

Literature Review

Beyond Numbers of Midwives – A Call for True and Honest Professionalism

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Abstract

Background: Despite substantial global declines in maternal mortality over the past two decades, progress has stalled in many low- and middle-income countries, where weak health systems and persistent inequities continue to limit gains. While global strategies have emphasized increasing the number of skilled birth attendants, particularly midwives, emerging evidence suggests that workforce expansion alone is insufficient to improve outcomes. Attention is increasingly shifting toward the quality of care, including the role of health worker motivation, professional engagement, and working conditions.

Objective: Driven by the call from “One Million More Midwives” by the International Confederation of Midwives, which is also a theme for the International Day of the Midwife 2026, this review examines the evidence on factors influencing the motivation and professional engagement of midwives in low-income settings and explores how these factors shape the quality of maternal and newborn care.


Methods: A narrative literature review was conducted drawing on published studies and global reports on midwifery, health worker motivation, and quality of care in low- and middle-income countries. Sources were identified through searches of major databases and relevant institutional publications, with emphasis on studies examining workplace conditions, supervision, workload, and professional identity.

Results: The literature consistently highlights that midwife performance is influenced by a combination of intrinsic and extrinsic factors. Intrinsic motivators, including professional pride, compassion, and a sense of purpose, are critical for sustaining high-quality care, particularly in resource-constrained environments. However, these are frequently undermined by systemic challenges such as high workload, inadequate staffing, weak supervision, and lack of recognition. Evidence also identifies incomplete clinical documentation and gaps in postpartum care as manifestations of broader disengagement and system-level dysfunction. The immediate postpartum period, a critical window for preventing maternal and neonatal deaths, is particularly vulnerable to neglect in overstretched facilities.

Conclusion: Efforts to reduce maternal mortality must move beyond a narrow focus on increasing the number of midwives toward strategies that strengthen motivation, professional identity, and supportive working environments. Policies that invest in mentorship, supportive supervision, recognition, and accountability systems are essential to sustain quality care. Reframing midwifery scale-up to include both numbers and professional engagement is critical for achieving meaningful and sustained improvements in maternal and newborn outcomes.

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Keywords: Midwifery; Maternal mortality; Quality of care; Health worker motivation; Professional engagement; Postpartum care; Health systems strengthening; Low- and middle-income countries





Introduction

Background

Over the past two decades, global maternal mortality has declined substantially; however, progress has stalled in many high-burden settings, revealing deep structural inequities in health systems. Despite commitments under SDG 3.1, reductions have been uneven, with low- and middle-income countries—particularly those affected by fragility, conflict, and weak health systems—continuing to bear a disproportionate burden (World Health Organization WHO, 2025). Sub-Saharan Africa alone accounts for nearly 70% of global maternal deaths, a pattern consistently linked to delayed access to care, shortages of skilled providers, and poor quality of facility-based services [1].

Importantly, the persistence of maternal mortality in these settings has shifted the global discourse from coverage to quality. Evidence increasingly suggests that expanding access to facility delivery without commensurate improvements in care quality yields limited mortality reductions [2]. This has catalyzed renewed attention to the health workforce—particularly midwives—as both the backbone of maternal health systems and a critical determinant of care quality [3].

Methodology

A narrative integrative approach [4] was employed to synthesize evidence on maternal mortality, midwifery workforce growth, quality of care, clinical documentation, and professional motivation in low- and middle-income countries.

The primary databases searched included PubMed/MEDLINE, Scopus, Web of Science, and Google Scholar. Institutional repositories from WHO, UNFPA, UNICEF, the World Bank, and the International Confederation of Midwives (ICM) were also reviewed. Search terms comprised maternal mortality, midwifery, quality of care, postpartum care, clinical documentation, worker motivation, burnout, and respectful maternity care. Reference lists of key publications were checked manually. Literature published between 2000 and 2025 was included to capture both foundational and recent studies.

Studies addressing care quality, record-keeping, and provider motivation were examined. Thematic synthesis was applied to research on midwifery scale-up, maternal mortality reduction, care quality beyond coverage, and provider motivation. These themes were integrated to develop a framework for understanding the drivers of effective maternal health care.

Limitations

This review has several limitations. As a narrative integrative review, it does not cover or formally assess the quality of all included studies [5]. Professional passion and motivation also vary by context, making consistent measurement across settings difficult [6].

Results

Midwifery scale-up as a global strategy

Midwives are widely recognized as central to the prevention of maternal, neonatal, and stillbirth deaths across the continuum of care, including antenatal, intrapartum, and postnatal periods. Modelling studies indicate that when midwives are trained to international standards and integrated into functional health systems, they can deliver up to 83% of essential reproductive, maternal, newborn, and adolescent health interventions [7]. On this basis, global actors have prioritized workforce expansion as a key strategy for accelerating progress toward SDG 3.1 [8]. While this is true, this analysis has not included motivation theories as enablers of expansion for better outcomes [9].

