Some
PNG	All	All	All	All	None	DK
Philippines	All	All	All	All	Some	Some
Sri Lanka	None	None	All	None	None	None
Thailand	All	All	All	All	All	All
Timor-Leste	Some	Some	Some	Some	Some	Some
Viet Nam	Some	Some	Some	Some	Some	Some

- = no response. DK = don't know. **Afghanistan is included here because a midwifery education programme existed at the time of data collection; however, the programme was stopped in November 2024, and at the time of going to press, there is no midwifery education in Afghanistan. *** Two of Cambodia's three midwifery education programmes adhere fully to ICM standards on programme and curriculum. ^ Even though Malaysia reported a shorter-than-recommended programme duration.

In 19 of the 20 participating countries, there is a national body responsible for accreditation of midwifery pre-service education programmes. In 15 of those countries all programmes are accredited, and in the remaining four countries (Bangladesh, Mongolia, Nepal, and Viet Nam), only some programmes are accredited (Table 3.11). Of the four countries in which only some programmes are accredited, only Bangladesh was able to provide an estimate of the percentage of midwives who graduate from an accredited programme (5 per cent). The only responding country without any system of accreditation is Sri Lanka.

Table 3.11: Accreditation of midwifery pre-service education programmes

Country	National accreditation body?	% of midwives graduating from an accredited programme	Notes
Afghanistan**	Yes, covering all programmes	100%	
Bangladesh	Yes, covering some programmes	5%	8 out of 171 schools are accredited
Bhutan	Yes, covering all programmes	100%	
Cambodia	Yes, covering all programmes	100%	
DPR Korea	Yes, covering all programmes	100%	
India	Yes, covering all programmes	100%	
Indonesia	Yes, covering all programmes	100%	
Iran	Yes, covering all programmes	100%	
Lao PDR	Yes, covering all programmes	100%	
Malaysia	Yes, covering all programmes	100%	
Maldives	Yes, covering all programmes	100%	
Mongolia	Yes, covering some programmes	DK	1 out of 5 schools is accredited
Nepal	Yes, covering some programmes	DK	
Pakistan	Yes, covering all programmes	100%	
PNG	Yes, covering all programmes	100%	
Philippines	Yes, covering all programmes	100%	
Sri Lanka	No	0	
Thailand	Yes, covering all programmes	100%	
Timor-Leste	Yes, covering all programmes	100%	
Viet Nam	Yes, covering some programmes	DK	

DK = don't know. **Afghanistan is included here because a midwifery education programme existed at the time of data collection; however, the programme was stopped in November 2024, and at the time of going to press, there is no midwifery education in Afghanistan.

Box 3.4: Preparing the next generation of midwives in Bhutan

The midwifery component of the Bachelor of Nursing and Midwifery, a four-year course at the Royal Thimphu College in Bhutan, seeks to educate and prepare the next generation of midwives. The College aims to train these young people to bring cultural understanding and provide context-specific care to diverse communities; adapt to changing health needs and evolving birth practices; and to be independent enough to work in difficult circumstances, such as during natural calamities and in areas with unstable health services and minimal equipment. Early training helps empower young people to take leadership roles in healthcare, as well as ensuring the sustainability of health systems, as it prepares a new generation of skilled professionals to replace older workers.

However, tutors responsible for training young midwives face a number of challenges.

- Emotional and psychological support is critical and tutors guide students through the emotional toll of dealing with difficult births, complications, and maternal health issues, helping them manage stress and prevent burnout.
- Ensuring students gain sufficient hands-on practical experience is another significant challenge as Bhutan experiences a shift in population dynamics: people of reproductive age are migrating to other countries and those remaining often do not opt for more children. However, the College and tutors ensure a balance of theoretical knowledge and practical training through simulation, role play, and clinical practices.
- Cultural sensitivity is essential, as midwives work with diverse populations and tutors prepare students to navigate different cultural beliefs and practices surrounding childbirth.
- Tutors keep up with technological advances and incorporate new tools like foetal monitoring systems and digital health technologies into teaching and learning, whilst also avoiding students becoming technology dependent.
- Students are prepared to work in interdisciplinary teams, learning to communicate effectively through mock sessions.

- Tutors also ensure that students understand legal and ethical guidelines governing midwifery, including providing privacy, maintaining confidentiality, and obtaining informed consent.

Photo credit: © UNFPA Bhutan / Yeshey Zangmo

- Building confidence is another key role of tutors, as many young midwives may experience self-doubt, particularly in high-pressure situations. They are helped to develop the decision-making skills and self-assurance necessary for handling complications and addressing gaps in knowledge, through additional practices, feedback, and assessment.

- Balancing autonomy with supervision is also essential, as midwifery often requires independent practice. Tutors ensure that students are appropriately supervised to ensure patient safety whilst encouraging independence.
- Finally, retention can be a challenge in midwifery, and tutors seek to motivate young midwives to stay in the profession long-term.

By addressing these challenges, the tutors at Royal Thimphu College play a vital role in preparing the next generation of midwives, ensuring they can provide skilled, compassionate, and culturally competent care.

Photo credit: © UNFPA Bhutan / Yeshey Zangmo

Faculty development

Strengthening midwifery education to improve quality of care and health outcomes for women and newborns requires a focus on developing the educational capacity of midwifery faculty. [48] Faculty development refers to the professional development of pre-service midwifery educators and clinical teachers. Most commonly, it includes quality improvement activities in traditional faculty roles such as curriculum development, teaching and learning, and assessment. However, there is an increasing expectation for faculty to be leaders and researchers and this needs to be addressed in faculty development programmes, [49] which are often provided by educational institutions, but can also be provided by governments or other organisations.

ICM's Global Standards for Midwifery Education determine that midwifery faculty be comprised predominantly of qualified midwives who maintain competency in both midwifery practice and teaching. [46] However, maintaining clinical practice is a common challenge for midwifery faculty globally. [48]

In nine of the 20 responding countries, all midwifery faculty members are qualified midwives. As midwifery has recently been introduced in India, eight national midwifery training institutes have been operationalised

to train and mentor new midwifery faculty, all of whom are nurse-midwife practitioners. In Afghanistan,[9] Bhutan, Philippines, and Timor-Leste, qualified midwives make up at least half of the midwifery faculty. In Bangladesh, Lao PDR, Mongolia, Nepal, Pakistan, and Sri Lanka, however, fewer than half of midwifery faculty are qualified midwives. Bangladesh plans to increase the proportion of qualified midwives in the faculty as the number of professional midwives increases in the coming years. The response from Nepal stated that all midwifery faculty for the PCL Midwifery degree are qualified midwives; however, faculty who teach the Bachelor's degree are not. Clinical midwifery teachers supervise students in the clinical setting in Mongolia, but in the educational setting, only one faculty member is a midwife; the remainder are medical doctors. This is also the case in Viet Nam, where it is common for obstetricians to teach in midwifery programmes.

Thirteen countries report having a national faculty development programme that is accessible to pre-service midwifery faculty (Table 3.12). National midwifery faculty development programmes are established in: Afghanistan, Bangladesh, Cambodia, DPRK, India, Iran, Malaysia, Philippines, Thailand, and Timor-Leste;[10] many of which are offered annually or every 2-5 years. Short-term programmes have been offered in Nepal and PNG, dependent on need and availability of funding.

The programmes in Lao PDR and Pakistan are newly developed and yet to commence. The programme in Lao PDR will be coordinated by the Department of Health and offered every 2-5 years. In Pakistan, the Nursing and Midwifery Council will be responsible for implementing the faculty development programme and plans to run the programme every 5 years. Pakistan has also recently conducted a faculty development programme facilitated by an external organisation (Burnet Institute) and funded by UNFPA. A virtual faculty development programme coordinated by the Medical University is available for midwifery faculty in Mongolia.

Most faculty development programmes are coordinated by governments in partnership with midwifery associations (Nepal, Philippines), nursing/midwifery councils (India, Nepal, Pakistan), or external partners including UNFPA. Only two programmes (in Iran and Mongolia) are coordinated by educational institutions. Additionally, over the past three years, UNFPA APRO has supported the development and delivery of a midwifery faculty development programme across the region, delivered regionally in an online format and tailored to regional faculty needs (Box 3.5). This programme has also been delivered in Afghanistan, Cambodia, DPRK, Pakistan, and Timor-Leste by UNFPA and the Burnet Institute.

No national midwifery faculty development programmes are offered in Bhutan, Indonesia, Maldives, Sri Lanka, or Viet Nam, although Bhutan, Indonesia, Maldives and Sri Lanka did participate in the virtual regional midwifery faculty development programme organised by UNFPA APRO. Bhutan offers continuing professional development (CPD) to all midwifery faculty in the public sector to ensure they can meet professional licensing requirements, but this is not specific to faculty.

[9] Afghanistan is included here because a midwifery education programme existed at the time of data collection. However, the programme was stopped in November 2024 and at the time of going to press there is no midwife education in Afghanistan.

[10] UNFPA supported the faculty development programmes in Afghanistan, DPRK, Cambodia and Timor-Leste.

Table 3.12: Faculty development activities, by country

Country	Proportion of midwifery faculty who are midwives	National faculty development programme?	Organisation/s that coordinate the programme	Frequency programme offered
Afghanistan*	At least half	Yes	Midwifery association; UNFPA	Annual from 2023
Bangladesh	Fewer than half	Yes	Government; UNFPA; private schools	Every 2-5 years
Bhutan	At least half	No	NA	NA
Cambodia	All	Yes	Government; UNFPA; other external partner	Annual
DPR Korea	All	Yes	Government	Annual
India	All	Yes	Government; nursing council	Annual
Indonesia	All	No	NA	NA
Iran	All	Yes	Government; educational institution	Annual
Lao PDR	Fewer than half	Yes**	Government	Every 2-5 years
Malaysia	All	Yes	Government	DK
Maldives	All	No	NA	NA
Mongolia	Fewer than half	Yes**	Educational institution	Annual
Nepal	Fewer than half	Short-term only	Government; midwifery association; nursing council	As needed
Pakistan	Fewer than half	Yes***	Nursing and midwifery council	Every 2-5 years
PNG	All	Short-term only	External partner	Every 2-5 years
Philippines	At least half	Yes	Midwifery schools; midwifery association	As needed
Sri Lanka	Fewer than half	No	NA	NA
Thailand	All	Yes	Government	Annual
Timor-Leste	At least half	Yes	Government; external partners	Less than 5 yearly
Viet Nam	DK	No	NA	NA

DK = don't know. NA = not applicable. * Afghanistan is included here because a midwifery education programme existed at the time of data collection; however, the programme was stopped in November 2024, and at the time of going to press, there is no midwifery education in Afghanistan. ** Programme is a general faculty programme (not specific to midwifery faculty) but is accessible to midwifery faculty. *** Programme is planned but not yet implemented.

Despite the apparent availability of faculty development programmes for pre-service midwifery educators, a recent survey of midwifery faculty in the region identified a high need for greater and ongoing faculty development in all aspects of faculty roles. [50] In particular, a need was identified for faculty development to focus on research capacity, hybrid/blended learning, use of simulation, and leadership and management. These needs are not commonly included in faculty development programmes, as they tend to focus on the more traditional faculty roles of learning and teaching. [49] It is therefore likely that many of the current faculty development programmes listed in Table 3.12 were not informed by the needs of midwifery faculty and the contemporary roles they are expected to undertake.

Midwifery faculty who are well-prepared, confident and competent educators are a necessity for quality midwifery education programmes that produce high-quality midwifery graduates. [48] Faculty development is not a one-off training – early and sustained support and professional development is most effective to ensure midwifery faculty are able to fulfil their diverse roles. [51] It is essential that investments are made to support midwifery faculty across the region to continue improving and strengthening midwifery education.

Box 3.5: UNFPA Asia-Pacific Regional Office midwifery faculty development programme

The UNFPA APRO Midwifery Faculty Development programme is the first regional initiative for midwifery faculty across the Asia-Pacific region. Designed and co-implemented with midwifery education specialists at the Burnet Institute in 2020-2022, the APRO Midwifery Faculty Development Programme design meets the need for high-quality faculty development in the region. The programme seeks to contribute to the delivery of high-quality midwifery education, ultimately improving maternal and neonatal health outcomes.

The programme is comprehensive and tailored to specifically support the development of knowledge and skills in the development, renewal, implementation, and evaluation of midwifery curricula. The programme covers the theoretical and practical aspects of learning and teaching in midwifery education and offers a range of activities and assessments to support the development of faculty members' knowledge and skills as midwifery educators. It is comprised of six core modules, with two supplementary modules:

Module 1: Curriculum Development and Review

Module 2: Developing Midwifery Graduate Attributes

Module 3: Designing Modules of Learning

Module 4: Authentic Assessment Processes and Practice

Module 5: Contemporary Learning and Teaching in Midwifery Education

Module 6: Clinical Teaching: Mentoring and Role-Modelling

Supplementary Module 7: Teaching Evidence-Based Practice

Supplementary Module 8: Blended Learning and Teaching

The APRO Midwifery Faculty Development programme has been delivered online, in hybrid form, and in-person with more than 200 participants from at least 16 countries across Asia: Afghanistan, Bhutan, Bangladesh, Cambodia, India, Indonesia, Iran, Lao PDR, Maldives, Myanmar, Nepal, Pakistan, Papua New Guinea, Philippines, Sri Lanka, and Timor Leste. The programme was also adapted and run in Pacific Island countries by the UNFPA Pacific Sub -Regional Office. A training programme for leading midwifery educators commenced in 2024 through a *Training of Trainers* approach to continue roll-out of the Faculty Development programme in local contexts, delivered by local faculty members, and tailored to local faculty needs.

