



Maternal health leaders' perceptions of barriers to midwife-led care in Ethiopia, Kenya, Malawi, Somalia, and Uganda

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ARTICLE INFO

Article history:

Received 29 August 2022

Revised 5 April 2023

Accepted 19 May 2023

Keywords:

Midwife-led care

MLC

Barriers

Gender norms

Leaders

Organisation

ABSTRACT

Objective: To identify and examine barriers to midwife-led care in Eastern Africa and how these barriers can be reduced

Design: A qualitative inductive study with online focus group discussions and semi-structured interviews using content analysis

Setting: The study examines midwife-led care in Ethiopia, Malawi, Kenya, Somalia, and Uganda -five African countries with an unmet need for midwives and a need to improve maternal and neonatal health outcomes.

Participants: Twenty-five participants with a health care profession background and current position as a maternal and child health leader from one of the five study countries.

Findings: The findings demonstrate barriers to midwife-led care connected to organisational structures, traditional hierarchies, gender disparities, and inadequate leadership. Societal and gendered norms, organisational traditions, and differences in power and authority between professions are some factors explaining why the barriers persist. A focus on intra- and multisectoral collaborations, the inclusion of midwife leaders, and providing midwives with role models to leverage their empowerment are examples of how to reduce the barriers.

Key conclusions: This study provides new knowledge on midwife-led care from the perspectives of health leaders in five African countries. Transforming outdated structures to ensure midwives are empowered to deliver midwife-led care at all healthcare system levels is crucial to moving forward.

Implications for practise: This knowledge is important as enhancing the midwife-led care provision is associated with substantially improved maternal and neonatal health outcomes, higher satisfaction of care, and enhanced utilisation of health system resources. Nevertheless, the model of care is not adequately integrated into the five countries' health systems. Future studies are warranted to further explore how reducing barriers to midwife-led care can be adapted at a broader level.

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Introduction

Despite progress over the last decades, East Africa has one of the highest preventable maternal and neonatal mortality ratios globally (World Health Organization, 2019). Midwives can help pre-

vent maternal and newborn deaths, reduce morbidity and provide a majority of essential sexual, reproductive, maternal, and newborn health services (Nove et al., 2021; United Nations Population Fund, 2019). Still, there is a lack of well-supported midwifery workforces in many countries, especially in low-resource settings like Eastern Africa (United Nations Population Fund, 2019).

Ethiopia, Kenya, Malawi, Somalia and Uganda, the countries included in this study, have some of the highest rates of maternal mortality rates (MMR) and neonatal mortality rate (NMR) in the world (see table 1) (United Nations Children's Fund, 2017, 2020).

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Table 1
MMR and NMR in study countries (United Nations Children's Fund, 2017, 2020).

Country	Maternal Mortality Rates 2017 (deaths/100,000 live births)	Country ranking MMR 2017 (from highest to lowest, 182 countries)	Neonatal Mortality Rate 2020 (deaths/1000 live births)	Country ranking NMR 2020 (from highest to lowest, 187 countries)
Ethiopia	401	24	27	22
Kenya	342	30	20	43
Malawi	349	29	19	46
Somalia	820	5	36	4
Uganda	375	28	19	49

Midwives are scarce across the five countries, with an unmet need between 68 per cent in Ethiopia and 85 per cent in Somalia (United Nations Population Fund, 2014), resulting in a deficiency in continuous, timely and quality maternal care (Bakker et al., 2020; United Nations Population Fund, 2014). At the same time, increased overutilisation of medical interventions such as c-sections and inductions during labour has been observed in Ethiopia, Malawi, Kenya, and Uganda (Ministry of Health Uganda, 2021; Odongo, 2020; Park et al., 2019; Yisma et al., 2019).

While there may be similarities in midwifery practices in Malawi, Kenya, Ethiopia, Somalia, and Uganda due to their geographical proximity and cultural ties, some differences arise due to variations in healthcare policies, cultural practices, and resource availability (World Health Organization, 2022). In Somalia, midwifery services are, for example, limited due to the ongoing conflict and the collapse of the healthcare system, and many women give birth at home without a skilled birth attendant (United Nations Population Fund, 2022). Meanwhile, in Ethiopia, which also faces conflicts, there has been a noteworthy increase in educated midwives in recent years due to governmental priorities. While still relatively few, these midwives are believed to have played a large part in Ethiopia's decline in maternal and neonatal mortality rates (United Nations Population Fund et al., 2021). In Uganda, a government policy on increasing the training of midwives has resulted in higher intakes and deployment of midwives at all levels (Ministry of Health Uganda, 2022). On the contrary, Malawi's government has emphasised educating community health workers, resulting in a negative growth rate of midwives in recent years (World Health Organization, 2022). Meanwhile, Kenya's legislation does not differentiate between midwives and nursing professionals, causing confusion among policymakers and communities about the midwife's role, with limited data available on the status of midwifery (United Nations Population Fund, 2022). Evidence from the countries in the region additionally suggests that midwives primarily engage in implementing policies rather than developing them, and insufficient chances for leadership have resulted in inadequate abilities of midwives to make significant contributions towards shaping health policies and strategies (World Health Organization, 2022).