The International Confederation of Midwives' call for one million additional midwives worldwide reflects both the scale of the workforce deficit and the potential impact of midwifery-led care [8]. Similarly, UNFPA and WHO estimates suggest that current shortages of skilled health personnel, especially midwives, pose one of the most significant barriers to reducing preventable maternal deaths [10,11].

However, critics have cautioned that an overemphasis on numerical targets risks obscuring deeper questions of workforce quality, deployment, and sustainability. Health systems characterized by chronic underfunding, weak supervision, and high workloads may absorb newly trained midwives without improving outcomes, particularly if working conditions undermine performance and motivation [3]. With the clarion call by the ICM of 1 million more midwives, ICM (2026), and following the seminal estimate by Boyce, et al. (2026) [12], we do not know of any other reviews that came after the ICM call and the Boyce, et al. estimates that caution on the overemphasis on numbers only.

Beyond numbers: Quality, motivation, and professional engagement

A growing body of literature emphasizes that health worker performance is shaped not only by skills and staffing ratios, but also by motivation, professional identity, and workplace environment. Studies across sub-Saharan Africa consistently document high levels of burnout, moral distress, and demoralization among midwives working in resource-constrained maternity wards [13,14]. These conditions erode vigilance and compromise adherence to routine but critical practices, particularly during periods of sustained workload pressure [9,15].

Health worker motivation theory highlights the role of intrinsic drivers such as professional pride, compassion, and a sense of purpose in sustaining high-quality care, especially in challenging contexts [9,15]. When these intrinsic motivators are undermined by a lack of recognition, poor supervision, or systemic neglect, providers may disengage



from practices perceived as low-value or unrewarded, including documentation and postnatal follow-up [2,13]. These findings, however, need to be contextualized as others such as Goldenberg and McClure [16] have done.

Documentation as a marker of quality and accountability

Incomplete clinical documentation has emerged as a persistent weakness in maternal and newborn care across low-resource settings. Studies have shown that omissions in recording vital signs, postnatal assessments, and adverse outcomes are common, particularly in high-volume facilities [17]. While often framed as clerical failures, documentation gaps reflect broader system dysfunctions, including time pressure, staff shortages, and weak accountability mechanisms [18].

The World Health Organization identifies accurate documentation as foundational to quality improvement, clinical audit, and surveillance systems such as Maternal and Perinatal Death Surveillance and Response (MPDSR) [19,20]. Evidence from multiple countries demonstrates that robust audit and feedback mechanisms—enabled by reliable records—are associated with reductions in maternal and perinatal mortality [18,21].

At the same time, documentation serves as a proxy for professional engagement. Completing records requires sustained attention, discipline, and belief in the value of the system. In this sense, documentation quality reflects not only technical competence, but also a provider's sense of accountability and connection to professional purpose [13,22].

The critical postpartum window

The immediate postpartum period represents one of the highest risk phases for maternal and newborn mortality, yet it remains systematically under-prioritized in both practice and research. A substantial proportion of maternal deaths occur within the first 24 to 48 hours after delivery, primarily due to postpartum haemorrhage, sepsis, and hypertensive disorders [23,24]. These conditions are highly preventable with timely monitoring and intervention.

Despite this, studies repeatedly document gaps in postnatal care provision, including early discharge, inadequate monitoring, and poor documentation [25]. In overstretched maternity wards, particularly in low-income settings, attention often shifts rapidly from the woman who has delivered to the next obstetric emergency, rendering postpartum surveillance particularly vulnerable to omission [26].

Synthesizing the evidence: Implications for midwifery scale-up

Taken together, the literature suggests that while expanding the midwifery workforce is necessary, it is insufficient on its

own to achieve sustained reductions in maternal and newborn mortality. Quality of care emerges as a function of not only staffing numbers, but also motivation, professional support, supervision, and system-level accountability [3,9].

Without deliberate investment in enabling environments that sustain professional passion and vigilance, scale-up efforts risk reproducing existing failures—producing a larger workforce operating within the same constrained and demoralizing conditions [13,14]. This underscores the need for empirical inquiry that moves beyond coverage metrics to examine how midwives experience their work, how care processes such as documentation are enacted in practice, and how these dynamics shape outcomes during the most critical moments of care [2,18].

