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Facilitators and barriers of midwife-led model of care at public health institutions of dire Dawa city, Eastern Ethiopia, 2022: a qualitative study

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Abstract

Background The midwife-led model of care is woman-centered and based on the premise that pregnancy and childbirth are normal life events, and the midwife plays a fundamental role in coordinating care for women and linking with other health care professionals as required. Worldwide, this model of care has made a great contribution to the reduction of maternal and child mortality. For example, the global under-5 mortality rate fell from 42 deaths per 1,000 live births in 2015 to 39 in 2018. The neonatal mortality rate fell from 31 deaths per 1,000 live births in 2000 to 18 deaths per 1,000 in 2018. Even if this model of care has a pivotal role in the reduction of maternal and newborn mortality, in recent years it has faced many challenges.

Objective To explore facilitators and barriers to a midwife-led model of care at a public health institution in Dire Dawa, Eastern Ethiopia, in 2021.

Methodology : A qualitative approach was conducted at Dire Dawa public health institution from March 1–April 30, 2022. Data was collected using a semi-structured, in-depth interview tool guide, focused group discussions, and key informant interviews. A convenience sampling method was implemented to select study participants, and the data were analyzed thematically using computer-assisted qualitative data analysis software Atlas.ti7. The thematic analysis with an inductive approach goes through six steps: familiarization, coding, generating themes, reviewing themes, defining and naming themes, and writing up.

Result Two major themes were driven from facilitators of the midwife-led model of care (professional pride and good team spirit), and seven major themes were driven from barriers to the midwife-led model of care (lack of professional development, shortage of resources, unfair risk or hazard payment, limited organizational power of midwives, feeling of demoralization absence of recognition from superiors, lack of work-related security).

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Conclusion The midwifery-led model of care is facing considerable challenges, both pertaining to the management of the healthcare service locally and nationally. A multidisciplinary and collaborative effort is needed to solve those challenges.

Keywords Continuous midwifery care model, Obstetric care by midwives, Barriers to obstetric care, Facilitators to obstetric care

Introduction

A midwife-led model of care is defined as care where "the midwife is the lead professional in the planning, organization, and delivery of care given to a woman from the initial booking to the postnatal period" [1]. Within these models, midwives are, however, in partnership with the woman, the lead professional with responsibility for the assessment of her needs, planning her care, referring her to other professionals as appropriate, and ensuring the provision of maternity services. Most industrialized countries with the lowest mortality and morbidity rates of mothers and infants are those in which midwifery is a valued and integral pillar of the maternity care system [2–5].

Over the past 20 years, midwife-led model of care (MLC) has significantly lowered mother and infant mortality across the globe. In 2018, there were 39 deaths for every 1,000 live births worldwide, down from 42 in 2015. From 31 deaths per 1,000 live births in 2000 to 18 deaths per 1,000 in 2018, the neonatal mortality rate (NMR) decreased. The midwifery-led care approach is regarded as the gold standard of care for expectant women in many industrialized nations, including Canada, Australia, the United Kingdom, Sweden, the Netherlands, Norway, and Denmark. Evidence from those nations demonstrates that women and babies who get midwife-led care, as opposed to alternative types of care, experience favorable maternal outcomes, fewer interventions, and lower rates of fetal loss or neonatal death [6–8].

In Pakistan, the MLC was accompanied by many challenges. Some of the challenges were political threats, a lack of diversity (midwives had no opportunities for collaborating with other midwives outside their institutions), long duty hours and low remuneration, a lack of a career ladder, and a lack of socialization (the health centers are isolated from other parts of the country due to relative geographical inaccessibility, transportation issues, and a lack of infrastructure). Currently, in Pakistan, 276 women die for every 100,000 live births, and the infant mortality rate is 74/1000. But the majority of these deaths are preventable through the midwife-led care model [7].

The MLC in African countries has faced many challenges. Shortages of resources, work overload, low interprofessional collaboration between health facilities, lack of personal development, lack of a well-functioning referral system, societal challenges, family life troubles, low professional autonomy, and unmanageable workloads are the main challenges [8].

Due to the aforementioned challenges, Sub Saharan Africa (SSA) is currently experiencing the highest rate of infant mortality (1 in 13) and is responsible for 86% of all maternal fatalities worldwide. As a result, it is imperative to look at the MLC issues in low-income countries, which continue to be responsible for 99% of all maternal and newborn deaths worldwide [8, 9].