Midwife-led care (MLC) means that *"the midwife is the lead healthcare professional, responsible for the planning, organisation, and delivery of care given to a woman from the initial booking of antenatal visits through to care during the postnatal period"* (International Confederation of Midwives, 2011).

Midwife-led care refers to a model of care provided by a group of midwives who are fully qualified, regulated and deployed only as midwives (Sandall et al., 2016; World Health Organization, 2021). This contrasts with systems in many countries where nurse-midwives are rotated to either nursing or midwifery duties (Waqas et al., 2022). While no reliable documented evidence on the extent of MLC practises in our five study countries has been identified, MLC is often the norm in many low- and middle-income countries. However, this practice is usually not made by choice but

rather due to the absence of other healthcare providers (Michel-Schuldt et al., 2020).

Midwife-led continuity of care (MLCC) is one of several variations of MLC, which involves the delivery of care by the same midwife or team of midwives throughout the pregnancy, birth, and early postpartum period (Sandall et al., 2016). Similarly to Michel-Schuldt et al. (2020) definition, this article uses midwife-led care to include care led by midwives, which may or may not include midwife-led continuity of care.

Although MLC has been shown to improve outcomes for women and newborns (Hailemeskel et al., 2022a, 2022b; Michel-Schuldt et al., 2020), its implementation has been frequently impeded by various constraints, including political, economic, social, gender-related, and cultural factors (Brunson, 2010; Filby et al., 2016; Koblinsky et al., 2006; Sandall et al., 2016). Addressing these issues has proven complex and challenging for leaders and health policymakers (Filby et al., 2016; Koblinsky et al., 2006; Sandall et al., 2016).

Leaders' and other decision-makers active engagement in healthcare policies, regulations, and clinical practice is necessary to enhance MLC (Agyepong et al., 2017; World Health Organization, 2019). To date, however, no research has examined MLC from the perspective of health leaders. Instead, previous studies have focused primarily on the barriers experienced by midwives and women when providing or receiving MLC (Brunson, 2010; Ezeonwu, 2011; Filby et al., 2016). The purpose of this article is to contribute towards closing this research gap by identifying and examining the structural barriers to MLC and ways to reduce these, as perceived by maternal health leaders working in Ethiopia, Malawi, Kenya, Somalia, and Uganda.

Method

Study design

We have applied an inductive qualitative research approach to analyse participants' perceptions, understandings and meanings of raised questions (Creswell and Poth, 2017).

Data collection and sampling

The empirical data, consisting of qualitative data from three Focus Group Discussions (FGD) and sixteen semi-structured interviews, was collected between November 2020 and August 2021. First, FGDs were conducted focusing on participants' MLC experience, midwives' roles at different levels of the health care system, interdisciplinary teamwork, gender issues, and interprofessional, organisational, and policy issues. These FGDs were conducted to get broader insights into the topic and explore the dynamics of participant perceptions. In addition, it also provided a direction for the subsequent individual interviews (Creswell and Poth, 2017). Following the FGDs, the semi-structured interviews were conducted to identify structural processes and factors influ-

Table 2
Background characteristics of study participants.

Background characteristics of participants	Participants FGD and interviews <i>n</i> = 25
Sex	
Women	18
Men	7
Country	
Ethiopia	4
Kenya	7
Malawi	5
Somalia/Somaliland	5
Uganda	4
Professional background	
Midwife or nurse/midwife	15
Public health specialist	3
Physician/obstetrician	4
Other	3
Position in healthcare system	
Educational/academic leader	6
Clinical leader	7
Policy leader/NGO/MoH/other government institution	12

encing MLC and the participants' professional and personal experiences and views on MLC.

The health leaders participated in the FGDs and interviews through Zoom and WhatsApp online platforms, and the sessions were audio-recorded. The FGDs lasted between 102 and 120 min (mean=110 min), and the interviews between 30 and 74 min (mean=53 min). All data was generated in English as all participants and facilitators speak English fluently, even if it is not the first language of most participants. The first author (JB) conducted all interviews and FGDs following a pre-developed interview and FGD guide in English to ensure consistency across the data collection while allowing for flexibility (Patton, 2014). An observer working with maternal and child health in Kenya, who had no prior connections to the participants, assisted with note-taking, asking follow up-questions and summarising the discussions.