In 2023, the APRO Midwifery Faculty Development programme was independently evaluated to assess the effectiveness and impact of the programme. The evaluation found that it effectively achieved the objective to meet the need for a high-quality programme of faculty development for the Asia-Pacific region. Key recommendations from the evaluation included strengthening the current programme design and adapting it for local contexts. Strengthening includes building on positive feedback, increasing interactivity, incorporating face-to-face components, and ensuring sufficient faculty resources. In addition, ensuring a focus on co-creation with local experts and cultural inclusivity to enhance program effectiveness and sustainability.

Photo credit: © UNFPA/Pakistan

Continuing professional development

CPD is the process of continuous in-service learning and development, and is a core component of midwifery practice and the philosophy of midwifery care. [52] ICM defines the enabling environment for midwives as a work environment that provides midwives with access to CPD, career pathways and supportive professional mechanisms. [41] As reported above, CPD is increasingly being included in licensure and registration requirements as maintaining competence is recognised as necessary for the provision of safe, effective and quality care. [53] Mandatory training through prescribed courses is often required by employers and health services to ensure that employed midwives continue their professional

development and maintain competency. ICM *Global Standards for Midwifery Regulation* recommend that midwifery regulatory authorities include continuing education and continuing competence as requirements for all midwives to maintain licensure. [54] Midwives in all countries need access to in-service learning and development opportunities.

Out of the 20 reporting countries, 14 have a national programme of in-service CPD training for midwives currently in the workforce (exceptions: Bangladesh, Bhutan, Maldives, Pakistan, Viet Nam). It is unclear if a national in-service CPD programme is offered to midwives in Malaysia. While no current national CPD programmes are available in Bangladesh, a national in-service training programme for public sector midwives has been included in the Health Sector Plan and is due to commence, and a structured programme exists specifically for midwives working in the humanitarian sector. The CPD programme in Lao PDR was planned to commence in 2024. In Pakistan, no structured in-service CPD programme exists at the national level, but training is provided within health institutions and with the support of development partners.

Mongolia offers five CPD programmes for midwives, covering: pre-pregnancy counselling, family planning, sexual and reproductive health counselling, antenatal and postnatal care counselling, and breastfeeding. In the Philippines, a comprehensive in-service programme offered by the Department of Health includes topics such as leadership and management, maternal health and BEmONC, family planning, essential newborn care, and mental health training. In Sri Lanka, CPD programmes are offered both nationally and within local health institutions. While these programmes are coordinated by government departments, in Afghanistan, the mentorship and capacity-building programme is coordinated by the Afghan Midwives Association and other non-governmental organisations.

Those reporting the existence of national CPD programmes were asked to describe: (i) the programme's stated objectives, (ii) which midwives are offered the training, and (iii) the amount of training offered (Table 3.13). The stated objectives of the programmes tended to be general and focussed on improving quality of care, maintaining midwifery competencies and providing opportunities for midwives to complete CPD requirements for re-licensure. Most national CPD programmes are offered to midwives currently employed in the public sector, and some are offered to private sector midwives at their own cost.

Table 3.13: Existence and characteristics of national in-service training programmes

Country	National in-service training programme?	Stated objectives	Which midwives are offered it	Notes
Afghanistan	Yes *	To enhance the quality of midwifery services		At the time of data collection, AMA and other organisations ran mentoring and capacity building training
Bangladesh	No *	NA	NA	Programme exists for humanitarian sector midwives. Programme was planned for 2024 for all public sector midwives
Bhutan	No	NA	NA	-
Cambodia	Yes	To build competence and fulfil CPD requirements	All midwives employed in health facilities	Programme timetable is variable, offered as little as one half-day to one-month in length
DPR Korea	Yes	-	-	-
India	Yes	To create a pool of trained midwives in line with ICM	Trained MSc/BSc with relevant experience	
Indonesia	Yes	-	All public sector midwives, plus self-funded private sector midwives.	-
Iran	Yes	To improve quality of midwifery care	Various	-
Lao PDR	Yes *	To develop and maintain knowledge and skills	All midwives	Programme was planned for 2024
Malaysia	DK	-	-	-
Maldives	No	NA	NA	Planned for 2025
Mongolia	Yes	For CPD	All midwives	5 programmes offered
Nepal	Yes *	DK	Staff nurses and associate professional midwives	Programme is not specific to midwives
Pakistan	No *	-	-	Training is offered by various organisations and institutions.
PNG	Yes	To upskill midwives	All midwives	Training is offered annually to those who have not accessed it in the past
Philippines	Yes	To upskill and provide latest updates to midwives	All public sector midwives, plus self-funded private sector midwives.	Some provided by DoH, some by development partners
Sri Lanka	Yes	DK	DK	Programmes are offered nationally and at local institutions
Thailand	Yes	To maintain and update competencies	-	-
Timor-Leste	Yes	To provide in-service training to midwives	All midwives employed in health facilities	Programme offerings vary according to topic
Viet Nam	No	-	-	

- = no data. NA = not applicable. * Exception exists; see notes.

Many of the region's CPD programmes appear to be offered inconsistently or irregularly, and it is not always clear which midwives can access them. In response to the identification of CPD for midwives as a global priority to strengthen SRMNAH care [25] and to the variation in type and quality of national programmes in the region, UNFPA APRO has published a CPD framework for midwives in clinical practice, [53] which aims to support countries to develop and strengthen CPD programmes to meet the needs of the midwifery workforce. It provides guidance on minimum requirements (hours) and learning frequency for maintaining competence and for re-licensure, and presents recommended content. Box 3.6 illustrates how CPD programmes can be responsive to the learning needs of midwives, meet the SRMNAH care needs of women and newborns, and align with the UNFPA CPD framework.

Overall, the existence of national in-service CPD programmes for midwives in most countries across the region is a positive step towards strengthening SRMNAH care. However, the existence of a CPD programme is just the first step: ongoing support and development for these programmes are needed to ensure that in-service CPD programmes reach all clinical midwives, that the content is tailored to the learning and practice needs of midwives, and that CPD programmes are offered regularly and are of high quality. It is vital that CPD programmes are available to midwives to ensure they are able to fulfil licensing requirements regarding continuing learning and clinical competence.

Box 3.6: Continuing professional development to empower midwives to meet SRMNAH care needs during natural disasters in Iran

Responding to the needs of women and newborns during natural disasters

On September 21, 2022, the city of Khoy in West Azerbaijan Province, northwest Iran, was hit by a series of earthquakes – the beginning of an 'earthquake swarm'. These earthquakes continued into 2023, injuring thousands of people and causing significant damage to infrastructure. In response, Khoy University of Medical Sciences and UNFPA collaborated to implement an in-service training workshop to enable midwives to effectively prepare for and respond to natural disasters, funded by UNFPA, the Iranian Red Crescent Society and the Ministry of Health and Education. The 'Reproductive Health in Disasters' workshop ran for three days and trained 30 midwives (10 midwives from two district hospitals and 20 midwives from 18 health posts) to provide life-saving services during disasters. The following topics were covered:

- **Emergency Obstetric and Newborn Care (EmONC)**
- **Cardiopulmonary resuscitation for pregnant women and newborns**
- **Providing maternal health care in disasters**
- **Rapid response protocols and triage in disasters**
- **The Minimum Initial Services Package (MISP)**
- **Responding to trauma during and after emergencies**

Using contemporary methods for clinical teaching and learning

Facilitators used innovative and interactive teaching strategies – simulation, case scenarios, games and teamwork activities – to support the midwives to gain confidence and competence in disaster preparedness and emergency response. Midwives were supported to practise maternal and newborn resuscitation in simulation. Time management skills were developed using games and teamwork. Participating midwives were also provided with communication materials to share with women and families to strengthen community knowledge regarding natural disasters.

Photo credit: © UNFPA/Iran

The workshop was positively reviewed by the midwives, who valued the opportunity to develop both theoretical and practical knowledge and skills. Evaluations of the workshop showed a lasting impact on midwives' knowledge and confidence to prepare for natural disasters and respond to the SRMNAH care needs of women and newborns in times of crisis.

Links to UNFPA CPD Framework for Midwives in Asia-Pacific

The CPD framework [53] provides guidance on minimum requirements and learning frequency for maintaining midwives' competence and re-licensure. The framework is based on the premise that clinical skills and knowledge diminish over time if not used regularly in practice and that all midwives may encounter or be called to support obstetric and newborn emergencies within their practice setting. This excellent example of responsive CPD for midwives in Iran aligns with the following recommendations outlined in the CPD framework:

Survive: Refresher updates on EmONC and resuscitation; providing midwifery care in humanitarian settings (recommended – annual)

Thrive: Disaster and emergency preparedness and practise (recommended – periodic); crisis counselling and mental health first aid (recommended – needs-based)

Transform: Climate change and health impact (recommended – periodic)

Photo credit: © UNFPA/Iran

Midwife-led improvements to service delivery

A midwife-led unit is one where midwives take primary professional responsibility for planning, organising and delivering services using a midwifery model of care (MMoC). An MMoC is one in which the main care providers are educated, licensed, regulated midwives who autonomously provide and coordinate care across their full scope of practice, using an approach that is aligned with the midwifery philosophy of care. The midwifery philosophy of care: (i) promotes a person-centred approach to care, (ii) values the woman-midwife relationship and partnership, (iii) optimises physiological, biological, psychological, social and cultural processes, and (iv) uses interventions only when indicated. [55] There is extensive evidence of the safety and benefits of midwife-led care during pregnancy, childbirth and the postpartum period. As a result, WHO recently released a global position paper about transitioning to this model of care. [7]

WHO recommends midwife-led care in settings with a functional midwifery programme. [56] A recent study identified a number of success factors for successful application of this model of care in low- and middle-income countries, including: effective financing models, the provision of high-quality care, interfacility coordination, and supportive leadership and governance. [57]

Table 3.14 shows that half of the 20 participating countries reported the existence of at least one midwife-led unit.[11] Three countries have units where midwives are the only available providers, but they are not committed to the midwifery philosophy of care so are not counted here as having midwife-led care. Of the ten countries with midwife-led units, eight reported plans to open additional such units within the next five years. In addition, four countries which currently do not have midwife-led units reported plans to introduce them within five years: Lao PDR, Mongolia, PNG, and Thailand. If these plans are implemented, by 2030 over half of Asian countries will offer care at midwife-led units.

Table 3.14: Midwife-led units at health facilities

Has one or more midwife-led units providing a midwifery model of care	**Afghanistan*, Bangladesh*, Cambodia*, DPRK, India*, Indonesia*, Iran*, Nepal*, Pakistan*, Philippines**
Has units where midwives are the only available provider, but it is not a midwifery model of care	**Bhutan, PNG*, Thailand***
No midwife-led units	**Lao PDR*, Malaysia, Maldives, Mongolia*, Sri Lanka, Timor-Leste, Viet Nam**

* = In this country, there are plans to introduce midwife-led units, or open additional ones, within the next 5 years.

[11] Defined in the questionnaire as one "where midwives take primary professional responsibility for planning, organizing, and delivering services using a midwifery model of care".

Previous research has found that, in many countries, midwife-led care is particularly valued in poor and marginalised communities which may not be well served by the prevailing model of SRMNAH care. [58]

Box 3.7 illustrates how this model of care is meeting the needs of indigenous and remote communities in two AP countries.

Box 3.7: Midwife-led care in indigenous / remote communities in Bangladesh and Philippines

Bangladesh:

In 2017 UNFPA supported four young women from the Santal community, a marginalised tribal group in northern Bangladesh, with scholarships to enrol in a 3-year midwifery programme at a private college. One of these was Minoti Murma, who said: *"In my neighbourhood, the usual age of marriage for a girl is ten to twelve. There are a lot of adolescent pregnancies for this reason. Even a few years ago, childbirth was ridden with antiquated rituals which forbade women from giving birth inside their homes or in the presence of loved ones; instead, labouring mothers were sent outside their houses and made to lay in uncomfortable makeshift straw beds to give birth with the assistance of a local birth attendant. The mother and newborn baby were prohibited from entering the house for seven days after birth."*

Norms like this inspired Minoti to build her capacity to support women, especially pregnant and labouring mothers. Midwifery education seemed like the perfect opportunity to achieve her dream. But this was not an easy road to take: *"Even getting admitted to the midwifery programme seemed impossible, my family was extremely poor and we were unable to pay the admission fees. It was at that bleak moment that I was informed about being selected as one of the four female students of the Santal community who had been awarded a scholarship to undertake midwifery education. That day, my older brother and I wept in delight"*.

After completing her three-year midwifery diploma in 2019, Minoti took the licensing examination and succeeded in becoming a registered midwife. In 2020, with her fellow

Photo credit: © UNFPA/Bangladesh

Santal midwives, Minoti joined Samara Union Health and Family Welfare Centre in Gaibandha, where she continues working hard to improve the Santal community's access to life-saving midwife-led care. Approximately 20 per cent of the facility's service users are Santal women and

awareness of midwife-led sexual and reproductive health services by these indigenous midwives is growing swiftly in the Santal community, as Minoti explained: *"I see women coming from my community, being surprised and inspired to see and talk to me. They express their satisfaction in coming here. I immediately ask them to tell their friends and family to come to the health facility for delivering babies and to receive antenatal and postnatal checkups. Women are becoming more aware of their rights for sexual and reproductive health"*.

On International Women's Day 2023, Minoti received a national award for her outstanding services and contributions.

Photo credit: © UNFPA/Bangladesh

Philippines:

Both Jacky Pangsiw and Evelyn Dungoc became midwives to make birth safer for the mothers and babies in their communities, and that is what they are doing at the two midwife-led units in the province of Kalinga, run by the Abundant Grace of God Maternity Centre. The units have been providing women of Kalinga with competent and compassionate maternity services since 2007. One of the units is in the municipality of Tinglayan, which is home to several indigenous groups living in 20 barangays (communities). Just one main road connects the communities of Tinglayan to Tabuk City where the closest hospital is located. Due to tribal conflicts and increasing frequency of landslides, reaching the hospital in times of emergency can be treacherous and sometimes even impossible.