Ethiopia's has a Maternal mortality rate (MMR) and NMR of 412 per 100,000 live births and 33 per 1000 live births, respectively, remain high, making Ethiopia one of the largest contributors to the global burden of maternal and newborn deaths, placed 4th and 6th, although MLC could prevent a total of 83% of all neonatal and maternal fatalities in an environment that supports it. The MMR & infant mortality rate (IMR) in the research area were indistinguishable from that, at 150 per 100,000 live births and 67 fatalities per 1,000 live births, respectively [10–13].

Since the Federal Ministry of Health is currently viewing midwifery-led care as an essential tool in reducing the maternal mortality ratio and ending preventable deaths of newborns, exploring the facilitators and barriers of MLC may have a great contribution to make in reducing maternal and newborn mortality [14]. Since there has been no study done in Ethiopia or the study area regarding the facilitators and barriers of MLC, the aim of this research was to explore the facilitators and barriers of MLC in Dire Dawa City public health institutions.

In so doing, the research attempted to address the following research questions:

1. What were the facilitators for a midwife-led model of care at the Dire Dawa city public health institution?
2. What were the barriers to a midwife-led model of care at the Dire Dawa city public health institution?

Methods

Study setting and design

Institutional based qualitative study was conducted from March 01-April 30, 2022 in Dire Dawa city. Dire Dawa city is one of the federal city administrations in Ethiopia which is located at the distance of 515killo meters away from Addis Ababa (the capital city) to the east. The city administration has 9 urban and 38 rural kebeles (kebeles

are the smallest administrative unit in Ethiopia). There are 2 government hospitals, 5 private hospitals, 15 health centers, and 33 health posts. The current metro area population of Dire Dawa city is 426,129.Of which 49.8% of them are males and 50.2% females. The total number of women in reproductive age group (15–49 years) is 52,673 which account 15.4% of the total population. It has hot temperature with a mean of 25 degree centigrade [15].

Study population and sampling procedure

The source population for this study included all midwives who worked at Dire Dawa City public health facilities as well as key informants from appropriate organizations (the focal person for the Ethiopian Midwives Association and maternal and child health (MCH) team leaders). The study encompassed basically 41 healthcare professionals who worked in Dire Dawa public health institutions in total, and the final sample size was decided based on the saturation of the data or information.

From the total 15 Health centers and 2 Governmental Hospitals found in Dire Dawa city administration, 8 Health centers and 2 Governmental Hospitals were selected by non-probability purposive sampling method. In addition to that a non-probability convenience sampling method was used to select midwives who were working in Dire Dawa city public health institutions and key informants from the relevant organization such as Ethiopian midwives association focal person and MCH team leaders. Midwives who were working for at least six months in the institution were taken as inclusion criteria while those who were working as a free service were excluded from the study.

Data collection tool and procedures

Focus groups, in-depth interviews, and key informant interviews were used in collecting data. A voice recorder, a keynote-keeping, and a semi-structured interview tool were all used to conduct the interviews. Voluntary informed written consent was obtained from the study participant's before they participated in the study. Then an in-depth interview and focus group discussion were held with midwives chosen from various healthcare organizations. The MCH department heads and the Dire Dawa branch of the Ethiopian Midwife Association served as the key informants. In-depth interview (IDI) and key informant interviews (KII) with participants took place only once and lasted for roughly 50–60 min. In the midwives' duty room, the interview was held. Six to eight people participated in focus group discussions (FGD), which lasted 90 to 100 min. Two midwives with experience in gathering qualitative data gathered the information.

Data quality control

The qualitative design is prone for bias but open-ended questions were used to avoid acquiescence and 2 day proper training was given for the data collector regarding taking keynotes and recording using a tape recorder. For consistency and possible modification, a pretest was done in one FGD and In-depth interviews at non selected health institutions of Dire Dawa city administrations. A detailed explanation was given for the study participants about the objectives of the study prior to the actual data collections. All (FGDs, key informant interview and In-depth interviews) were taken in a silent place.