All participants included in the study are connected to the Centre of Excellence for Sustainable Health (CESH), a collaborative centre between Makerere University in Uganda and Karolinska Institutet in Sweden. The participants have either been involved in an online capacity training program called Midwize targeting maternal health care leaders in low-income countries organised by CESH or have links to other collaborative projects associated with CESH.

Participants for the FGDs were selected using convenience sampling. All participants from the online capacity-building programme (*n* = 25) were invited to the FGD, and eighteen participated. Seven leaders declined participation, three due to time constraints, and four did not leave a reason for not participating. The seven leaders who did not choose to participate come from all four countries. Three worked at the policy level, one at an NGO, and three at the clinical level. No leaders from Uganda participated in the FGDs because they were not part of the online capacity-building program.

Sixteen leaders from the five countries were purposively sampled, invited and agreed to participate in the semi-structured interviews. Nine participants had partaken in one of the FGDs. These participants were sampled based on having presumed valuable information that was not fully elaborated on due to the conversational nature of the discussions and therefore required further exploration through a one-on-one interview. The remaining seven interviewees were selected through the CESH network. The sampling criteria was based on their professional position and previous experience or perceived knowledge of MLC. A diversity of participants based on nationality, gender, and age was targeted

to maximise the utility of information. The gender ratio mirrored the leaders involved in the capacity-building program. See [table 2](#) for more detailed information on the participants. The inclusion of new participants ceased when the data collected and analysed reached saturation (Patton, 2014).

Data analysis

Data were analysed using inductive qualitative content analysis to systematically examine the leaders' various experiences (Elo and Kyngäs, 2008). The FGDs and interviews were recorded and transcribed verbatim. To facilitate data management and analysis, the software NVivo™ was used.

During the preparation phase, transcripts were read and re-read to facilitate immersion and get a sense of the data as a whole (Elo and Kyngäs, 2008). The data were then organised using open coding, and meaning units were created from the raw text. In the next step, codes were identified and grouped into six sub-categories based on similarities and differences. The generic categories were identified by grouping sub-categories with similar events and incidents. The development of categories occurred in several iterative cycles and was discussed among all authors until a consensus on the final analysis was reached. The iterative engagement with data facilitated a deeper probing to appropriately organise and determine the more profound layers behind the issue (Elo and Kyngäs, 2008). See [table 3](#) for examples of the systematic steps applied to the data analysis.

Study rigor

We applied the methodological criteria for trustworthiness presented by Lincoln and Guba (1981). The entire process, including the characteristics of the participants, has been described in detail, and verbatim quotations of the findings have been used throughout the text to promote neutrality towards the data. A recurrent dialogue regarding interpretation and preconceptions was held among the researchers to understand the leaders' perceptions better.

Due to this study's qualitative design, the results are not intended to be generalised but rather to provide a description and insights into the leaders' perception of MLC from their viewpoint. However, as this study focuses on structural issues connected to MLC barriers, the results can be assumed to apply to other low-resource settings with similar healthcare systems and structures.

Table 3
Two examples of the systematic steps applied to the data.

	Example 1	Example 2
Step 1 Raw text	<i>"Midwives are seen as women and therefore don't mind a lot of hardship. They don't complain, and even if they complain today, tomorrow everything will be okay and as before."</i>	<i>"I think that sometimes there is a sense of like, I don't know, superiority. I think that there are a lot of these complexes that are not being addressed."</i>
Step 2 Meaning unit	Midwives are seen as women, women rarely complain, and if they do, nothing will change	Feelings of superiority/inferiority between professions are not addressed
Step 3 Code	Midwives are disempowered based on gender	Tensions between professions
Step 4 Sub-category	Gender disparities (barrier to MLC)	Organisational structures and traditional hierarchies (barrier to MLC)
Step 5 Generic category	Creating awareness to increase status and respect for the profession	Reforming the healthcare organisation at all levels to support the provision of quality midwifery care

Ethical considerations

This article is not based on information from patients or volunteers and is based on a Master Thesis conducted in Sweden. As such, the data collection did not require ethical approval according to Swedish legislation (Ministry of Education Sweden, 2003). The authors aimed to act within the framework of internationally accepted ethical research principles, with the overall objective of protecting the individual and ensure that human values are respected (World Medical Association, 2013).

All participants obtained written and verbal information reflecting the research objectives, their voluntary participation, their right to withdraw at any time, and that all data were anonymised and kept confidential. Participants gave verbal, recorded, informed consent before the interviews or FGDs started. The participants were given the researcher's contact information if concerns or clarifications were needed after the interview.

Findings

The findings are organised into three generic categories focusing on health leaders' perceptions of MLC, and what is needed to change the current state of practice. Subordinate to the generic categories is six sub-categories that depict the various barriers to MLC and ways to reduce them.