Because of Jacky and Evelyn, women from the surrounding communities of Tinglayan can receive complete perinatal services close to their homes. The unit is stocked with life-saving medications, an emergency vehicle, and most importantly, two extremely competent midwives.

Photo credit: © UNFPA/Philippines

In October 2024, a teacher from the local high school gave birth at the centre under the care and support of Jacky and Evelyn. The teacher shared that she was so pleased that she could give birth safely, close to her home, and in a way that was culturally appropriate for her.

Photo credit: © UNFPA/Philippines

Midwifery leadership and governance

The existence of midwives in leadership positions can improve the quality of decision-making on issues that affect midwives and their clients, and they may also facilitate the provision of effective midwife supervision and mentoring systems. The development of midwives' leadership skills is therefore an essential component of CPD.

Figure 3.5 shows that midwives occupy leadership positions within national-level organisations in some of the responding countries. In most countries with a professional association for midwives, a midwife leads the association, but in a few cases (where the association is open to both midwives and nurses), this position is held by a nurse. Twelve countries have a person who is responsible for setting the strategic direction for midwifery at a national level, but in nine of these countries the position is held by someone who is not a midwife. Fewer countries (n=9) have a midwife advisor within the national MoH, and in four of those countries this position is held by a midwife. Most regulatory bodies for midwifery are led by people who are not midwives: all 20 reporting countries have a regulatory body, of which only seven are led by a midwife.

The questionnaire included the option to provide details of other national-level leadership positions in maternal and newborn health. Fourteen countries mentioned at least one of these, of which four reported that the role was held by a midwife. Bangladesh, Thailand, and Timor-Leste have midwives in leadership roles within a department or directorate within the MoH with responsibility for aspects of SRMNAH, and Indonesia has a midwife leading an association of midwifery education institutions.

Figure 3.5: Midwives in national leadership positions

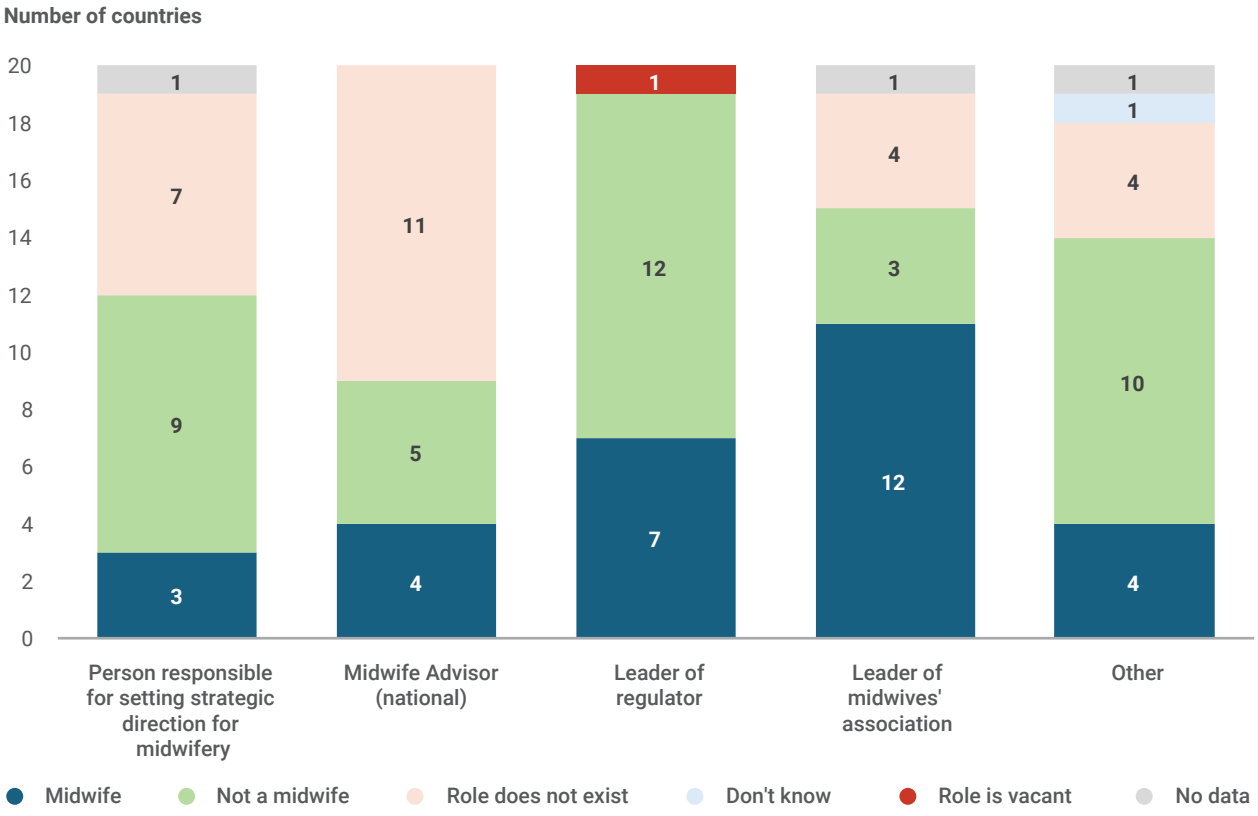


Table 3.15 shows country-by-country responses to the above questions. Afghanistan, Iran, and Malaysia stand out for having midwives in a wide variety of national leadership roles. By contrast, seven countries report no midwives at all in national leadership positions: Bhutan, DPRK, India, Lao PDR, Nepal, Pakistan, and Sri Lanka. In some of these countries, midwifery is a young profession and midwife leaders might be expected to emerge in the near future. In others, it may be a reflection of negative gender norms and/or a health service hierarchy that does not consider midwives to have leadership potential.

Table 3.15: Midwives in leadership positions, by country

Country	Person responsible for setting strategic direction for midwifery	Midwife Advisor (national)	Leader of regulator	Leader of midwives' association	Other
Afghanistan	Midwife	Midwife	Midwife	Midwife	na
Bangladesh	Not a midwife	na	Not a midwife	Midwife	Midwife
Bhutan	na	na	Not a midwife	na	Not a midwife
Cambodia	Not a midwife	Not a midwife	Midwife	Midwife	Not a midwife
DPR Korea	Not a midwife	Not a midwife	Not a midwife	-	Not a midwife
India	Not a midwife	Not a midwife	Not a midwife	Not a midwife	Not a midwife
Indonesia	na	na	Not a midwife	Midwife	Midwife
Iran	Midwife	Midwife	Midwife	Midwife	DK
Lao PDR	Not a midwife	na	Not a midwife	Not a midwife	Not a midwife
Malaysia	Midwife	Midwife	Midwife	Midwife	Not a midwife
Maldives	na	na	Midwife	na	na
Mongolia	na	na	Not a midwife	Midwife	na
Nepal	Not a midwife	na	Not a midwife	Not a midwife	Not a midwife
Pakistan	Not a midwife	na	Not a midwife	Not a midwife	Not a midwife
PNG	na	na	Midwife	Midwife	Not a midwife
Philippines	na	na	Not a midwife	Midwife	Not a midwife
Sri Lanka	Not a midwife	Not a midwife	Not a midwife	na	-
Thailand	-	Midwife	Midwife	na	Midwife
Timor-Leste	na	na	Not a midwife	Midwife	Midwife
Viet Nam	Not a midwife	Not a midwife	Role vacant	Midwife	na

DK = don't know. na = role does not exist in this country. - = No data.

The survey also collected information about which countries have midwives in legislative positions, i.e. members of national or sub-national legislative bodies (Table 3.16). Six of the responding countries have midwives in legislative roles, including two with midwives elected to the national parliament (Indonesia and Timor-Leste).

Table 3.16: Midwives in legislative positions, by country

Country	National parliament	Sub-national parliament	Local authority
Afghanistan	no	no	DK
Bangladesh	no	no	no
Bhutan	no	no	no
Cambodia	DK	DK	DK
DPR Korea	-	yes	yes
India	no	no	no
Indonesia	yes	yes	yes
Iran	DK	yes	yes
Lao PDR	no	no	no
Malaysia	no	DK	DK
Maldives	no	no	no
Mongolia	no	no	no
Nepal	no	no	no
Pakistan	no	no	yes
PNG	no	no	no
Philippines	no	no	no
Sri Lanka	no	DK	yes
Thailand	no	no	no
Timor-Leste	yes	na	yes
Viet Nam	no	no	no

DK = don't know. - = no data. na = not applicable.

In addition to highly visible leadership roles such as those described above, it is also important to have midwives involved in key activities and structures that influence SRMNAH care, regulation and research. Table 3.17 shows that most responding countries have midwives routinely involved in six of the listed activities: MPDSR committees, quality improvement initiatives, defining and reviewing the midwife's scope of practice, production of national guidelines, ob/gyn education and training, and monitoring and evaluation. Fewer AP countries have midwives routinely involved in other important activities such as research ethics committees, trialling of new drugs, and professional misconduct hearings.

The only country that reported midwife involvement in all 12 of the listed activities is Thailand. A further four countries reported that midwives were involved in 11 of the 12: Bhutan, Indonesia, Iran, and Timor-Leste. By contrast, midwives are routinely involved in

fewer than half of the listed activities in: Bangladesh, DPRK, India, Mongolia, Nepal, PNG, and Sri Lanka. Again, in some countries this likely reflects the fact that midwifery is a new profession, and as midwives gain more experience and as countries continue to develop midwife deployment strategies, they might be expected to play a role in these activities in the future.

Table 3.17: Midwives' involvement in key SRMNAH activities

Activity	Number of countries where midwives are routinely involved (/20)	Midwives are NOT routinely involved in this activity in…	No data from…
Maternal and perinatal death surveillance and response (MPDSR) committee	18	India, PNG	-
Quality improvement initiatives for women's health or maternal and newborn health	18	Bangladesh	Sri Lanka
Defining and periodically reviewing the midwife's scope of practice	16	India, Nepal, Sri Lanka	Viet Nam
Production of national guidelines for women's health or maternal and newborn health	14	India, Mongolia, Nepal, PNG, Viet Nam	Sri Lanka
Ob/gyn education and training curriculum development	14	Bangladesh, India, Indonesia, Nepal, Sri Lanka, Viet Nam	-
Monitoring and evaluation of maternal and newborn health initiatives	14	Afghanistan, Bangladesh, India, Mongolia, Nepal, Philippines	-
Implementation of Minimum Initial Service Package (MISP) in humanitarian crises	11	India, Lao PDR, Maldives, Mongolia, Nepal, Viet Nam	Afghanistan, PNG, Sri Lanka
Committees / initiatives that receive and analyse feedback from health service users, e.g. satisfaction surveys, complaint systems	11	Bangladesh, India, Nepal, Philippines, Sri Lanka	Afghanistan, Lao PDR, Pakistan, PNG
Professional misconduct hearings	10	Bangladesh, DPRK, Lao PDR, Mongolia, Nepal	Afghanistan, India, Pakistan, PNG, Sri Lanka
Expert witnesses in clinical negligence cases or similar	9	Bangladesh, Cambodia, Lao PDR, Mongolia, Nepal, Sri Lanka	Afghanistan, India, Pakistan, PNG, Timor-Leste
Trialling and rolling out new drugs or treatments for maternal and newborn health, e.g. heat-stable carbetocin	8	Bangladesh, Bhutan, India, Malaysia, Maldives, Mongolia, Nepal, Philippines, Sri Lanka	Afghanistan, Lao PDR, Viet Nam
Research ethics committees	6	Bangladesh, DPRK, India, Lao PDR, Malaysia, Mongolia, Nepal, Pakistan, PNG, Philippines, Sri Lanka, Viet Nam	Cambodia, Iran

Box 3.8 describes the range of midwifery leadership roles that exist in Cambodia, a country where the midwifery profession is somewhat more established. Box 3.9 describes the process and results of an initiative to share knowledge and experience between Bangladesh and Nepal.

Box 3.8: Midwifery leadership in Cambodia

Midwife-led care was introduced in Cambodia in the late 1990s. Between 2010-2023 the number of midwives has more than doubled, and now stands at over 8,500. The core competency framework for midwives was updated in 2020 to meet the local context and ICM standards, and endorsed in 2022. The Cambodian government is committed to provide a better quality of midwifery care by implementing these recent standards and scope of practice; and is also determined that health centres should have at least two midwives - to date, 85% of health centres meet this aim, and 68% of births in Cambodia are attended by midwives or nurses. [59]

These developments have been facilitated by midwives being recognised as key stakeholders for policy formulation and strategic direction for SRMNAH care, including their active membership of the Technical Working Group for Maternal and Child Health led by the Secretary of State, Ministry of Health. Midwives currently chair both the regulatory body for midwifery (Cambodian Midwives Council) and the professional association for midwives (Cambodia Midwives Association), which represent midwives in both the public and private sectors.

Midwife leadership and involvement in policy formulation and strategy has also led to a clear distinction between nursing and midwifery practice and responsibility, and the midwife being recognised as an autonomous health professional competent to plan and lead midwifery care at different levels of health facilities. Midwife-led care is not only recognised by the women and the community but also respected by other health professionals like obstetricians and nurses. According to the 2023 Health Congress Report, this enabled an increase in the number of vaginal births in the community.

Photo credit: © UNFPA/Cambodia

Box 3.9: South-South collaboration and learning: Bangladesh & Nepal

The UNFPA Country Offices of Bangladesh and Nepal embarked on a South-South collaboration to bolster the development of professional midwifery in both nations. Nepal and Bangladesh, both climate-vulnerable countries, have persisting challenges and this initiative sought to strengthen each country's national midwifery programme and to synergise midwifery development across the region.