Data analysis

Atlas.ti7, a qualitative data analysis program, was used for analyzing the data thematically. An inductive approach to thematic analysis involves six steps: familiarization, coding, generation of themes, review of themes, defining and naming of themes, and writing up. By listening to the taped interview again, the data was transcribed. The participants' well-spoken verbatim was used to extract and describe the inductive meanings of the statements. The data was then coded after that. Each code describes the concept or emotion made clear in that passage of text. Then we look at the codes we've made, search for commonalities, and begin to develop themes. To ensure the data's accuracy and representation, the generated themes were reviewed. Themes were defined and named, and then the analysis of the data was written up.

Trustworthiness of data

Meeting standards of trustworthiness by addressing credibility, conformability, and transferability ensures the quality of qualitative research. Data triangulation, data collection from various sites and study participants, the use of multiple data collection techniques (IDI, KII, and FGD), multiple peer reviews of the proposal, and the involvement of more than two researchers in the coding, analysis, and interpretation decisions are all instances of the methods that were used in order to fulfill the criteria for credibility. To increase its transferability to various contexts, the study gave details of the context, sample size and sampling method, eligibility criteria, and interview processes. To ensure conformability, the research paths were maintained throughout the study in accordance with the work plan [16, 17].

Result

Background characteristics of the study participants

In this study, a total of 41 health care providers who are working in Dire Dawa public health facilities participated in the three FGDs, six KIIs, and fifteen IDIs. The years of experience of study participants range from one year to 12 years. The participants represented a wide age range

Table 1 Socio-demographic characteristics of respondents for the facilitators and barriers of a midwife-led model of care at a public health institution of dire Dawa city, Eastern Ethiopia, 2021

Characteristics of respondent	Frequency(*n*)	Percent (%)
Age		
20–29	15	35.72
30–39	21	50
40 and above	6	14.28
Gender		
Female	23	54.76
Male	19	45.24
Educational status		
Diploma	11	26.2
Degree	29	69.04
Master	2	4.76
Year of experience		
6month – 2 year	9	21.42
2 year – 5	22	52.38
5 year and above	11	26.2

Table 2 Themes and subthemes of qualitative data for the facilitators and barriers of a midwife-led model of care at public health institution of dire Dawa city, Eastern Ethiopia, 2021

No Themes	Sub themes
Facilitators of MLC	• Professional pride • Good team sprite
Barriers of MLC	• lack of professional development • Shortage of resources • Unfair risk /hazard payment • limited organizational power of midwifes • Feeling of demoralization • Absence of recognitions from superiors • Insufficient work related security

(30–39 years), and the educational status of the respondents ranged from diploma to master's degree. (Table 1)

As shown in Table 2, from the qualitative analysis of the data, two major themes were driven from facilitators of MLC, and seven major themes were driven from barriers to MLC. (Table 2).

Facilitators of midwife-led model of care at a public health institution of Dire Dawa city, Eastern Ethiopia, in 2021

Professional pride

This study found that saving the lives of mothers and newborns was a strong facilitator. Specifically, it was motivational to have skills within the midwifery domain, such as managing the full continuum of care during pregnancy and labour, supporting women in having normal physiologic births, being able to handle complications, and building relationships with the women and the community, as mentioned below by one of the IDI participants.

> *"I am so proud since I am a midwife; nothing is more satisfying than seeing a pregnant mother give birth almost without complications. I always see their smile and happiness on their faces, especially in the postpartum period, and they warmly thank me and say, "Here is your child; he or she is yours." They bless me a lot. Even sometimes, when they sew me in the transport area, cafeteria, or other area, they thank me warmly, and some of them also want to invite me to something else. The sum total of those things motivates me to be in this profession or to provide midwifery care."*
> *IDI participants.*

This finding is also supported by other participants in FGD.

> *"We have learned and promised to work as midwives. We are proud of our profession, to help women and children's health. The greatest motivation is that we are midwives, we love the profession, and we are contributing a great role in decreasing maternal and child mortality…."*
> *FGD discussant.*

Good teamwork

The research revealed that good midwifery teamwork and good social interaction within the staff have become

facilitators of MLC. FGD participants share their experiences of working in a team.