Reforming the healthcare organisation at all levels

Traditional hierarchies and organisational structures

Several participants across the five countries illustrate how tensions and hierarchies between different professions hamper interdisciplinary teamwork and diminish midwives' ability to provide MLC. The reason why this barrier to MLC persists in the healthcare system is described as complex. Examples indicate an interlinkage to unclear professional boundaries, different views on roles and responsibilities embedded in organisational traditions, and differences in power and authority. One example comes from a study participant with a professional background in medicine:

...I think that sometimes there is a sense of like, I don't know, superiority. I think that there is a lot of these complexes that are not being addressed. And so, people don't realise that it's the team together. Everyone has a role to play... (Participant B, Malawi)

The organisational traditions and differences in power and authority create an additional barrier when leaders at hospitals and wards do not welcome changes. One respondent from Uganda describes:

...I really want to push for the issue of organisational culture. Because if you go to a religious hospital, mission church hospitals, and then you have some traditional men there. And you want to introduce these policies like an MLC policy, you'll find that you don't have much progress... (Participant N, Uganda)

The participants see midwives working in private or higher-level public facilities, e.g., district hospitals and specialist referral hospitals, as being especially far from utilising their professional capacity and providing MLC. In these settings, organisational structures and doctors' higher status often hinder midwives from providing quality of care in line with MLC, even in uncomplicated pregnancies and births. One participant describes her experience when she, as part of her job as a leader, visited a private hospital in Malawi:

...Midwives were just getting the vital signs, weighing the clients, and handing over the information to the obstetrician who made all the exams. A long queue of patients was waiting for the obstetrician to do procedures or exams that all the midwives at the clinics had been trained to do. They were wasting their resources... (Participant J, Malawi)

In contrast to private and higher-level facilities, MLC is, according to study participants from all countries, almost always practised unintentionally in lower-level public settings, as no other professionals are available. In these settings, the midwives have to take full responsibility for maternal and newborn care, sometimes outside their professional scope. This lack of supportive structures is described as preventing them from delivering quality of care in line with MLC.

Intrasectoral and multisectoral collaboration

Participants from all countries emphasize the importance of disrupting the current compartmentalized approach and improving collaboration within and between sectors to reduce barriers to MLC related to traditional hierarchies and organizational structures. For example, as described in some settings in Uganda, Malawi and Kenya, by having managers who organise collaborative educational activities and create opportunities to discuss different professionals' scope of practice - "to clearly outline who does what when it is a normal delivery and when the doctor should come" (Participant G, Malawi).

Another example of enhancing collaboration and thereby reducing barriers to MLC comes from a hospital setting in Malawi, where midwives have prior experience working with the model of care from a South African context. Their previous experience and knowledge enable the work at the clinic:

...I often find that those who haven't been exposed in practicality to that system are resistant because they sort of see it as a power dynamic and taken away from the doctor and so forth. Whereas if you have been exposed to the system, you see the benefits for yourself, you see how that helps you...to focus on the critical cases instead of being everywhere and nowhere... (Participant C, Malawi)

One positive example of multisectoral collaboration called the “The Quad” is mentioned in the Malawi context. The Quad regularly gathers and concurrently shares information with representatives from the Ministry of Health, educational institutions, professional associations, and leaders of clinical sites. This has, for example, facilitated improvements in midwives’ ability to provide care according to their scope of practice. One leader from Somalia describes a similar need in her country *...We need to interact with each other. So, if the policy level proposes or set a policy, they need the cooperation of the clinical or education and vice versa. And if this is not done, nothing can be bridged, because policy cannot develop without the cooperation and implementation of the other both fields... (Participant F, Somalia)*

According to several study participants, another way to increase collaboration and reduce barriers to midwives’ autonomy and ability to practice MLC is to strengthen midwifery associations’ roles. In Kenya and Ethiopia, several participants explain how the stronger Obstetric/Gynecology Associations out-rule the midwives’ professional associations. Therefore, midwives’ work is often absent in ministry policy publications or guidelines. One participant describes: *“They make very minute policy decision that is affecting even midwifery practice... you find that they will have the expert in the panels of decision-making bodies” (Participant H, Kenya)*. Participants explain that more midwives must join the associations to balance the influential power, and collaboration with other professional associations must increase. A positive example is shared from Somalia, where different professional associations regularly discuss collaborative ways to move maternal health care practices forward. According to the study participant, this has resulted in several beneficial outcomes of joint practices and a strengthened role for midwives, their status, and MLC. Another example of reducing barriers for MLC comes from Uganda, where the Ministry of Health has a reserved timeslot for nurses and midwives at their monthly meetings to discuss their roles and care practices.