In November 2023, a delegation from UNFPA Bangladesh, accompanied by the First Secretary of the Embassy of Sweden, embarked on a trip to Nepal to immerse themselves in Nepal's midwifery programme. A reciprocal visit in February 2024 brought a delegation from UNFPA Nepal to Bangladesh where staff met with representatives from Directorate General of Nursing and Midwifery (DGNM), Bangladesh Nursing and Midwifery Council (BNMC) and various midwifery educational institutions. They also visited Dhaka Medical College Hospital to see the clinical placement of midwifery students and the fistula centre. Field visits to various health facilities at different levels in Cox's Bazar demonstrated the context in which midwives operate, from district to union levels and even in humanitarian response.

Dr. Sangeeta Kaushal Mishra, Director-General, Department of Health Services, Ministry of Health and Population, Nepal said: "*We have heard so much about the Bangladesh health system model. It is highly encouraging that I got to see what goes on the ground. It has given me a good insight and a good understanding, and now I can relate to how Nepal's health system is doing and how we can work together. It's very encouraging to see all these midwives. And the most important thing that I realised is that (in this health facility) you have a high rate of normal delivery and a decreasing C-section. So, congratulations on that!*"

Members of the Nepal delegation expressed their appreciation: "*Midwives in Bangladesh are playing a crucial role for saving mothers, reaching from the heart of communities to the furthest corners. Their presence, extending even to floating ship hospitals, embodies the unwavering commitment to ensuring every woman's access to maternal health services aiming for 'no one left behind'. Appreciating UNFPA Bangladesh's advocacy and strong collaboration with the government,*

we recognise the transformative impact of a dedicated force in safeguarding the journey of motherhood for all".

The key results of this collaboration were as follows:

1. Technical inputs to the Nepal Midwifery Roadmap through review of draft document and virtual consultations
2. Organise high level exchange visit for Nepal delegation in 2024 - government officials, parliamentarians etc.
3. Develop a comprehensive advocacy framework with a clear narrative as part of the national midwifery roadmap including engagement of high level decision makers and influencers
4. Document Bangladesh's midwifery journey - success, challenges & learnings-and share with Nepal
5. Document and share UNFPA Nepal's experience of establishing a midwife-led unit at the Paropakar Maternity Hospital including the powerful testimony of the hospital director
6. Using the statement made by the Health Secretary as an opportunity, as an immediate action, explore possibility of deployment of available midwives in primary health care centres and demonstrate impact of midwives on maternal health and beyond
7. As part of the national roadmap, develop a plan for training of midwives and step by step deployment to primary health care centres as per Secretary's suggestion
8. Establish executive exchange programme between Bangladesh and Nepal for key policy- and decision-makers

9. Establish faculty exchange programme between Bangladesh and Nepal for peer to peer faculty development
10. Initiate UNFPA technical team exchange programme for cross learning (e.g. UNFPA Nepal midwifery leading to participation in main midwifery event in Bangladesh in 2024)

This South-South collaboration not only strengthened the individual capacities of Bangladesh and Nepal but also laid the groundwork for a transformative regional initiative, showing the power of collaboration as a platform for mutual learning and in advancing SRMNAH across borders.

Photo credit: © UNFPA/Bangladesh/Nepal

Chapter 4:

Midwives in challenging environments

Photo credit: © UNFPA/Afghanistan

In some countries, the policy environment makes it difficult for midwives to work to their full scope of practice and therefore to meet the need for compassionate, woman-centred SRMNAH care. This chapter discusses the effects of a challenging work environment for midwifery in two AP countries: Afghanistan and Myanmar.

Afghanistan

Photo credit: © UNFPA/Afghanistan

In Afghanistan, there are strict rules about interactions between women and men. Effectively, these rules mean that women can obtain SRMNAH services only from female providers, which makes it essential that the health workforce includes women working as midwives, doctors and nurses. Rising emigration of female healthcare workers due to increased restrictions on their freedom of movement has led to a severe, and worsening, shortage of midwives, especially in rural areas.

Furthermore, shortly after the data were collected for this report, the Afghanistan government took the decision to ban women from education. Because midwifery in Afghanistan is an exclusively female profession, this ban has effectively stopped the production of new graduate midwives. Afghanistan's midwife shortage is therefore set to worsen as midwives leave or retire from the profession with no new graduates to replace them. Furthermore, recent changes in the donor landscape for Afghanistan have led to a focus on keeping health facilities open rather than adding additional health workers to the payroll.

Restricted access to high-quality education and training for midwives in Afghanistan impedes their ability to work to their full scope of practice. This is exacerbated by the lack of a robust regulatory body for midwifery, low salaries, limited career advancement opportunities, and cultural and religious norms that influence women's freedom to seek SRMNAH services.

Within this challenging environment, UNFPA continues to provide support where it can. At the time of writing, the government had

not moved against the provision of CPD for female health workers, including midwives working in family health houses and other health facilities. UNFPA has supported unemployed midwives to undertake refresher training so that they could be deployed to locations in need of a midwife. UNFPA also supports implementing partners with CPD activities for midwives, such as supervisory visits and online, telephone, and app-based learning and support.

However, there is increasing pushback from the religious authorities against Afghan women working with the international organisations that provide most of the CPD for health workers. In addition, in some areas of the country there are restrictions on women gathering in large groups, which means that in-person CPD activities must be low-profile, e.g. conducted in small groups by female providers within health facilities.

The mentorship programme for new graduate midwives that was mentioned in Chapter 3 is currently inactive due to the closure of the midwifery schools. To enhance the sustainability and cost-effectiveness of the mentorship programme, UNFPA Afghanistan intends to train implementing partners' reproductive health supervisors and community health worker trainers in mentorship. This will enable them to provide support to midwives working in Afghanistan's family health houses.

Myanmar

Photo credit: © UNFPA/Myanmar/Benny Manser

Myanmar's midwifery sector is currently facing one of the most critical challenges, following the political upheaval in 2021. While the SoWMy 2021 report initially projected a positive outlook, with Myanmar nearing the global average for midwife density and poised to meet all of the need for essential SRMNAH care by 2030, in

recent years the situation has become concerning. The number of midwives has decreased significantly, from 13,500 in 2020-21 to 8,000 in 2022-23. Similarly, the number of nurses fell from 24,000 to 10,600, and the physician headcount fell from over just over 11,000 to 4,400 during the same period. [60]

This workforce shortage is compounded by a considerable decrease in the education pipeline, with annual midwifery graduates falling from over 1,300 in 2019 to just 21 in 2023. [18] Similar declines are evident in medical doctor and nurse graduates, signalling a severe challenge in health worker education, training and deployment. The shortage is due to significant numbers of healthcare staff leaving Myanmar since 2021, as well as repeated attacks on health care facilities. Insecurity Insight documented 1,507 attacks on facilities in Myanmar between February 2021 and October 2024. [61]

The consequences of this situation are extremely serious, with clear potential to impact access to skilled midwifery care and SRMNAH outcomes such as maternal mortality. Disruptions to essential healthcare services and health worker education have been exacerbated by natural disasters, including the earthquake in March 2025. This means the midwifery profession faces significant challenges, including limited resources, disrupted education and training programmes, and security concerns.

Addressing this crisis requires immediate and innovative actions. Prioritising the safety and well-being of midwives and all health care workers is paramount. This includes ensuring adequate resources and support, investing in rebuilding healthcare infrastructure, and actively working to mitigate risks to healthcare. Strengthening and scaling up midwifery education and training programmes is crucial. Empowering midwives to participate in decision-making processes and advocating for policies that support the profession and improve maternal health outcomes is essential. Finally, addressing gender inequality within the healthcare sector and recognising the specific challenges faced by female healthcare workers, including midwives, is critical.

The future of SRMNAH in Myanmar depends on a concerted effort from all stakeholders to address this crisis. By prioritising the midwifery workforce, investing in education and training, strengthening healthcare infrastructure, and empowering midwives, Myanmar can begin to rebuild its health care system and work towards a future where all women and their families have access to quality SRMNAH care.

Conclusion

The Asia region demonstrates a variety of approaches to midwifery education, regulation, and deployment. A significant achievement for the region since the global SoWMy 2021 report is that several countries – with the support of UNFPA - have established clear national standards for midwifery education, updated curricula, and invested in faculty development. There is still work to be done to align with international standards and ensure that midwife education programmes are regulated, accredited, and led by midwives. The existence and implementation of midwife deployment strategies and sanctioned positions also differ significantly between countries, leading to gaps in workforce distribution and sometimes underutilisation of the educated midwife graduates within existing healthcare systems.

A significant challenge is the transition of newly graduated midwives into practice, with some countries lacking structured support or mentorship programmes. This continues to be an area of need. Variations in regulatory body functions, particularly regarding the monitoring of quality of care and fitness-to-practice assessments, also exist. The proportion of qualified midwives serving as faculty members remains inconsistent across the region, affecting the overall quality of pre-service education. Furthermore, the lack of comprehensive tracking systems for graduate recruitment and deployment hinders effective policy alignment between the education and health sectors.

Overall, the report highlights both progress and persistent challenges in strengthening midwifery services in the Asia region. While many countries have made efforts to develop midwifery education standards and regulatory frameworks, further investment and strategic planning are needed to ensure successful deployment, retention, and support for midwives. Addressing the gaps in faculty development, transition to practice programmes, and workforce tracking will be crucial in optimising the contributions of midwives to maternal and newborn health outcomes across the region.

Country profiles

Afghanistan

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	nr	nr	nr	nr	nr	nr	nr	nr
Midwifery associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nursing professionals*	nr	nr	nr	nr	nr	nr	nr	nr
Nursing associate professionals*	nr	nr	nr	nr	nr	nr	nr	nr
Community health workers	nr	nr	nr	nr	nr	nr	nr	nr
Paramedical practitioners	nr	nr	nr	nr	nr	nr	nr	nr
Medical assistants	nr	nr	nr	nr	nr	nr	nr	nr
General medical practitioners	nr	nr	nr	nr	nr	nr	nr	nr
Obstetricians and gynaecologists	nr	nr	nr	nr	nr	nr	nr	nr
Paediatricians	nr	nr	nr	nr	nr	nr	nr	nr
TOTAL SRMNAH WORKFORCE		-		-	-			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	7	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2021**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	**yes**	1 of 1
Post-nursing	**no**	na
Combined	**no**	na

Transition to practice programme for new graduates? **yes**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	don't know	all	all	all	all

Midwifery Regulation

How often are midwives required to renew their licence? **Never - a licence is for life**

Compulsory continuing professional development (CPD)? **It is not compulsory, but it is recommended**

Midwife-specific deployment strategy? **Yes, fully implemented**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	midwife	midwife	midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	don't know

Notes:
Data collection took place before midwife education was stopped in 2024

nr = not reported; na = not applicable

Bangladesh

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	2024	7,880	100%	7,880	0.5	2023	3,000	38%
Midwifery associate professionals	2024	21,034	100%	21,034	1.2	na	na	na
Nurse-midwife professionals	2024	95,267	60%	57,160	5.5	2023	15,000	16%
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	2024	12,278	44%	5,402	0.7	nr	nr	nr
Nursing associate professionals*	2024	2,425	50%	1,213	0.1	nr	nr	nr
Community health workers	nr	nr	nr	nr	nr	nr	nr	nr
Paramedical practitioners	2024	48,205	30%	14,462	2.8	nr	nr	nr
Medical assistants	2024	3,443	30%	1,033	0.2	nr	nr	nr
General medical practitioners	2021	60,143	20%	12,029	3.5	nr	nr	nr
Obstetricians and gynaecologists	2024	3,200	50%	1,600	0.2	nr	nr	nr
Paediatricians	2024	1,750	15%	263	0.1	nr	nr	nr
TOTAL SRMNAH WORKFORCE		255,625		122,075	14.7			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	6	of 7
Number of modern contraceptive methods midwives authorised to provide	4	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2019**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	yes	1 of 1
Post-nursing	no	na
Combined	yes	na

Transition to practice programme for new graduates? **no**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	all	some	some

Midwifery Regulation

How often are midwives required to renew their licence? **Every 4-5 years**

Compulsory continuing professional development (CPD)? **No**

Midwife-specific deployment strategy? **Yes, not fully implemented**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	na	not a midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:

nr = not reported; na = not applicable

Bhutan

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	na	na	na	na	na	na	na	na
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	2023	1,617	100%	1,617	20.6	2023	201	12%
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	na	na	na	na	na	na	na	na
Nursing associate professionals*	na	na	na	na	na	na	na	na
Community health workers	2020	580	10%	58	7.5	nr	nr	nr
Paramedical practitioners	**2022**	**659**	30%	198	8.4	nr	nr	nr
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	2023	401	20%	80	5.1	nr	nr	nr
Obstetricians and gynaecologists	2024	18	50%	9	0.2	nr	nr	nr
Paediatricians	2024	19	15%	3	0.2	nr	nr	nr
TOTAL SRMNAH WORKFORCE		3,294		1,965	42.1			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	4	of 7
Number of modern contraceptive methods midwives authorised to provide	4	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content? — Yes, and all public and private sector schools base their curriculum on the standards

Year last revised — 2018

National faculty development programme? — no

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	**no**	na
Post-nursing	**no**	na
Combined	**yes**	na

Transition to practice programme for new graduates? — no

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
none	none	none	none	none	none

Midwifery Regulation

How often are midwives required to renew their licence? — Every 4-5 years

Compulsory continuing professional development (CPD)? — It is a compulsory element of the process of licence renewal