> *"In our facility, all the midwives have good teamwork; we have good communication, and we share client information accurately and timely. In case a severe complication happens, we manage it as a team, and we try to cover the gap if some of our staff are absent. Further from that, we do have good social interactions in the case of weeding, funeral ceremonies, and other social activities. We do have good team spirit; we work as a team in the clinical area, and we also have good social relationships. "If some of our staff gets sick or if she or he has other social issues, the other free staff will cover her or his task."*
> *FGD discussant.*

Another participant from IDI also shared the same experience regarding their good teamwork and their social interactions.

> *"As a maternal and child health team, we do have a good team spirit, not only with midwives but also with other professions. We are not restricted by the ward that we assign. If there is a caseload in any unit, some midwives will volunteer to help the other team. Most of the time in the night, we admit more than 3 or 4 labouring mothers at the same time. Since in our health center only one midwife is assigned in the night, we always call nurses to help us. This is our routine experience."*
> *IDI participants.*

Barriers of midwife-led model of care at a public health institution of Dire Dawa city, Eastern Ethiopia, in 2021

Lack of professional development

This study revealed that insufficient opportunities for further education and updated training were the main barriers for MLC. Even the few trainings and update courses that were actually arranged were unavailable to them, either because they did not meet the criteria seated or because the people who work in administration were selected. Even though opportunities are not arranged for them to upgrade themselves through self-sponsored. One of the participants from IDI narrates her opinion about opportunities for further education as follows:

> *"Training and updates are not sufficient; currently we are almost working with almost old science. For example, the new obstetrics management protocol for 2021 has been released from the ministry of health, and many things have changed there. But we did not receive any training or even announcements. Even the few trainings and update courses that were truly organized and turned in to us are unavailable since the selection criteria are not fair. As a result, we miss those trainings either because we did not meet the selection criteria or because those who work in administration are prioritized."*
> *IDI participant.*

FGD discussants also support this idea. She mentioned that even though opportunities are not arranged for them to upgrade themselves through self-sponsorship,

> *"There is almost no educational opportunity in our institution. Every year, one or two midwives may get institutional sponsorship. Midwives that will be selected for this opportunity are those who have served for more than five to ten years. Imagine that to get this chance, every midwife is expected to serve five or more years. Not only this, even if staff want to learn or upgrade at governmental or private colleges through self-sponsored programmes, whether at night or in an extension programme, they are not cooperative. Let me share with you my personal experience. Before two years, I personally started my MSc degree at Dire Dawa University in a weekend programme, and I have repeatedly asked the management bodies to let me free on weekends and to compensate me at night or any time from Monday to Friday. Since they refuse to accept my concern, I withdraw from the programme."*
> *FGD discussant.*

Shortage of resource

The finding indicates that a shortage of equipment, staff, and rooms or wards was a challenge for MLC. Midwives claimed they were working with few staff, insufficient essential supplies, and advanced materials. This lack of equipment endangers both the midwives and their patients. One of the participants from IDI narrates her opinion about the shortage of resources as follows:

> *"Of course there is a shortage of resources in our hospital, like gloves and personal protective devices. Even the few types of medical equipment available, like the autoclave, forceps, vacuum delivery couch, and BP apparatus, are outdated, and some of them are unfunctional. If you see the Bp apparatus we used in ANC, it is digital but full of false positives. When I worked in the ANC, I did not trust it and always brought the analogue one from other wards. This is the routine experience of every staff member."*
> *IDI participants.*

Another participant from IDI also shared the same experience regarding the crowdedness of rooms or wards.

> *"In our health center, there are no adequate wards or rooms. For example, the delivery ward and postnatal ward are almost in one room. Postnatal mothers and neonates did not get enough rest and sleep because of the sound of laboring mothers. Not only is this, but even the antenatal care and midwifery duty rooms are also very narrow."*
> *IDI participants.*

The study also revealed midwifery staff were pressured to work long hours because they were understaffed, which in turn affected the quality of midwifery care. The experience of a certain midwife is shared as follows:

> *"I did not think that the management bodies understood the risk and stress that we midwives face. They did not want to consider the risk of midwives even equal to that of other disciplines but lower than the others. For example, in our health centre, during the night, only one midwife is assigned for the next 12 hours, but if you see in the nurse department, two or more nurses are assigned at night in the emergency ward."*
> *IDI participants.*

The discussion affirms the fact that being understaffed and not having an adequate allocation of midwife professionals on night shifts are affecting labouring mothers' ability to get sufficient health midwifery care. The above narration is also supported by the FGD discussant.