Creating awareness to increase status and respect

Gender disparities

Several participants describe midwifery as traditionally seen as a low-skilled profession only suitable for women. This is still believed to affect midwives’ status in communities and organisations and creates a barrier to midwives’ empowerment to lead the care in the MLC model and change the current state of practice. A study participant from Kenya explains how traditional gender norms cause this barrier to MLC to persist:

...Midwives are seen as women and therefore don't mind a lot of hardship. They don't complain, and even if they complain today, tomorrow everything will be okay and as before... (Participant H, Kenya)

Additionally, some participants from Ethiopia, Malawi, and Somalia describe how cultural taboos, stigma, and faith-based beliefs connected to birth, bleeding, and body fluids sometimes negatively disturb midwives’ personal lives and status, which, in the broader perspective, may impact their position as leaders of care in the MLC model.

In Somalia, for example, midwives report that colleagues have experienced how their husbands do not want to eat with them or sleep in the same bed after working a shift at the delivery ward,

and one participant from Ethiopia portrays how religious norms affect not only women who were bleeding but also the midwives, as they were, through their work, in contact with women’s blood.

...As the woman should be clean in every aspect, but particularly she should not be in contact with blood, so if she is attending birth at night, she would not be allowed to enter the church in the morning... (Participant I, Ethiopia)

Several leaders highlight that midwives’ status and thereby their ability to lead the care in the MLC model are affected by other gender norms, such as the lack of equal educational opportunities between men and women. Girls’ lower level of school attendance is seen to create professional development barriers, which later inhibit female midwives’ capacity and confidence in taking up leadership positions and leading the care. The participants describe how girls and women are hindered from attending school by household chores, early marriage, and difficulties managing menstrual bleeding in many settings.

A female midwife who has struggled to attain a higher professional position illustrates how these gender norms affected her:

...It started from home, for example, me and my brother. When I was a little girl, during school, I was so busy to prepare food, to clean. Then he was studying...This is a bad culture. Men get out of the home to spend their time on working, leadership, and education, and the women should be home to prepare food and the home for the pleasure of men...(Participant K, Ethiopia)

Females’ inferior educational status is demonstrated even at the countries’ highest academic education and research level. One participant from Ethiopia describes: *“In our PhD program for midwives in Ethiopia, there is a majority of males. Even though most midwives are women” (Participant D)*.

Role models and norm transformation

Changing society’s norms around midwives, birth, and body fluids is described as multifaceted, and solutions must come from different directions. However, study participants across the countries witness positive changes and give examples of ways these norms already have or could be reduced - like holding sensitisation workshops for healthcare workers and public awareness campaigns highlighting women’s and midwives’ dignity. Additionally, examples are given of midwives who have expanded their knowledge and skills in other areas to visualise and communicate the benefits of midwives and MLC convincingly. This is seen as a way forward:

Midwives need to come out of the box of midwifery and involve themselves in law, economics, cost-benefit analysis, public health statistics...so they can learn how to communicate their situation. (Participant FGD2)

Creating role models for midwives is seen as an essential step to reducing barriers to MLC. One study participant shares an example of how an NGO she worked for organised “fireside chats”, where young midwives inspired and encouraged each other by sharing stories about their experiences and visions about their profession. According to the study participant, this was a way to trigger a positive change in power for midwives in the local context.

Even though most of the students in the described Ethiopian PhD program are male, participants from all countries see the increase of midwives involved in research as a positive way to create role models, transform norms and further strengthen midwives’ status and ability to influence decision-making processes.

Strengthening midwives to take an active role in decision-making

Inadequate leadership

Most participants across all countries witness a distressing lack of midwife leaders at middle and higher leadership levels within maternal health care. The participants who are midwives often describe themselves as rare exceptions in their position as leaders within maternal health care. The low number of midwife leaders is described as central when explaining barriers to enabling work environments for midwives and their position to deliver MLC.

...Women and midwives still continue to suffer a very, very big discrimination. You'll find that they are missing at that table...and still this representation is important, for the allocation of resources... (Participant G, Kenya)

Why this barrier to MLC persists is seen to connect to several of the other barriers already described, like traditional institutional hierarchies, midwives' status in society and at workplaces, and a lifelong gender gap in education. One leader from Malawi explains:

...Why? Because of inferiority complex, because they don't have the education, they don't have the confidence and all that... (Participant J, Malawi)

Study participants across the countries further describe how females' and midwives' decision-making powers and leadership abilities differ depending on socioeconomic status and religious groups. Words like "culture", "religion", and "tradition" are also used by participants when discussing why the barriers for midwife and female leaders persists. One participant from Somalia, where female leaders are scarce in comparison to the other three countries, give an example:

...According to our culture, in the constitution, it's not allowed for females to be on higher levels...we allow only for males, and they claim that females cannot take higher positions when the situation is very difficult... (Participant F, Somalia)

Across the countries, it is commonly described that women and female midwives need to "change", "rise to the occasion", or "speak up" to facilitate their chances of a leadership position and to advocate for MLC (Participant J, G, and K). However, women who try to "rise to the occasion" or "speak up" are sometimes hindered by traditional gender roles:

...There was a joke we used to make when the female nurse-midwives participated in the boardroom meetings. They are the ones who will be sent out serving tea while everyone else is discussing stuff...We also made some observations that female healthcare providers are not as combative, which is like naturally, women are not as combative as men. So, when you go to the boardroom discussions where combativeness can help in negotiations on the way resources should flow, you find that it is missing in the nursing and midwife profession... (Participant H, Kenya)

Inclusion of midwife leaders and decision-makers

Even though barriers for future and existing female midwife leaders are described, one of the most potent ways to reduce barriers for MLC and empower midwives to act within their professional scope is, according to most participants, to include more midwives in decision-making.