Midwife-specific deployment strategy? — Yes, fully implemented

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	na	na	not a midwife	na

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:
All nurses are counted as nurse-midwives

nr = not reported; na = not applicable

Cambodia

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	2023	6,452	100%	6,452	3.8	2023	498	8%
Midwifery associate professionals	2023	2,166	100%	2,166	1.3	na	na	na
Nurse-midwife professionals	na	na	na	na	na	na	na	na
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	2023	10,497	44%	4,619	6.2	nr	nr	nr
Nursing associate professionals*	2023	2,569	50%	1,285	1.5	nr	nr	nr
Community health workers	na	na	na	na	na	na	na	nr
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	2023	424	30%	127	0.3	nr	nr	nr
General medical practitioners	2023	4,591	20%	918	2.7	nr	nr	nr
Obstetricians and gynaecologists	2024	568	50%	284	0.3	nr	nr	nr
Paediatricians	nr	nr	nr	nr	nr	nr	nr	nr
TOTAL SRMNAH WORKFORCE		27,267		15,851	16.1			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	7 of 7
Number of modern contraceptive methods midwives authorised to provide	5 of 5
Midwife-led units providing a midwifery model of care?	Yes

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2020**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	yes	2 of 2
Post-nursing	yes	0 of 1
Combined	no	na

Transition to practice programme for new graduates? **yes**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	some	some	some

Midwifery Regulation

How often are midwives required to renew their licence? **Every 2-3 years**

Compulsory continuing professional development (CPD)? **It is a compulsory element of the process of licence renewal**

Midwife-specific deployment strategy? **Yes, not fully implemented**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	not a midwife	midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	don't know	don't know	don't know

Notes:
Two of Cambodia's three midwifery education programmes adhere fully to ICM standards on 'programme and curriculum'

nr = not reported; na = not applicable

Democratic People's Republic of Korea

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	na	na	na	na	na	na	na	na
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	2022	111,549	100%	111,549	42.9	nr	nr	nr
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	na	na	na	na	na	na	na	na
Nursing associate professionals*	na	na	na	na	na	na	na	na
Community health workers	na	na	na	na	na	na	na	na
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	2022	95,955	20%	19,191	36.9	nr	nr	nr
Obstetricians and gynaecologists	nr	nr	nr	nr	nr	nr	nr	nr
Paediatricians	nr	nr	nr	nr	nr	nr	nr	nr
TOTAL SRMNAH WORKFORCE		207,504		130,740	79.7			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	2	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content?	Yes, and all public and private sector schools base their curriculum on the standards		Year last revised	2019	National faculty development programme?	yes

Pre-service education programmes:

		Number meeting recommendations re: duration		
Direct entry	no	na	Transition to practice programme for new graduates?	no
Post-nursing	no	na		
Combined	yes	na		

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
nr	nr	nr	all	nr	all

Midwifery Regulation

How often are midwives required to renew their licence?	Every 2-3 years	Compulsory continuing professional development (CPD)?	It is a compulsory element of the process of licence renewal	Midwife-specific deployment strategy?	Yes, fully implemented

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	not a midwife	not a midwife	nr

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	nr	yes	yes

Notes:
All nurses are counted as nurse-midwives

nr = not reported; na = not applicable

India

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	nr	nr	nr	nr	nr	nr	nr	nr
Midwifery associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nursing professionals*	nr	nr	nr	nr	nr	nr	nr	nr
Nursing associate professionals*	nr	nr	nr	nr	nr	nr	nr	nr
Community health workers	nr	nr	nr	nr	nr	nr	nr	nr
Paramedical practitioners	nr	nr	nr	nr	nr	nr	nr	nr
Medical assistants	nr	nr	nr	nr	nr	nr	nr	nr
General medical practitioners	nr	nr	nr	nr	nr	nr	nr	nr
Obstetricians and gynaecologists	nr	nr	nr	nr	nr	nr	nr	nr
Paediatricians	nr	nr	nr	nr	nr	nr	nr	nr
TOTAL SRMNAH WORKFORCE		-		-	-			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	4	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2022**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	**no**	na
Post-nursing	**yes**	1 of 1
Combined	**no**	na

Transition to practice programme for new graduates? **yes**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	all	all	all	all	all

Midwifery Regulation

How often are midwives required to renew their licence? **Every 4-5 years**

Compulsory continuing professional development (CPD)? **It is not compulsory, but it is recommended**

Midwife-specific deployment strategy? **Yes, fully implemented**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	not a midwife	midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	don't know	don't know	don't know

Notes:

nr = not reported; na = not applicable

Indonesia

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	2023	254,806	100%	254,806	9.2	nr	nr	nr
Midwifery associate professionals	2023	66,429	100%	66,429	2.4	nr	nr	nr
Nurse-midwife professionals	na	na	na	na	na	na	na	na
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	**2022**	**687,954**	30%	206,386	25.1	nr	nr	nr
Nursing associate professionals*	na	na	na	na	na	na	na	na
Community health workers	**2022**	**503,208**	10%	50,321	18.3	nr	nr	nr
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	2023	35,156	30%	10,547	1.3	nr	nr	nr
General medical practitioners	2023	160,636	20%	32,127	5.8	nr	nr	nr
Obstetricians and gynaecologists	2023	6,114	50%	3,057	0.2	nr	nr	nr
Paediatricians	2023	5,756	15%	863	0.2	nr	nr	nr
TOTAL SRMNAH WORKFORCE		1,720,059		624,536	62.5			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content?	Yes, and all public and private sector schools base their curriculum on the standards	Year last revised	2017	National faculty development programme?	no

Pre-service education programmes:

		Number meeting recommendations re: duration		
Direct entry	yes	2 of 2	Transition to practice programme for new graduates?	no
Post-nursing	no	na		
Combined	no	na		

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	some	some	some

Midwifery Regulation

How often are midwives required to renew their licence?	Every 4-5 years	Compulsory continuing professional development (CPD)?	It is a compulsory element of the process of licence renewal	Midwife-specific deployment strategy?	No

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	na	na	not a midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	yes	yes	yes

Notes:

nr = not reported; na = not applicable

Iran

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	**2023**	**77,531**	100%	77,531	8.7	2023	3,000	4%
Midwifery associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nursing professionals*	**2023**	**177,324**	30%	53,197	20.0	nr	nr	nr
Nursing associate professionals*	**2023**	**5,712**	40%	2,285	0.6	nr	nr	nr
Community health workers	nr	nr	nr	nr	nr	nr	nr	nr
Paramedical practitioners	nr	nr	nr	nr	nr	nr	nr	nr
Medical assistants	nr	nr	nr	nr	nr	nr	nr	nr
General medical practitioners	**2023**	**100,661**	20%	20,132	11.3	nr	nr	nr
Obstetricians and gynaecologists	**2018**	**4,223**	50%	2,112	0.5	nr	nr	nr
Paediatricians	**2018**	**5,772**	15%	866	0.6	nr	nr	nr
TOTAL SRMNAH WORKFORCE		371,223		156,123	41.8			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	4	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: 2012

National faculty development programme? yes

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	yes	1 of 1
Post-nursing	no	na
Combined	no	na

Transition to practice programme for new graduates? no

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	all	all	all	all	all

Midwifery Regulation

How often are midwives required to renew their licence? **Never - a licence is for life**

Compulsory continuing professional development (CPD)? **It is not compulsory, but it is recommended**

Midwife-specific deployment strategy? **No**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	midwife	midwife	midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	don't know	yes	yes

Notes:
All nurses are counted as nurse-midwives

nr = not reported; na = not applicable

Lao People's Democratic Republic

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	**2020**	**207**	100%	207	0.3	2023	174	84%
Midwifery associate professionals	**2020**	**1,472**	100%	1,472	1.9	na	na	na
Nurse-midwife professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife associate professionals	2023	2,752	60%	1,651	3.6	na	na	na
Nursing professionals*	2023	1,477	44%	650	1.9	nr	nr	nr
Nursing associate professionals*	2023	3,642	50%	1,821	4.8	nr	nr	nr
Community health workers	**2019**	**75**	10%	8	0.1	nr	nr	nr
Paramedical practitioners	**2019**	**781**	30%	234	1.1	nr	nr	nr
Medical assistants	**2019**	**1,145**	30%	344	1.6	nr	nr	nr
General medical practitioners	**2021**	**1,734**	20%	347	2.4	nr	nr	nr
Obstetricians and gynaecologists	**2019**	**54**	50%	27	0.1	nr	nr	nr
Paediatricians	**2019**	**81**	15%	12	0.1	nr	nr	nr
TOTAL SRMNAH WORKFORCE		13,420		6,772	17.9			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	7	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2021**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	**yes**	1 of 1
Post-nursing	**no**	na
Combined	**no**	na

Transition to practice programme for new graduates? **yes**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	all	some	some

Midwifery Regulation

How often are midwives required to renew their licence? **Every 4-5 years**

Compulsory continuing professional development (CPD)? **It is a compulsory element of the process of licence renewal**

Midwife-specific deployment strategy? **No**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	na	not a midwife	not a midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:
National faculty development programme is general, and not specific to midwifery faculty

nr = not reported; na = not applicable

Malaysia

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	na	na	na	na	na	na	na	na
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	2023	14,479	85%	12,307	4.2	2023	789	5%
Nurse-midwife associate professionals	2023	20,188	85%	17,160	5.9	na	na	na
Nursing professionals*	2023	106,526	30%	31,958	31.2	nr	nr	nr
Nursing associate professionals*	2023	1,206	40%	482	0.4	nr	nr	nr
Community health workers	na	na	na	na	na	na	na	na
Paramedical practitioners	2023	22,830	30%	6,849	6.7	nr	nr	nr
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	2023	68,210	20%	13,642	20.0	nr	nr	nr
Obstetricians and gynaecologists	2023	1,314	50%	657	0.4	nr	nr	nr
Paediatricians	2023	1,509	15%	226	0.4	nr	nr	nr
TOTAL SRMNAH WORKFORCE		236,262		83,282	69.2			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	3	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: 2018

National faculty development programme? yes

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	no	na
Post-nursing	yes	0 of 1
Combined	no	na

Transition to practice programme for new graduates? yes

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	all	all	all	all	all

Midwifery Regulation

How often are midwives required to renew their licence? Never - a licence is for life

Compulsory continuing professional development (CPD)? It is not compulsory, but it is recommended

Midwife-specific deployment strategy? No

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	midwife	midwife	midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	No	don't know	don't know

Notes:

nr = not reported; na = not applicable

Maldives

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	na	na	na	na	na	na	na	na
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	2024	1,724	85%	1,465	33.2	2023	8	0.5%
Nurse-midwife associate professionals	2024	27	85%	23	0.5	nr	nr	nr
Nursing professionals*	2024	2,252	30%	676	43.4	nr	nr	nr
Nursing associate professionals*	2024	286	40%	114	5.5	nr	nr	nr
Community health workers	**2020**	**224**	10%	22	4.4	nr	nr	nr
Paramedical practitioners	**2018**	**234**	30%	70	4.9	nr	nr	nr
Medical assistants	**2018**	**445**	30%	134	9.2	nr	nr	nr
General medical practitioners	**2020**	**651**	20%	130	12.7	nr	nr	nr
Obstetricians and gynaecologists	**2018**	**128**	50%	64	2.5	nr	nr	nr
Paediatricians	**2018**	**104**	15%	16	2.0	nr	nr	nr
TOTAL SRMNAH WORKFORCE		6,075		2,714	118.3			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content?	Yes, and all public and private sector schools base their curriculum on the standards	Year last revised	2022	National faculty development programme?	no

Pre-service education programmes:

		Number meeting recommendations re: duration		
Direct entry	no	na	Transition to practice programme for new graduates?	yes
Post-nursing	yes	0 of 1		
Combined	yes	na		

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
none	none	none	none	none	none

Midwifery Regulation

How often are midwives required to renew their licence?	Every 2-3 years	Compulsory continuing professional development (CPD)?	No	Midwife-specific deployment strategy?	Yes, not fully implemented

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	na	na	midwife	na

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:

nr = not reported; na = not applicable

Mongolia

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	2023	1,127	100%	1,127	3.3	2023	52	5%
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	na	na	na	na	na	na	na	na
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	2022	13,947	30%	4,184	41.3	nr	nr	nr
Nursing associate professionals*	2022	439	40%	176	1.3	nr	nr	nr
Community health workers	na	na	na	na	na	na	na	na
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	2022	2,398	20%	480	7.1	nr	nr	nr
Obstetricians and gynaecologists	2022	923	50%	462	2.7	nr	nr	nr
Paediatricians	2022	780	15%	117	2.3	nr	nr	nr
TOTAL SRMNAH WORKFORCE		19,614		6,545	58.1			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2024**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	**yes**	1 of 1
Post-nursing	**no**	na
Combined	**no**	na

Transition to practice programme for new graduates? **yes**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	some	some	some	some	some

Midwifery Regulation

How often are midwives required to renew their licence? **Every 2-3 years**

Compulsory continuing professional development (CPD)? **It is a compulsory element of the process of licence renewal**

Midwife-specific deployment strategy? **No**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	na	na	not a midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:
National faculty development programme is general, and not specific to midwifery faculty

nr = not reported; na = not applicable

Nepal

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	**2023**	**91**	100%	91	0.0	2023	35	38%
Midwifery associate professionals	**2023**	**37,444**	100%	37,444	12.2	na	na	na
Nurse-midwife professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nursing professionals*	**2023**	**83,966**	44%	36,945	27.3	nr	nr	nr
Nursing associate professionals*	nr	nr	nr	nr	nr	nr	nr	nr
Community health workers	**2023**	**51,423**	10%	5,142	16.7	nr	nr	nr
Paramedical practitioners	nr	nr	nr	nr	nr	nr	nr	nr
Medical assistants	**2023**	**90,915**	30%	27,275	29.6	nr	nr	nr
General medical practitioners	**2023**	**20,204**	20%	4,041	6.5	nr	nr	nr
Obstetricians and gynaecologists	2024	832	50%	416	0.3	nr	nr	nr
Paediatricians	**2019**	**629**	15%	94	0.2	nr	nr	nr
TOTAL SRMNAH WORKFORCE		285,504		111,448	92.8			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	7	of 7
Number of modern contraceptive methods midwives authorised to provide	3	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2023**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	yes	2 of 2
Post-nursing	yes	1 of 1
Combined	no	na