> *"In our case, only one midwife is assigned to the labour ward during the night shift. I think this is the main challenge for midwives that needs attention. Let me share with you my experience that happened months before. While I was on night shift, two labouring mothers were fully dilated within three or four minutes. It was very difficult for me, to manage two labouring mothers at the same time. Immediately, I call one of my nurse friends from the emergency department to help me. If my friend was so busy, what could happen to the labouring mother and also to me? This is not only my experience but also the routine experience of other midwives."*
> *FGD discussant.*

Unfair risk or hazard payments

It is reported that the compensation amount paid for risk is lower than in other health professions. The health risks are not any less, but the remuneration system failed to capture the need to fairly compensate midwifery professionals. The narration from the FGD discussant regarding unfair payment is mentioned below.

> *"Only 470 ETB is paid for midwives as risk payments, which is incomparable with the risks that midwives are facing. But contrary to that, the risk payments for nurses (in emergencies) are about 1200 Ethiopian birr (ETB), and Anesthesia is 1000 ETB. I did not want to compare my profession with other disciplines, but with the lowest cost, how the risk of midwifery cannot be equal to that of nursing and other professions. I did not know whose professionals made such types of unfair decisions and with what scientific background or base this calculation was done."*
> *FGD discussant.*

The above finding is also supported by an IDI participant.

> *".....Even though the midwifery profession is full of risks, with the current Ethiopian health care system, midwives are being paid the lowest risk payments compared to other disciplines....."*
> *IDI participants.*

Limited organizational power of midwives

Midwives' interviews reported that limited senior midwifery positions in the health system have become the challenge of midwifery care. This constrains the decision-making power and capability of midwives. This was compounded by limited opportunities for midwifery personnel to address their concerns to the responsible bodies, as stated by one of the key informants.

> *"Our staff has many concerns, especially professional-related concerns, which can contribute to the quality of midwifery care. Personally, as department head, I have tried to address those concerns in different management meetings at different times. But since the leadership positions are dominated by other disciplines, many of our staff concerns have not been solved yet. But let me tell you my personal prediction... If those concerns are not solved early and if this trend continues, the quality of midwifery care will be in danger."*
> *Participant from Key Informant.*

The above finding is also supported by another IDI participant.

"In our hospital, at every hierarchal and structural level, midwives are not well represented. That is why all of our challenges or concerns have not been solved yet. For example, as a structure in the Dire Dawa Health Office (DDHO), there is a team of management related to maternal and child health. But unfortunately, those professionals working there are not midwives. I was one of three midwives chosen to meet with Dr. X (former DDHO leader) to discuss this issue. At the time, we were reaching an agreement that two or three midwives would be represented on that team. But since a few months later the leader resigned, the issue has not gotten a solution yet."
IDI participant.

Feeling of demoralization

One of the main concerns reported by the participants during the interviews was a feeling of demoralization induced by both their clients and their supervisors about barriers to midwifery care. They reported having been verbally abused by their patients, something that made them feel that their hard work was being undermined, as stated by an FGD participant.

"I don't think there is any midwife who would be happy for anybody to lose their baby, or that there is any midwife who would want a woman to die. These things are accidents, but the patient and leaders will always blame the midwife."
FDG discussant.

A narration from an IDI participant also mentioned the following:

".....If something happens, like a conflict with the patients or clients, the management is on the patient side. Not only that, the way in which they communicate with us is in an aggressive or disrespectful manner."
IDI participant.

Absence of recognition or /motivation from superiors

This study revealed that midwives experience a loss of motivation at work due to limited support from their superiors. Their effort is used only for reporting purposes. A midwife from FGD shared her experience as follows.

"In our scenario, till the nearest time, the maternal and child health services are provided in a good way. But this was not easy; it is the cumulative effort of midwives. But unfortunately, only those in managerial positions are recognized. Nothing was done for us despite our efforts. To me, our efforts are used only for reporting purposes."
FGD discussant.

This finding was also supported by IDI participants.