One participant from Ethiopia explains:

...We need someone who fights and contributes for midwifery at a policy level...the leader who decides on midwifery has a public health background or medical background so they will insert their interest because they don't know midwifery, the education or its practice... (Participant I, Ethiopia)

One way of doing this is to have reserved seats in higher leadership positions for women and healthcare professionals, described in the Ethiopian, Kenya, Malawi, and Uganda contexts. Due to this, things are slowly changing positively, and in Kenya and Malawi, some midwives hold critical positions connected to policy and higher decision-making.

Participants also mention how midwives need to be confident enough and have the status and the capacity to be able to drive change towards improved quality of care in the MLC model, regardless of whether they work at the clinical, academic, association, or policy level of their countries' healthcare systems. "The capacity building program", in which several of the participants took part, is mentioned as one way to push the capacity of midwives on how to lead improvements in care and MLC forward. Other examples, such as continuous capacity development, project management, and courses on running quality improvement projects, are also mentioned across the five countries as ways to reduce barriers to providing MLC.

Summary of findings

The provision of MLC in the studied countries are hindered due to various factors, including traditional hierarchical organisational structures, inadequate leadership, and differences in power and authority among professions stemming from societal and gender norms. The identified ways to reduce barriers to MLC, according to the health leaders, are summarised in Fig. 1.

Discussion

The empirical findings demonstrates how all five study countries share barriers to improved MLC and that several of these are connected to persistent gender norms and a lack of empowerment for women and midwives. Like all social relations, gender norms are multifaceted and embody values, ideas, and identities, which allocate labour responsibilities, determine resource distribution, and assign agency, authority, and decision-making power (Kabeer, 2005). Given that midwifery in the study context is perceived as a predominantly female profession, this significantly impacts how agency, authority, and decision-making power within the midwifery profession are enacted and performed.

Midwives in many resource-poor settings (here identified as lower-level public health establishments, often in rural areas) hold a "passive form of agency" (Kabeer, 2005) when they are forced to work with MLC due to the absence of other healthcare professionals. This should not be mistaken for empowerment. On the contrary, this deceptive form of decision-making power, whereby action is only taken due to the limitation of other choices, leads to maternal care that is usually provided "too little too late" (Miller et al., 2016). The unintentional practice of MLC has been demonstrated to negatively affect midwives' personal and professional safety and create anxiety and stress because they are forced to cross professional boundaries (Ackers et al., 2016; Michel-Schuldt et al., 2020). Unintentionally practising MLC is linked to inadequate resources and investments in maternal health (Filby et al., 2016). These shortcomings can be viewed as indicative of the status and influence of the professionals and end-users involved. In the cultural settings described in this study, midwives generally lack both agency at the clinical level and a voice in decision-making at the policy level. While this phenomenon is specifically pertinent in the context of these five studied countries, it also exists in other geographical areas of the world. For example, Rumsey et al. (2022) describe that midwifery leaders in the South Pacific are not in a position to contribute to central decision-making on health policy, and a global scoping review by