Transition to practice programme for new graduates? **no**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
none	none	all	all	some	some

Midwifery Regulation

How often are midwives required to renew their licence? **Every 6 years**

Compulsory continuing professional development (CPD)? **It is not compulsory, but it is recommended**

Midwife-specific deployment strategy? **No**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	na	not a midwife	not a midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:
National faculty development programme is general, and not specific to midwifery faculty

nr = not reported; na = not applicable

Pakistan

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	2023	15,193	100%	15,193	0.6	2023	0	0%
Midwifery associate professionals	2023	36,395	100%	36,395	1.5	nr	nr	nr
Nurse-midwife professionals	2023	100	60%	60	0.0	2023	19	19%
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	2023	25,147	44%	11,065	1.1	nr	nr	nr
Nursing associate professionals*	2023	1,774	50%	887	0.1	nr	nr	nr
Community health workers	2023	92,252	10%	9,225	3.9	nr	nr	nr
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	2023	298,143	20%	59,629	12.5	nr	nr	nr
Obstetricians and gynaecologists	2023	8,108	50%	4,054	0.3	nr	nr	nr
Paediatricians	2023	78	15%	12	0.0	nr	nr	nr
TOTAL SRMNAH WORKFORCE		477,190		136,519	20.0			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	4	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content? **Yes, but not all schools base their curriculum on the standards**

Year last revised **2021**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	yes	1 of 4
Post-nursing	yes	1 of 1
Combined	no	na

Transition to practice programme for new graduates? **no**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	some	some	some

Midwifery Regulation

How often are midwives required to renew their licence? **Every 4-5 years**

Compulsory continuing professional development (CPD)? **It is not compulsory, but it is recommended**

Midwife-specific deployment strategy? **No**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	na	not a midwife	not a midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	yes

Notes:
- National standards guide the BSc midwifery curriculum, but not other programmes.
- National faculty development programme is planned but not yet implemented.

nr = not reported; na = not applicable

Papua New Guinea

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	na	na	na	na	na	na	na	na
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	2024	1,500	100%	1,500	1.4	2023	84	6%
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	**2021**	**4,221**	60%	2,532	4.3	nr	nr	nr
Nursing associate professionals*	nr	nr	nr	nr	nr	nr	nr	nr
Community health workers	**2021**	**6,690**	10%	669	6.8	nr	nr	nr
Paramedical practitioners	**2023**	**580**	30%	174	0.6	nr	nr	nr
Medical assistants	nr	nr	nr	nr	nr	nr	nr	nr
General medical practitioners	**2023**	**382**	20%	76	0.4	nr	nr	nr
Obstetricians and gynaecologists	**2019**	**33**	50%	17	0.0	nr	nr	nr
Paediatricians	**2019**	**30**	15%	5	0.0	nr	nr	nr
TOTAL SRMNAH WORKFORCE		13,436		4,973	13.5			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content?	Yes, and all public and private sector schools base their curriculum on the standards	Year last revised	2020	National faculty development programme? yes

Pre-service education programmes:

		Number meeting recommendations re: duration	
Direct entry	no	na	Transition to practice programme for new graduates? no
Post-nursing	yes	1 of 1	
Combined	no	na	

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	all	all	all	none	don't know

Midwifery Regulation

How often are midwives required to renew their licence?	Every 2-3 years	Compulsory continuing professional development (CPD)?	No	Midwife-specific deployment strategy?	No

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	na	na	midwife	na

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:

nr = not reported; na = not applicable

Philippines

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	2024	73,624	100%	73,624	6.2	2023	6,000	8%
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	na	na	na	na	na	na	na	na
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	2024	538,068	44%	236,750	45.5	nr	nr	nr
Nursing associate professionals*	na	na	na	na	na	na	na	na
Community health workers	2024	268,542	10%	26,854	22.7	nr	nr	nr
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	2024	101,740	20%	20,348	8.6	nr	nr	nr
Obstetricians and gynaecologists	2021	4,890	50%	2,445	0.4	nr	nr	nr
Paediatricians	2023	7,381	15%	1,107	0.6	nr	nr	nr
TOTAL SRMNAH WORKFORCE		994,245		361,128	84.1			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	5	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	Yes	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2023**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	yes	2 of 3
Post-nursing	no	na
Combined	no	na

Transition to practice programme for new graduates? **no**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	all	all	all	some	some

Midwifery Regulation

How often are midwives required to renew their licence? **Every 2-3 years**

Compulsory continuing professional development (CPD)? **It is a compulsory element of the process of licence renewal**

Midwife-specific deployment strategy? **Yes, fully implemented**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	na	na	not a midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:

nr = not reported; na = not applicable

Sri Lanka

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	**2023**	**8,751**	100%	8,751	4.0	2023	997	11%
Midwifery associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nurse-midwife professionals	2023	1,864	60%	1,118	0.9	nr	nr	nr
Nurse-midwife associate professionals	nr	nr	nr	nr	nr	nr	nr	nr
Nursing professionals*	2023	41,246	44%	18,148	18.9	nr	nr	nr
Nursing associate professionals*	nr	nr	nr	nr	nr	nr	nr	nr
Community health workers	nr	nr	nr	nr	nr	nr	nr	nr
Paramedical practitioners	**2018**	**956**	30%	287	0.4	nr	nr	nr
Medical assistants	nr	nr	nr	nr	nr	nr	nr	nr
General medical practitioners	**2023**	**23,261**	20%	4,652	10.6	nr	nr	nr
Obstetricians and gynaecologists	**2019**	**145**	50%	73	0.1	nr	nr	nr
Paediatricians	**2019**	**207**	15%	31	0.1	nr	nr	nr
TOTAL SRMNAH WORKFORCE		76,430		33,060	35.0			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	1	of 7
Number of modern contraceptive methods midwives authorised to provide	3	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content?	Yes, but not all schools base their curriculum on the standards	Year last revised	2016	National faculty development programme?	no

Pre-service education programmes:

		Number meeting recommendations re: duration		
Direct entry	yes	0 of 1	Transition to practice programme for new graduates?	yes
Post-nursing	yes	0 of 1		
Combined	no	na		

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	some	some	some

Midwifery Regulation

How often are midwives required to renew their licence?	Every 4-5 years	Compulsory continuing professional development (CPD)?	No	Midwife-specific deployment strategy?	Yes, fully implemented

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	not a midwife	not a midwife	na

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	don't know	yes

Notes:

nr = not reported; na = not applicable

Thailand

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	na	na	na	na	na	na	na	na
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	2023	33,000	85%	28,050	4.6	2023	240	1%
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	2023	225,000	30%	67,500	31.4	nr	nr	nr
Nursing associate professionals*	na	na	na	na	na	na	na	na
Community health workers	**2019**	**39,928**	10%	3,993	5.6	nr	nr	nr
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	**2020**	**66,301**	20%	13,260	9.3	nr	nr	nr
Obstetricians and gynaecologists	**2014**	**3,154**	50%	1,577	0.4	nr	nr	nr
Paediatricians	nr	nr	nr	nr	nr	nr	nr	nr
TOTAL SRMNAH WORKFORCE		367,383		114,380	51.3			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	2	of 7
Number of modern contraceptive methods midwives authorised to provide	1	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content? **Yes, and all public and private sector schools base their curriculum on the standards**

Year last revised: **2020**

National faculty development programme? **yes**

Pre-service education programmes:

		Number meeting recommendations re: duration
Direct entry	**no**	na
Post-nursing	**no**	na
Combined	**yes**	na

Transition to practice programme for new graduates? **yes**

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
all	all	all	all	all	all

Midwifery Regulation

How often are midwives required to renew their licence? **Every 4-5 years**

Compulsory continuing professional development (CPD)? **It is a compulsory element of the process of licence renewal**

Midwife-specific deployment strategy? **No**

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	nr	midwife	midwife	na

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:

nr = not reported; na = not applicable

Timor-Leste

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	**2020**	**678**	100%	678	5.3	2023	359	53%
Midwifery associate professionals	na	na	na	na	na	na	na	na
Nurse-midwife professionals	na	na	na	na	na	na	na	na
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	**2020**	**1,410**	44%	620	10.9	nr	nr	nr
Nursing associate professionals*	**2020**	**217**	50%	109	1.7	nr	nr	nr
Community health workers	**2020**	**4,450**	10%	445	34.5	nr	nr	nr
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	na	na	na	na	na	na	na	na
General medical practitioners	**2020**	**937**	20%	187	6.8	nr	nr	nr
Obstetricians and gynaecologists	2024	9	50%	5	0.1	nr	nr	nr
Paediatricians	2024	8	15%	1	0.1	nr	nr	nr
TOTAL SRMNAH WORKFORCE		7,709		2,045	59.3			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	7	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content?	Yes, and all public and private sector schools base their curriculum on the standards	Year last revised	nr	National faculty development programme?	yes

Pre-service education programmes:

		Number meeting recommendations re: duration		
Direct entry	yes	2 of 2	Transition to practice programme for new graduates?	no
Post-nursing	yes	na		
Combined	no	na		

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	some	some	some

Midwifery Regulation

How often are midwives required to renew their licence?	Every 2-3 years	Compulsory continuing professional development (CPD)?	No	Midwife-specific deployment strategy?	No

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	na	na	not a midwife	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	yes	na	yes

Notes:
The national standards that guide the midwife education curriculum do not align with ICM global standards for midwifery education

nr = not reported; na = not applicable

Viet Nam

SRMNAH WORKFORCE AVAILABILITY

Occupation	Year	headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Density per 10,000 population	Graduates		Percentage of headcount
						Year	Number	
Midwifery professionals	2020	2,914	100%	2,914	0.3	nr	nr	nr
Midwifery associate professionals	2020	36,056	100%	36,056	3.7	nr	nr	nr
Nurse-midwife professionals	na	na	na	na	na	na	na	na
Nurse-midwife associate professionals	na	na	na	na	na	na	na	na
Nursing professionals*	2020	16,963	44%	7,464	1.8	nr	nr	nr
Nursing associate professionals*	2020	88,868	50%	44,434	9.2	nr	nr	nr
Community health workers	na	na	na	na	na	na	na	na
Paramedical practitioners	na	na	na	na	na	na	na	na
Medical assistants	2020	44,794	30%	13,438	4.7	nr	nr	nr
General medical practitioners	nr	nr	nr	nr	nr	nr	nr	nr
Obstetricians and gynaecologists	nr	nr	nr	nr	nr	nr	nr	nr
Paediatricians	nr	nr	nr	nr	nr	nr	nr	nr
TOTAL SRMNAH WORKFORCE		189,595		104,306	19.7			

Source: **If in bold type: WHO National Health Workforce Accounts (NHWA) data platform, accessed Dec 2025, most recent year**
If not in bold type: communication with UNFPA Country Office, Oct 24 - April 25 *excluding nurse midwives

ENABLING ENVIRONMENT FOR MIDWIVES

Policy Environment

Number of BEmONC signal functions midwives authorised to provide	6	of 7
Number of modern contraceptive methods midwives authorised to provide	5	of 5
Midwife-led units providing a midwifery model of care?	No	

Midwifery Education

National standards to guide curriculum content?	Yes, and all public and private sector schools base their curriculum on the standards	Year last revised	2015	National faculty development programme?	no

Pre-service education programmes:

		Number meeting recommendations re: duration		
Direct entry	yes	2 of 3	Transition to practice programme for new graduates?	yes
Post-nursing	no	na		
Combined	no	na		

Programmes' adherence to ICM global standards on

Governance	Faculty	Students	Programme & Curriculum	Resources	Quality improvement
some	some	some	some	some	some

Midwifery Regulation

How often are midwives required to renew their licence?	Every 4-5 years	Compulsory continuing professional development (CPD)?	It is a compulsory element of the process of licence renewal	Midwife-specific deployment strategy?	No

Midwives in Leadership

	Person setting strategic direction for midwifery	National midwife advisor	Leader of regulator	Leader of midwives' association
Midwives in national leadership roles?	not a midwife	not a midwife	position vacant	midwife

	MP (national / federal)	MP (sub-national)	Local councillor
Midwives in legislativeroles?	no	no	no

Notes:

nr = not reported; na = not applicable

Technical annex

The methods used to produce the analyses in this report closely follow those described in the SoWMy 2021 webappendices, with some minor exceptions detailed here.

1. Graduate numbers: Primary data collection for this report requested midwife graduate numbers for each education pathway for 2023, 2024, 2025 and 2026. This provided a significantly richer source of data than was available for SoWMy 2021, so the modelled projections in this report utilised the graduate numbers provided. Years 2027 to 2030 were estimated as the average of the graduate numbers reported for the years 2023-2026. As with previous reports, gaps were filled using regional averages. Regional averages were also used to estimate graduate numbers for nurses and doctors.
2. Age distribution: For this report, the age profile for all occupation groups was assumed to mirror the overall female working age population in the country. Expected retirees were then estimated according to the same methodology as applied in SoWMy 2021 and subsequent regional reports.
3. Midwife shortage: In the exceptional situation where a country has not reported any nurses (either professionals or associate professionals), but only nurse-midwives (professional and associate), then the estimated shortage for nurses was added to the estimated shortage for midwives (as this is the only occupation group available to meet the need).

Table A.1 defines the health occupations considered to be part of the SRMNAH workforce for the purposes of this report.