"Even though we have good achievements in the MCH services, there is no motivation mechanism done to motivate midwives." But if something or a minor mistake happens, they are on the front lines to intimidate us or write a warning letter. Generally, their concern is a report or a number issue. We are tired of such types of scenarios."
IDI participant.

Insufficient of work-related security

One of the main concerns reported by the participants during the interviews was the work related security, which has become a challenge for MLC. The midwives' work environment was surrounded by insecurity, especially during night shifts, when midwives were facing verbal and even physical attack, as mentioned by participants.

"In the labour ward, especially at night, we face many security-related issues. The families of labouring mothers, especially those who are young, are very aggressive. Sometimes they even want to enter the delivery room. They did not hear what we told them to do, but if they hear any labour sounds from their family, they disturb the whole ward. This leads to verbal abuse, and sometimes we face physical abuse. There may be one or two security personnel at the main gate, but since the delivery ward is far from the main gate, they do not know what is happening in the delivery ward. When things become beyond our scope, we call security guards. Immediately after the security guards go back, similar things will continue. What makes it difficult to manage such situations is that only one midwife is assigned at night, and labouring mothers will not get quality midwifery care."
IDI participant.

FGD discussants also shared their experience that their working environment is full of insecurity.

"In case any complications occur, especially at night, it is very difficult to tell the labouring mother's family or husband unless we call security personnel. It

is not only swearing that we face but also that they intimidate us."
FDG discussant.

Discussions

The aim of this study was to explore facilitators' and barriers to a midwifery-led model of care at Dire Dawa public health facilities. In this study, professional pride was the main facilitator of the midwifery-led model of care. Another qualitative study that examined the midwifery care challenges and factors that motivate them to remain in their workplace lends confirmation to this conclusion. It was found that a strong feeling of love for their work was the main facilitator's midwifery-led model of care [9]. Having a good team spirit was also another facilitator's midwifery-led model of care in our study. Another study's findings confirmed this one, which emphasizes that building relationships with the midwives, women, and community was the driving force behind providing midwifery care [7, 18].

The midwives in this study expressed a need for additional professional training, updates, and competence as part of their continuing professional development. Similar findings have been reported in the worldwide literature that midwives were struggling for survival due to a lack of limited in-service training opportunities to improve their knowledge and skills [19]. This phenomenon does not seem to differ between settings in high-, middle-, and low-income countries [7, 9, 18], in which midwives experienced difficult work situations due to a lack of professional development to autonomously manage work tasks, which made them feel frustrated, guilty, and inadequate. As such, this can contribute to distress and burnout, which in turn prevent midwives from being able to provide quality care and can eventually cause them to leave the profession [19].

Shortages of resources (shortage of staff, lack of physical space, and equipment) were the other reported barriers to midwifery care explored in this study. They reported that they are working in an environment with a shortage of resources, which leads to poor patient outcomes. This finding is supported by many other studies conducted around the globe [20–23]. Another qualitative finding, which likewise supports the aforementioned finding, which emphasizes that a shortage of resources was reported as a barrier to providing adequate midwifery care [19]. Delivery attended by skilled personnel with appropriate supplies and equipment has been found to be strongly associated with a reduction in child and maternal mortality [24].

The feeling of demoralization and lack of motivation from their superiors were other barriers to midwifery care explored in this study. This finding is concurrent with other studies conducted around the globe [19, 25, 26, 28]. The above finding is also is in accord with another qualitative narration, which emphasizes that feelings of demoralization and a lack of motivation were the main challenges of midwifery care [22]. Positive support from supervisors has been demonstrated to be important for the quality of services that health workers are able to deliver. In the World Health Organization's report on improving performance in healthcare, the WHO stresses that supportive supervision can contribute to the improved performance of health workers [27].

Unfair risk payment was the other challenge identified by the current study. Even though there is no difference in the risk they face among health professionals, the risk payment for midwives is very low compared to others. This finding was in conformity with another qualitative narration, which emphasizes that the lack of an equitable remuneration system was experienced by the DRC midwives, and it has also been confirmed to be highly problematic in other studies in low- and middle-income settings [7, 8, 22, 28], leading to serious challenges. In settings where salaries are extremely low or unpredictable, proper remuneration is seen as crucial to worker motivation and the quality of midwifery care [29, 30].