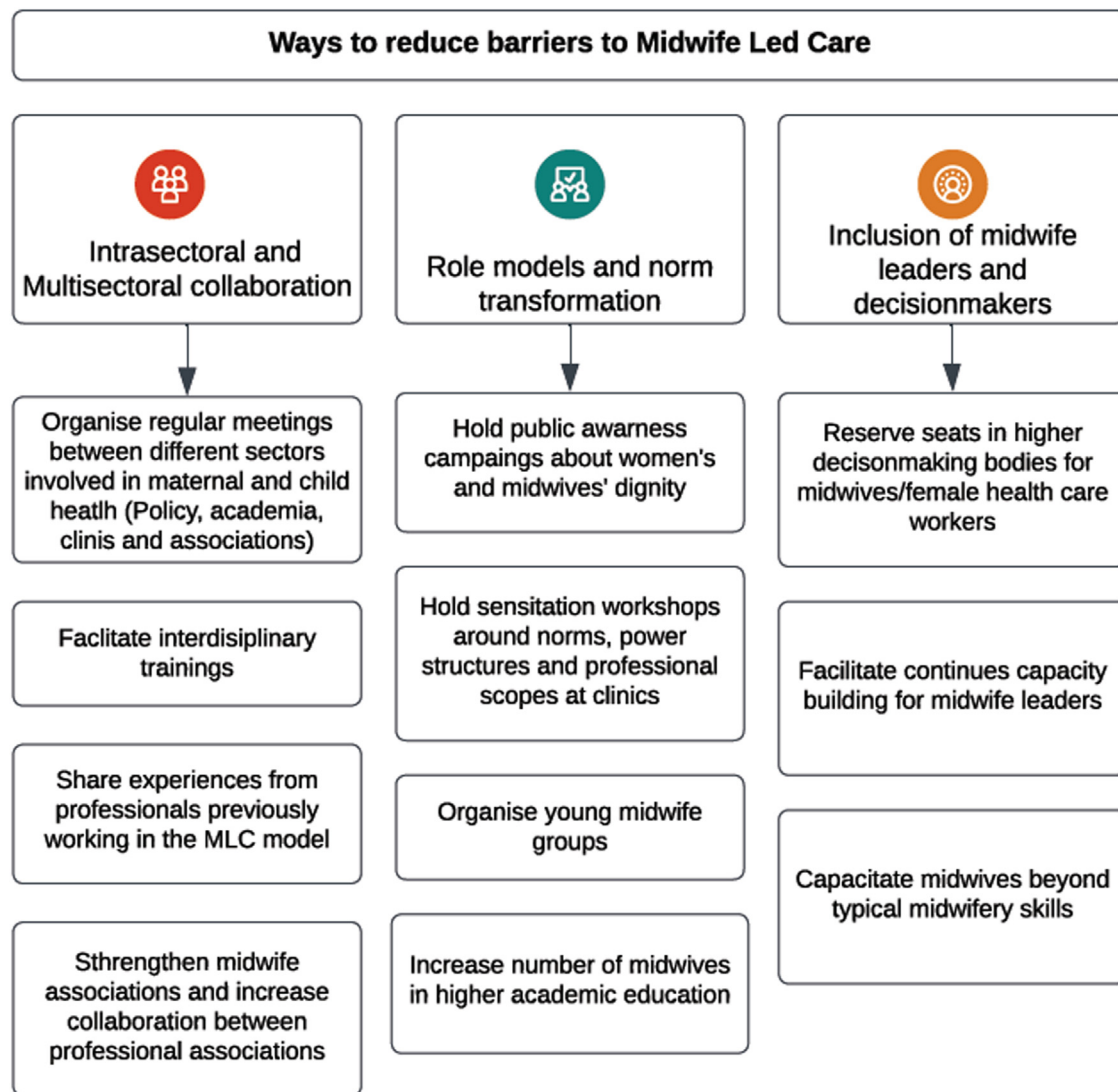


Fig. 1. Ways to reduce barriers to MLC according to health leaders in Ethiopia, Malawi, Kenya, Somalia, and Uganda.

Hewitt et al. (2021) finds that leadership is not a prominent feature for midwives.

The importance of leadership for developing and sustaining MLC is described by Michel-Schuldt et al. (2020), who means that midwives in low- and middle-income countries are rarely supported to provide MLC by their managers and leaders (Michel-Schuldt et al., 2020). Attaining decision-making power and leadership roles for midwives can be challenging to achieve as it often relates to the same constraints that have prevented women from taking a strategic presence in other decision-making arenas of society (World Health Organization, 2019). Barriers for women and midwife leaders are several; they are less likely to be in a position of power and authority, less likely to be given the opportunity to advance, and are, more often than men lacking the necessary supportive network to reach leadership positions (World Health Organization, 2019). Additionally, and in line with our study findings, leadership qualities are traditionally associated with masculine traits, and traditional gender norms do not picture women, or in this case, female midwives, as leaders (Sen and Östlin, 2008). The privileged position of specific actors in many institutions regarding the operation of rules, norms, and conventions may create obstacles for both the implementation of MLC at the clinical level and the advancement of midwives into leadership roles within tra-

ditional hierarchical organisational structures. However, removing this “organisational plaque” can be difficult, as traditional values and ways to work often hinder change processes and the implementation of new policies (Sen and Östlin, 2008). These persistent patriarchal structures lead to women’s underrepresentation in higher positions and explain the general sentiment “women deliver global health while men lead it” (World Health Organization, 2019, p 3).

Focusing on creating more opportunities for female leaders can be crucial in breaking down barriers for MLC. When women assume leadership positions in organisations with supportive cultures, they can serve as change agents and disrupt gender and cultural norms, as suggested by Mattison et al. (2020). Political reforms to address the gender gaps in higher leadership levels, like those described in Kenya, Malawi, and Ethiopia, are thus seen as an effective way to set the agenda for equal representation of genders within all healthcare organisations (World Health Organization, 2019). It can lead to improved motivation, enhanced quality of care, a more empowered workforce, and a better understanding of health systems, which feeds into creating suitable solutions (World Health Organization, 2019). Addressing gender gaps in leadership is also vital for resource allocation to MLC and increased health equity, as it has been demonstrated that female leaders,

more often than men, implement policies that support women's and children's health (Downs et al., 2014).