Table A.1: SRMNAH workforce occupation definitions

Occupation	Definition
Midwifery professionals	Midwifery professionals plan, manage and provide midwifery care services before, during and after pregnancy and childbirth. They provide delivery care to reduce health risks to women and newborn children according to the practice and standards of modern midwifery, working autonomously or in teams with other health-care providers. They may conduct research on midwifery practices and procedures, and implement midwifery education activities in clinical and community settings.
Midwifery associate professionals	Midwifery associate professionals provide basic health care and advice before, during and after pregnancy and childbirth. They provide advice to women, families and communities on birth and emergency plans, breastfeeding, infant care, family planning and related topics; monitor health status during pregnancy and childbirth; and implement care, treatment and referral plans usually established by medical, midwifery and other health professionals.
Nurse-midwives	Nursing professionals who have successfully completed a midwifery education programme and have the requisite qualifications to be registered and/or licensed to practise midwifery. Usually this is achieved by qualifying as a nursing professional and then acquiring a further qualification in midwifery.

Occupation	Definition
Associate nurse-midwives	Nursing associate professionals who have also successfully completed formal education to provide basic health care and advice before, during and after pregnancy and childbirth. They provide advice to women, families and communities on birth and emergency plans, breastfeeding, infant care, family planning and related topics; monitor health status during pregnancy and childbirth; and implement care, treatment and referral plans usually established by medical, midwifery and other health professionals.
Nursing professionals	Nursing professionals provide treatment, support and care services for people in need of nursing care due to the effects of ageing, injury, illness or other physical or mental impairment, or potential risks to health, according to the practice and standards of modern nursing. They assume responsibility for the planning and management of patient care, including the supervision of other health-care workers, working autonomously or in teams with medical doctors and others in the practical application of preventive and curative measures in clinical and community settings.
Nursing associate professionals	Nursing associate professionals provide basic nursing and personal care for people needing such care due to effects of ageing, illness, injury or other physical or mental impairment. They provide health advice to patients and families, monitor patients' conditions, and implement care, treatment and referral plans usually established by medical, nursing and other health professionals.
Community health workers	Community health workers provide health education, referral and follow-up, case management, and basic preventive health care and home visiting services to specific communities. They support and assist individuals and families in navigating the health and social services systems.
Paramedical practitioners	Paramedical practitioners provide advisory, diagnostic, curative and preventive medical services more limited in scope and complexity than those carried out by medical doctors. They work autonomously or with limited supervision by medical doctors, and perform clinical, therapeutic and surgical procedures to treat and prevent diseases, injuries and other physical or mental impairments common to specific communities.
Medical assistants	Medical assistants perform basic clinical and administrative tasks to support patient care under the direct supervision of a medical practitioner or other health professional. They perform routine tasks and procedures such as measuring patients' vital signs, administering medications and injections, recording information in medical record-keeping systems, preparing and handling medical instruments and supplies, and collecting and preparing specimens of bodily fluids and tissues for laboratory testing.
General medical practitioners	General medical practitioners (including family and primary-care doctors) diagnose, treat and prevent illness, disease, injury and other physical and mental impairments, and maintain general health in humans by applying the principles and procedures of modern medicine. They plan, supervise and evaluate the implementation of care and treatment plans by other health-care providers. They do not limit their practice to particular disease categories or methods of treatment, and may assume responsibility for providing continuing and comprehensive medical care to individuals, families and communities.
Obstetricians & gynaecologists	Doctors in obstetric and gynaecological specialties and related branches focusing on the care of women's reproductive systems including before, during and after pregnancy and childbirth.
Paediatricians	Doctors in paediatrics and related specialties focusing on the prevention, diagnosis and treatment of health problems in infants, children and adolescents.

The data used to estimate the level of need for SRMNAH worker time was accessed during August and September 2024, mostly from the same sources as shown in SoWMy 2021 webappendices. However, if a different source was used, it is specified in Table A.2 below.

Table A.2: Data sources updated since SoWMy 2021 which affected estimates of health worker time needed to deliver essential SRMNAH interventions

Intervention	Number and average duration of contacts needed with an SRMNAH worker	Data requirements and sources
WOMEN (INCLUDING PRE-PREGNANCY INTERVENTIONS)		
Delivery of condoms, vaginal barriers, vaginal tablets	Three contacts per year totalling 35 minutes per WRA using condoms, estimated as follows: WRA x (contraceptive prevalence rate (CPR) + unmet need) x % of female contraceptive users who use male or female condoms	**Indicator**: CPR (modern), 2020-2030. **Source**: UN Data Portal Population Division, (https://population.un.org/dataportal/) accessed 20 August 2024. A regional income-group mean was applied for countries not included within this source. **Indicator**: Unmet need for contraception (%), 2020-2030 **Source**: UN Data Portal Population Division, (https://population.un.org/dataportal/) accessed 20 August 2024. A regional income-group mean was applied for countries not included within this source. **Indicator**: % of female contraceptive users (aged 15-49) who use each type. **Source**: UN Department of Economic and Social Affairs World Contraceptive Use dataset 2021 (https://www.un.org/development/desa/pd/data/world-contraceptive-use), accessed 13 September 2024. A regional income-group mean was applied for countries not included within this source.
Delivery of contraceptive pills and injectables	Three contacts per year totalling 40 minutes per WRA using pills or injectables, estimated as follows: WRA x (CPR + unmet need) x % of female contraceptive users who use pills or injectables	
Insertion and extraction of contraceptive implants	One 60-minute contact every 5 years per WRA using implants (assuming Jadelle), estimated as follows: WRA x (CPR + unmet need) x % of female contraceptive users who use implants	
Intrauterine device (IUD) insertion	One 55-minute contact every 10 years per WRA using IUD (assuming Copper T 380-A-IUD), estimated as follows: WRA x (CPR + unmet need) x % of female contraceptive users who use IUDs	
Female sterilisation	One 100-minute contact per unsterilised WRA requesting sterilization, estimated as follows: (New members of the WRA cohort, i.e. 20% of women aged 15-19) x (CPR + unmet need) x (% of female contraceptive users who use female sterilisation)	

Intervention	Number and average duration of contacts needed with an SRMNAH worker	Data requirements and sources
Detection of HIV	One 10-minute contact per WRA reporting risky behaviours, estimated as follows: WRA x (prevalence of intravenous drug use among women + % of WRA reporting higher-risk sex in last year)	**Indicator**: Number of WRA (2019-2030). **Source**: United Nations (UN) Population Division World Population Prospects database, medium variant, 2022 revision (https://population.un.org/wpp/), accessed 13 June 2024, **Indicator**: Prevalence of intravenous drug use among women. **Source**: United Nations Office on Drugs and Crime (https://dataunodc.un.org/dp-drug-use-characteristics). accessed 28 August 2024. A regional income-group mean was applied for countries not included within this source. **Indicator**: % of WRA reporting higher-risk sex in last year. **Source**: Most recent Demographic & Health Survey (DHS) for LMICs (https://www.statcompiler.com/en/), accessed 28 August 2024.
Treatment of HIV	Four contacts per year totalling 240 minutes* per WRA with HIV per year, estimated as follows: WRA x HIV prevalence in WRA * To cover first-link anti-retroviral therapy only	**Indicator**: Number of WRA (2019-2030). **Source**: As above. **Indicator**: HIV prevalence in WRA (%). **Source**: AIDSinfo Global data on HIV epidemiology and response (https://aidsinfo.unaids.org/), accessed 28 August 2024
PREGNANCY (ANTENATAL CARE)		
Treatment of gestational diabetes	Contacts totalling 70 minutes per pregnant woman with gestational diabetes, estimated as follows: pregnancies x prevalence of gestational diabetes	**Indicator**: Number of pregnancies (2019-2030). **Source:** : Live births from UN World Population Prospects 2019 revision (https://population.un.org/wpp/) accessed 5 October 2020, with a multiplier to account for stillbirths, spontaneous abortions and inducted abortions based on estimates made by the Guttmacher Institute[1] and used in Tatem et al. 2014 (https://ij-healthgeographics.biomedcentral.com/articles/10.1186/1476-072X-13-2) **Indicator**: Prevalence of gestational diabetes. **Source**: International Diabetes Federation: Diabetes Atlas (https://diabetesatlas.org/data/en/indicators/14/), accessed 30 August 2024
POSTNATAL (MOTHER)		
Response to intimate partner violence (IPV)	Contacts totalling 35 minutes per new mother experiencing IPV, estimated as follows: (live births + stillbirths) x lifetime prevalence of IPV among women aged 15-49.	**Indicator**: Intimate partner violence prevalence among ever partnered women in the previous 12 months (%) **Source**: WHO Global Health Observatory (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/intimate-partner-violence-prevalence-among-ever-partnered-women-(-)), accessed 30 August 2024. A regional income group mean was applied for countries not included within this source.

1 Guttmacher Institute, 16 February 2014, tabulations of data for Singh S, Darroch JE and Ashford LS. Adding it up: The costs and benefits of investing in sexual and reproductive health. New York: Guttmacher Institute; 2014.

Intervention	Number and average duration of contacts needed with an SRMNAH worker	Data requirements and sources
POSTNATAL (NEWBORN)		
Kangaroo mother care for small babies	Contacts totalling 135 minutes per newborn with low birth weight, estimated as follows: live births x % of newborns with birth weight <2500g	**Indicator:** Number of live births (2019-2030). **Source: :** United Nations Population Division World Population Prospects database, medium variant, 2022 revision (https://population.un.org/wpp/), accessed 13 June 2024. **Indicator**: % of newborns with birth weight <2500g. **Source**: UNICEF Data (https://data.unicef.org/topic/nutrition/low-birthweight/), accessed 30 August 2024. A regional income group mean was applied for countries not included within this source.
ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH		
Prevention of harmful practices such as female genital mutilation (FGM) and early and forced marriage	Contacts totalling 5 minutes for all 10-19 year-old girls living in countries with prevalence of FGM >0 (on the assumption that this intervention will be delivered in groups of 30, each lasting 2.5 hours)	**Indicator:** FGM prevalence (%). **Source:** World Bank World Development Indicators (https://databank.worldbank.org/source/world-development-indicators), accessed 29 September 2021.

CPR = contraceptive prevalence rate; DHS = demographic and health survey; FGM = female genital mutilation; GBD = global burden of disease; HICs = high-income countries; HIV = human immunodeficiency virus; IPV = intimate partner violence; IUD = intrauterine device; LMICs = low- and middle-income countries; ob/gyn = obstetrician and gynaecologist; PEE = pre-eclampsia and eclampsia; PID = pelvic inflammatory disease; PMTCT = prevention of mother-to-child transmission of HIV; PPH = postpartum haemorrhage; pPROM = preterm premature rupture of membranes; pSBI = possible severe bacterial infection; RDS = respiratory distress syndrome; SGBV = sexual and gender-based violence; SRMNAH = sexual, reproductive, maternal, newborn and adolescent health; STI = sexually transmitted infection; TFR = total fertility rate; UN = United Nations; WHO = World Health Organization; WRA = women of reproductive age (15-49 years).

References

1. United Nations: **International Conference on Population and Development programme of action: twentieth anniversary edition.** New York: United Nations Population Fund; 2014.
2. High-Level Commission on ICPD25: **Nairobi Statement on ICPD25: accelerating the promise.** 2019 [https://www.nairobisummiticpd.org/content/icpd25-commitments, accessed 4 November 2024]
3. World Health Organization: **Global strategy on human resources for health: workforce 2030.** Geneva: World Health Organization; 2016.
4. Nove A, Friberg IK, de Bernis L, McConville F, Moran AC, Najjemba M, Ten Hoope-Bender P, Tracy S, Homer CSE: **Potential impact of midwives in preventing and reducing maternal and neonatal mortality and stillbirths: a Lives Saved Tool modelling study.** *Lancet Glob Health* 2021, **9:**e24–e32.
5. Every Woman Every Newborn Everywhere: **Health workforce - midwifery.** 2024 [https://ewene.org/accelerate-maternal-and-newborn-survival/midwifery/, accessed 9 December 2024]
6. United Nations Population Fund: **Global call to action & commitment.** 2023 [https://www.unfpa.org/sites/default/files/event-pdf/Call-to-Action_5th-Midwifery-Symposium.pdf, accessed 9 December 2024]
7. World Health Organization: **Transitioning to midwifery models of care: global position paper.** 2024 [https://www.who.int/publications/i/item/9789240098268, accessed 29 November 2024]
8. United Nations Population Fund: **UNFPA strategic plan, 2022-2025.** 2021 [https://www.unfpa.org/strategic-plan-2022, accessed 4 November 2024]
9. United Nations Population Fund: **Start with her: UNFPA strategy for reproductive, maternal and newborn health and well-being 2025-2030.** 2025 [https://www.unfpa.org/publications/start-her-unfpa-strategy-reproductive-maternal-and-newborn-health-and-well-being-2025, accessed 24 March 2025]
10. United Nations Population Fund, World Health Organization, UNICEF, International Confederation of Midwives, Jhpiego: **The Midwifery Accelerator: expanding health care for women and newborns.** 2025 [https://www.unfpa.org/publications/midwifery-accelerator-expanding-health-care-women-and-newborn, accessed 20 May 2025]
11. United Nations Population Fund: **UNFPA strategic plan 2022-2025: Asia and the Pacific regional programme.** 2021 [https://www.unfpa.org/sites/default/files/board-documents/DP.FPA_.2021.8_-_strategic_plan_2022-2025_-_Annex.4_-_Asia_and_the_Pacific_-_Final_-_21Jul21.pdf, accessed 4 November 2024]
12. United Nations Population Fund, World Health Organization, International Confederation of Midwives: **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.
13. United Nations Population Fund, World Health Organization, International Confederation of Midwives: **State of the world's midwifery: delivering health, saving lives.** New York: United Nations Population Fund; 2011.

14. United Nations Population Fund, World Health Organization, International Confederation of Midwives: **State of the world's midwifery: a universal pathway. A woman's right to health.** New York: United Nations Population Fund; 2014.