Cultivating passion, professional purpose, and meaning in midwifery practice

While global and national strategies frequently emphasize competencies, protocols, and staffing ratios, a growing body of scholarship suggests that professional passion and sense of meaning are equally critical to sustaining high-quality maternal and newborn care. Passion, understood here as a form of intrinsic motivation rooted in professional identity, compassion, and moral commitment, cannot be transmitted through manuals or clinical guidelines alone. Rather, it is cultivated through relational, organizational, and leadership practices that reconnect providers to the purpose and social value of their work [9,15].

Evidence from health workforce research highlights several mechanisms through which professional purpose is nurtured. Mentorship, particularly the pairing of newly qualified midwives with experienced practitioners who model both technical excellence and compassionate care, has been shown to strengthen confidence, accountability, and adherence to standards [11,14]. Such relationships transmit not only skills, but professional norms and values that sustain vigilance under pressure [13].

Recognition and feedback also play a central role. Studies demonstrate that when health systems reward only productivity indicators—such as delivery counts or throughput—providers may deprioritize less visible but equally critical practices, including documentation, counselling, and postnatal follow-up [2]. Conversely, recognition that values accuracy, empathy, and completeness reinforces a culture of quality and professional pride [9].

Opportunities for reflection further enable midwives to maintain a sense of meaning in high-burden settings. Reflective practice—whether through debriefs, audits, or peer discussion—helps providers see each woman and newborn not as a statistic, but as part of a life narrative deserving of attention and respect [13,27]. This aligns closely with the principles of respectful maternity care, which emphasize dignity, personhood, and continuity across the care pathway [27].



Finally, leadership and supervision shape how passion is sustained or extinguished. Compassionate leadership that combines accountability with support has been shown to mitigate burnout and reinforce professional responsibility, particularly in resource-constrained environments [22]. In such settings, reminders that care does not end with delivery—but extends into the postpartum period—are critical for sustaining attention to documentation, monitoring, and follow-up [23,24].

Within this context, clinical records take on significance beyond their technical function. When completed with care, records serve as a bridge between shifts, ensuring continuity, safety, and respect. Conversely, incomplete documentation can erase a woman's experience from the system, undermining learning, accountability, and at times survival itself [18,19]. Documentation quality, therefore, reflects not only system capacity but also the degree of professional engagement and moral investment of the provider [13,22].

Research shows that midwifery care improves over 50 outcomes for mothers and newborns. These include lower rates of mortality, stillbirths, preterm births, unnecessary interventions, and psychosocial issues [28]. Midwifery care is also linked to fewer cases of perineal trauma, fewer instrumental deliveries, and fewer admissions to neonatal intensive care units [28]. Other studies suggest that using midwifery interventions everywhere could prevent up to 61% of maternal, fetal, and neonatal deaths [7], with the largest gains in low and middle-income countries where motivation and support are critical to achieving safe outcomes. These results show the importance of supporting a strong midwifery workforce to improve clinical outcomes.

Conclusion

Reframed in this light, the “One Million More Midwives” movement is not merely a call for numerical expansion, but an implicit challenge to cultivate compassion, dedication, and professional integrity at scale [3,8]. The literature suggests that without deliberate attention to motivation and meaning, workforce growth risks reproducing disengagement rather than transforming care [13].

Importantly, the question of passion is not confined to health systems alone. Scholars of public sector reform argue that motivation, integrity, and empathy are foundational to effective service delivery across sectors, particularly in post-crisis and low-resource contexts [29]. In this sense, struggles to deliver respectful maternity care mirror broader development challenges: progress cannot be imported solely through policies or external resources, but must be inspired and sustained from within institutions and individuals [15].

As midwifery advocacy moves forward, the literature increasingly supports a shift beyond a narrow focus on workforce numbers toward strategies that rekindle

professional purpose. A passionate midwife delivers not only babies, but dignity, continuity, and hope. In this framing, passion becomes the heartbeat of reform—whether in a maternity ward, a ministry of health, or the wider public service—without which systems may persist, but people do not truly thrive [22,27].

This thesis, not only numbers, is backed by quantified evidence as demonstrated in the Lancet Midwifery Series, which shows that expanding care by trained, licensed, and well-supported midwives could prevent up to 61% of maternal, fetal, and neonatal deaths worldwide [7]. In high-income countries, robust safety nets contribute to low maternal and newborn mortality rates. This environment enables midwives to focus on care quality, client-centered services, and efficiency [16]. However, in contrast, low-income countries often lack such safety nets, increasing the risks for mothers and newborns. As a result, strengthening midwifery motivation and support is especially vital in these settings to improve survival rates and promote fairness [26].

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Availability of data and materials: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request. All papers referred to are available.

Authors' contributions: The author (“BFK”) is responsible for data collection, writing, and review.

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