In addition to this, many midwives and midwife leaders, here highlighted specifically by participants from Ethiopia and Somalia, are forced to navigate MLC despite entrenched taboos and stigma linked to birth blood and fluids, further devaluing maternal health care work as low-skilled and 'dirty' in the eyes of society (Cislaghi and Heise, 2020; Filby et al., 2016). It may, therefore, not come as a surprise that midwives in our study sometimes are described as being unable to "rise to the occasion", "speak up", or being "combative". In our study setting, this occurs partly because of the low status given to the midwifery profession at the outset and the limited room to manoeuvre that many midwives have, i.e. practising MLC in highly restrictive work environments, where someone else's agency is dominant, often leading to subordination to traditional organisational hierarchies and interprofessional tensions. The association between stigma, gender disparities, and the inferior status of women and the midwifery profession has been demonstrated also in other geographical settings, such as Bangladesh (Blum et al., 2006) and Mozambique (Pettersson et al., 2006).

In summary, leveraging empowerment for midwives and improving MLC requires transformational changes in many spheres and levels - from individual agency and private negotiations in the informal sphere to collective agency and public action in the formal arenas where power is legitimately exercised. As seen in this study, transforming traditional hierarchical organisational structures rooted in patriarchy to increase midwives' ability to provide MLC is complex, and even though this study provides examples of ways to reduce barriers to MLC, further research on ways to empower midwives to enhance the quality of care and provide MLC within their workplaces are necessary.

Strengths and limitations

In this study, it is not the countries included that are under investigation but rather the phenomenon of MLC. As such, the five countries represent a varied sample to generate diverse insights and the collective insights have facilitated the identification of categories and patterns to understand and explain the structural issues in a broader context. In addition, including several countries can also strengthen the transferability of findings to similar low-resource settings. Nevertheless, the varied samples of countries may also pose a limitation, as a more thorough investigation of specific contextual issues arising from a single country's situation was hindered.

Another possible limitation and strength of the study are linked to the positionality of the first author (JB). She is herself a midwife with previous experience in MLC, but from a Swedish context, and she is also a lecturer in the online program participants took part in. To reduce participants' dependability, it was clearly stated that joining the FGD or interviews was not mandatory and would not affect their grades in the online program. However, this may still have affected how participants expressed themselves during the empirical data collection. Moreover, due to the first author's lack of experience with the participants' cultural context, her positionality may have limited the analysis from possible unconscious bias in her interpretation of the empirical data. To reduce this potential bias, the content analysis of the empirical data was reviewed and discussed in an iterative process with the other authors, who combined have both situated cultural knowledge and extensive research experience from the study countries. On the other hand, having the first author share a similar professional background as the participants may have strengthened the study by enabling participants to share professional issues with a healthcare peer.

The participation of leaders with a background in medicine, public health, nursing and midwifery is an advantage for the study, as this provides reflections on MLC from various perspectives. The participants were recruited from the program, and it is unknown how the participants in this program differ from other leaders in maternal and child health in the targeted country.

Conclusion and implications for practise

The findings from this qualitative study indicate that MLC provisions in Ethiopia, Malawi, Kenya, Somalia, and Uganda are hampered by patriarchal norms and structures that disempower midwives. To reduce the identified structural barriers and facilitate MLC's implementation and expansion, midwives need increased access to leadership positions, higher education, female role models, collaborative networks, and platforms where their knowledge, opinions, and research can be heard and considered. The examples of reducing barriers found in this study can be further examined and potentially locally adapted to facilitate MLC across geographical settings.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have influenced the work reported in this paper.

CRediT authorship contribution statement

Johanna Blomgren: Conceptualization, Methodology, Investigation, Formal analysis, Writing – original draft. **Sara Gabrielsson:** Conceptualization, Supervision, Formal analysis, Writing – review & editing. **Kerstin Erlandsson:** Formal analysis, Writing – review & editing. **Miriam C.A. Wagoro:** Writing – review & editing. **Mariam Namutebi:** Writing – review & editing. **Eveles Chimala:** Writing – review & editing. **Helena Lindgren:** Formal analysis, Supervision, Writing – review & editing.

Funding Sources

The online Capacity Building Program was funded by The Swedish Institute.

Acknowledgement

The authors would like to acknowledge the participants in the online Capacity Building Program and the participants in the interviews who contributed to the research. We would also like to express our gratitude to the Swedish Institute for investing in the Midwifery Capacity Building Programme.

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