15. United Nations Population Fund: **The state of the world's midwifery 2021: webappendices.** 2021 [https://www.unfpa.org/sowmy-webappendices, accessed 4 November 2024]

16. International Confederation of Midwives: **Professional midwife-led care in India.** 2024 [https://internationalmidwives.org/professional-midwife-led-care-in-india/, accessed 11 December 2024]

17. International Labour Organization: **Employment in Afghanistan in 2022: a rapid impact assessment.** 2023 [https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40asia/%40ro-bangkok/documents/briefingnote/wcms_869949.pdf, accessed 11 December 2024]

18. Republic of the Union of Myanmar Ministry of Labour: **Handbook on human resources development indicators 2021-2023.** Nay Pyi Taw: Republic of the Union of Myanmar Ministry of Labour; 2024.

19. World Health Organization, United Nations Children's Fund, United Nations Population Fund, World Bank Group, United Nations Department of Economic and Social Affairs: **Trends in maternal mortality 2000 to 2023.** Geneva: World Health Organization; 2025.

20. UN Inter-agency Group for Child Mortality Estimation: **Levels & trends in child mortality report 2023.** New York: UNICEF; 2024.

21. World Health Organization: **Strategies toward ending preventable maternal mortality (EPMM).** Geneva: World Health Organization; 2015.

22. United Nations: **Transforming our world: the 2030 agenda for sustainable development. Resolution 70/1.** 2015 [https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf, accessed 23 August 2024]

23. UN Inter-agency Group for Child Mortality Estimation: **Never Forgotten: The situation of stillbirth around the globe.** New York: UNICEF; 2023.

24. United Nations Department of Economic and Social Affairs: **World fertility report 2024: advance unedited version.** New York: United Nations; 2025.

25. Every Woman Every Child: **The global strategy for women's, children's and adolescents' health 2016–2030.** Geneva: World Health Organization; 2015.

26. United Nations Population Fund: **World Population Dashboard.** 2024 [https://www.unfpa.org/data/world-population-dashboard, accessed 12 June 2024]

27. United Nations Children's Fund: **Data: antenatal care coverage.** 2024 [https://data.unicef.org/topic/maternal-health/antenatal-care/, accessed 26 March 2025]

28. World Health Organization: **WHO statement on caesarean section rates.** 2015 [https://www.who.int/publications/i/item/WHO-RHR-15.02, accessed 26 March 2025]

29. International Labour Organization: **International standard classification of occupations (ISCO).** 2008 [https://ilostat.ilo.org/methods/concepts-and-definitions/classification-occupation/, accessed 23 August 2024]

30. International Confederation of Midwives: **International definition and scope of practice of the midwife.** 2024 [https://internationalmidwives.org/resources/international-definition-of-the-midwife/, accessed 23 August 2024]

31. World Health Organization: **Density of nurses and midwives.** 2025

https://www.who.int/data/nutrition/nlis/info/density-of-nurses-and-midwives#:~:text=It%20has%20been%20estimated%2C%20however,important%20primary%20health%20care%20interventions.&text=WHO accessed 20 May 2025

32. World Health Organization, United Nations Population Fund, United Nations Children's Fund, International Confederation of Midwives, International Council of Nurses, International Federation of Gynecology and Obstetrics, International Pediatric Association: **Definition of skilled health personnel providing care during childbirth.** 2018 [https://www.who.int/publications/i/item/definition-of-skilled-health-personnel-providing-care-during-childbirth, accessed 29 August 2024]

33. World Health Organization: **WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas: an update of the WHO guideline *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations* (2010).** Geneva: World Health Organization; 2021.

34. Center for Reproductive Rights: **The world's abortion laws.** 2024 [https://reproductiverights.org/maps/worlds-abortion-laws/, accessed 30 August 2024]

35. Anderson R, Williams A, Jess N, Read JM, Limmer M: **The impact of professional midwives and mentoring on the quality and availability of maternity care in government sub-district hospitals in Bangladesh: a mixed-methods observational study.** *BMC Pregnancy Childbirth* 2022, **22:**827.

36. Inagaki Y, Tam Y, Rahman M, Winch P: **Impact of skills midwives on saving maternal and newborn lives in Bangladesh.** 2024 [https://www.evidencefund.com/lib/M6ZF5WES, accessed 20 May 2025]

37. World Health Organization Regional Office for South-East Asia: **Decade for health workforce strengthening in the South-East Asia Region 2015-2024: second review of progress.** 2018 [https://iris.who.int/bitstream/handle/10665/274310/9789290226574-eng.pdf, accessed 18 December 2024]

38. International Confederation of Midwives: **Enabling environment policy brief.** 2021 [https://internationalmidwives.org/resources/enabling-environment-policy-brief-2021/, accessed 14 December 2024]

39. Begum F, Ara R, Islam A, Marriott S, Williams A, Anderson R: **Health system strengthening through professional midwives in Bangladesh: best practices, challenges, and successes.** *Glob Health Sci Pract* 2023, **11**.

40. Islam A, Begum F, Williams A, Basri R, Ara R, Anderson R: **Midwife-led pandemic telemedicine services for maternal health and gender-based violence screening in Bangladesh: an implementation research case study.** *Reprod Health* 2023, **20:**128.

41. International Confederation of Midwives: **Building the enabling environment for midwives: a call to action for policymakers.** 2021 [https://internationalmidwives.org/wp-content/uploads/11061-eng_icm-enabling-environment-policy-brief_v1.1_20210629.pdf, accessed 14 December 2024]

42. Bangladesh Bureau of Statistics: **Bangladesh sample vital statistics 2023.** Dhaka: Government of the People's Republic of Bangladesh; 2024.

43. Hutchinson E, Kiwanuka S, Muhindo R, Nimwesiga C, Balabanova D, McKee M, Kitutu FE: **The paradoxical surplus of health workers in Africa: The need for research and policy engagement.** *Int J Health Plann Manage* 2024, **39:**956-962.

44. Nolan S, Baird K, McInnes RJ: **What strategies facilitate & support the successful transition of newly qualified midwives into practice: An integrative literature review.** *Nurse Educ Today* 2022, **118:**105497.

45. Van Lerberghe W, Matthews Z, Achadi E, Ancona C, Campbell J, Channon A, de Bernis L, De Brouwere V, Fauveau V, Fogstad H, et al: **Country experience with strengthening of health systems**

and deployment of midwives in countries with high maternal mortality. *Lancet* 2014, **384:**1215–1225.

46. International Confederation of Midwives: **ICM global standards for midwifery education (2010 revised 2021).** 2021 [https://internationalmidwives.org/resources/global-standards-for-midwifery-education/, accessed 2 September 2024]

47. Neal S, Bokosi M, Lazaro D, Vong S, Nove A, Bar-Zeev S, Pairman S, Ryan E, Hoope-Bender PT, Homer CS: **Diverse pre-service midwifery education pathways in Cambodia and Malawi: A qualitative study utilising a midwifery education pathway conceptual framework.** *Midwifery* 2023, **116:**103547.

48. World Health Organization, United Nations Population Fund, United Nations Children's Fund, International Confederation of Midwives: **Strengthening quality midwifery education for universal health coverage 2030: framework for action.** Geneva: World Health Organization; 2019.

49. Smith RM, Gray JE, Homer CSE: **Common content, delivery modes and outcome measures for faculty development programs in nursing and midwifery: A scoping review.** *Nurse Educ Pract* 2023, **70:**103648.

50. Smith RM, Gray JE, Homer CS: **"It would be nice to have more than basic support": A learning needs assessment survey of midwifery faculty in low- and middle-income countries of the Asia Pacific region.** *Women Birth* 2024, **37:**101624.

51. Smith R, Homer CSE, Gray J: **Pathways, development needs, and clinical connections for midwifery faculty in low- and middle-income settings of the Asia Pacific region: a qualitative study.** *Women & Birth* 2025, **38:**101841.

52. International Confederation of Midwives: **Essential competencies for midwifery practice.** 2024 [https://internationalmidwives.org/resources/essential-competencies-for-midwifery-practice/, accessed 9 December 2024]

53. UNFPA Asia and the Pacific Regional Office: **Continuing professional development framework for midwives in clinical practice in Asia and the Pacific.** 2024 [https://asiapacific.unfpa.org/en/publications/CPD-framework-midwives, accessed 16 December 2024]

54. International Confederation of Midwives: **Global standards for midwifery regulation.** 2011 [https://internationalmidwives.org/resources/global-standards-for-midwifery-regulation/, accessed 16 December 2024]

55. International Confederation of Midwives: **Midwifery led care, the first choice for all women.** 2017 [https://internationalmidwives.org/resources/midwifery-led-care-the-first-choice-for-all-women/, accessed 10 September 2024]

56. World Health Organization: **WHO recommendations: intrapartum care for a positive childbirth experience.** Geneva: World Health Organization; 2018.

57. Bazirete O, Hughes K, Lopes SC, Turkmani S, Abdullah AS, Ayaz T, Clow SE, Epuitai J, Halim A, Khawaja Z, et al: **Midwife-led birthing centres in four countries: a case study.** *BMC Health Serv Res* 2023, **23:**1105.

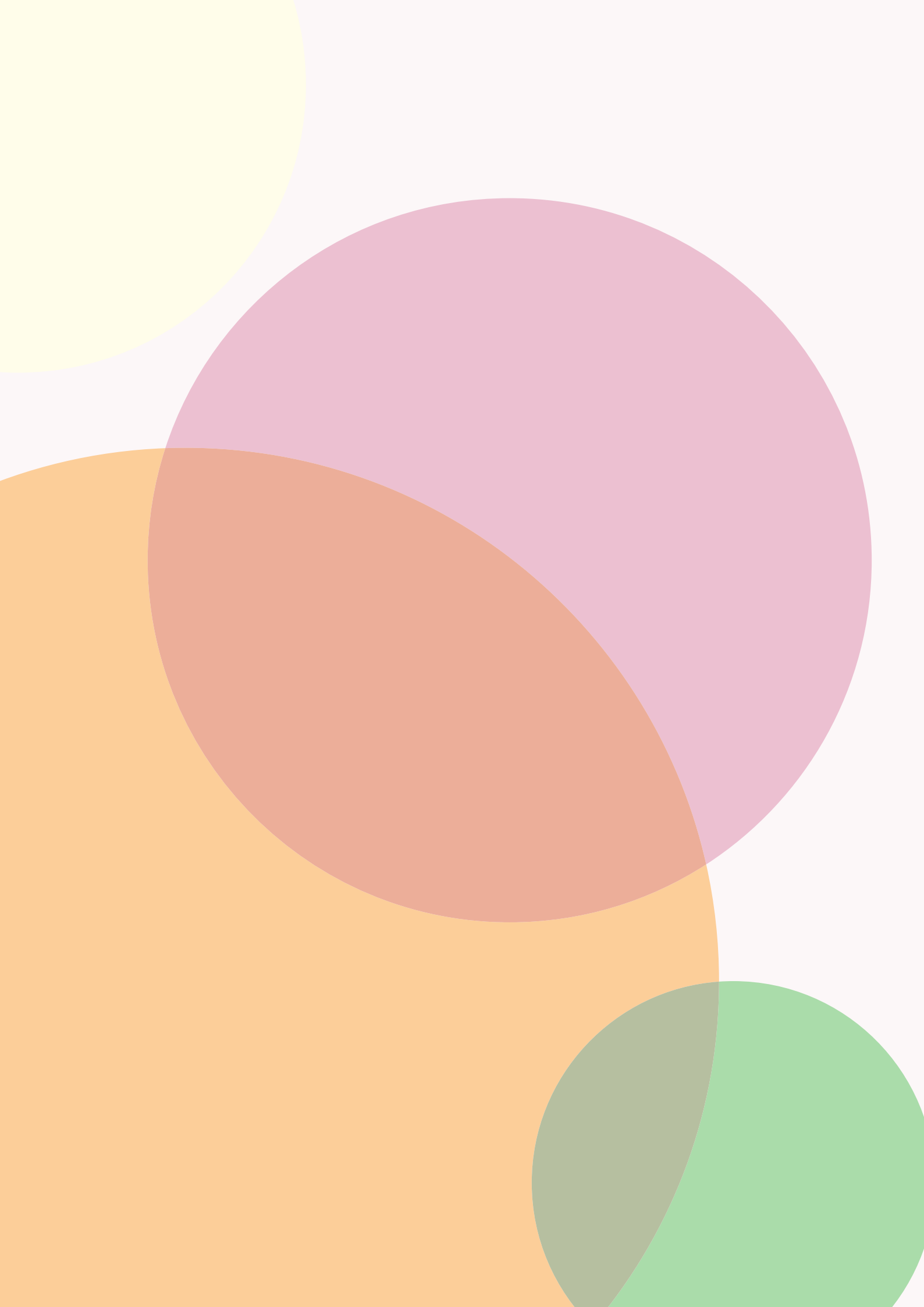
58. Nove A, Bazirete O, Hughes K, Turkmani S, Callander E, Scarf V, Forrester M, Mandke S, Pairman S, Homer CS: **Which low- and middle-income countries have midwife-led birthing centres and what are the main characteristics of these centres? A scoping review and scoping survey.** *Midwifery* 2023, **123:**103717.

59. National Institute of Statistics (Cambodia), Ministry of Health (Cambodia), ICF: **Cambodia demographic and health survey 2021-22 final report.** 2023 [https://dhsprogram.com/pubs/pdf/

FR377/FR377.pdf,

60. The Republic of the Union of Myanmar Central Statistical Organization: **Myanmar Statistical Yearbook 2023.** 2023 [https://www.csostat.gov.mm/PublicationAndRelease/StatisticalYearbook, accessed 14 May 2025]

61. Insecurity Insight: **Myanmar.** 2025 [https://insecurityinsight.org/country-pages/myanmar, accessed 17 April 2025]

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