The limited organizational power of midwives was another identified challenge of MLC. This finding was in step with other studies that emphasize that limited senior midwifery positions in the health system constrain the decision-making power and capability of midwives. This was compounded by limited opportunities for midwifery personnel to address their concerns to the responsible bodies. Hence, midwives need to take control of their own situations. When midwives are included in customizing their work environments, it has proven to result in improved quality of care for women and newborns around the globe [8, 15].

Lack of work-related security was another barrier to MLC explored in this study, in which the midwives' work environment was surrounded by insecurity, especially during night shifts, when midwives are facing verbal and even physical attack, as mentioned by participants. This finding is supported by many other studies conducted around the globe [22, 23, 25, 31]. The above finding is also in agreement with another qualitative narration, which emphasizes that the midwives' work environment was surrounded by insecurity, especially during night shifts due to a lack of available security personnel; they often felt frightened on their way to and from work [7]. In order for midwives to provide quality care, it is crucial to create supportive work environments by ensuring sufficient pre-conditions, primarily security issues [31].

Conclusions

The study findings contribute to a better understanding of the facilitators' and barriers of a midwifery-led model of care in the case of Dire Dawa public health facilities. Professional pride and having good team spirit were the main facilitators of midwifery-led model care. Contrary to that, insufficient professional development, shortage of resources, feeling of demoralization, lack of motivation, limited organizational power of midwives, unfair risk payment, and lack of work-related security were the main barriers to a midwifery-led model of care in the case of Dire Dawa public health facilities. Generally, midwifery care is facing considerable challenges, both pertaining to the management of the healthcare service locally and nationally.

Study implications

The findings of the study have implications for midwifery care practices in Eastern Ethiopia. Addressing these areas could potentially contribute to the reduction of IMR and MMR.

Strengths and limitations

The first strength of the study is that the participants represented different healthcare facilities, both urban and rural, thereby offering deeper and more varied experiences and reflections. A second strength is using a midwife as a moderator. She or he understood the midwives' situation, thereby making the participants feel more comfortable and willing to share their stories. However, focusing solely on the perspective of the midwives is a limitation.

Recommendations

To overcome the barriers of midwifery care, based on the result of this study and in accordance with the 2020 Triad Statement made by the International Council of Nurses, the International Confederation of Midwives, and the World Health Organization, it is suggested that policymakers, Ethiopian federal ministry of health, Dire dawa health office, and regulators in Dire Dawa city and settings with similar conditions coordinate actions in the following:

To the Ethiopian federal ministry of health (FMOH)

Should strengthen regular and continuous educational opportunities, trainings, and updates for midwives, prioritizing and enforcing policies to include adequate and reasonable remuneration and hazard payment for midwives. Support midwifery leadership at all levels of the health system to contribute to health policy development and decision-making.

To dire Dawa health Bureau

Ensure decent working conditions and an enabling environment for midwives. This includes reasonable working hours, occupational safety, safe staffing levels, and merit-based opportunities for career progression. Special efforts must be made to ensure safe, respectful, and enabling workplaces for midwives operating on the night shift. Midwifery leaders should be involved in management bodies within an appropriate legal framework. Made regular mentorships on the functionality of different diagnostic instruments in respective health facilities.

To Dire Dawa public health facility's

Create an arena for dialogue and implement a more supportive leadership style at the respective health facilities. Should address professional-related concerns of midwives early. Ensure midwives' representation at the management bodies. Ensure the selection criteria for educational opportunities and different trainings are fair and inclusive. Ensure the safety and security of midwives, especially those who work night shifts. Should assign adequate staff (midwives and security guards) to the night shifts.

Ethiopian midwifery association

Should influence different stakeholders to solve midwife's concerns like hazards payment and educational opportunity.

Abbreviations

FGD	Focused group discussion
IDI	In-depth interview
IMR	Infant mortality rate
KII	Key informant interview
MCH	Maternal and child health
MLMC	Midwives led model of care
NMR	Neonatal mortality rate

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-024-11417-x.

Supplementary Material 1

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Author contributions

MH developed the study proposal, served as the primary lead for study implementation and data analysis/interpretation, and was a major contributor in writing and revising all drafts of the paper. AM, DT, NA, LA, and SA supported study implementation and data analysis, and contributed to writing the initial draft of the paper. YD, TW, MG, TH and, NM supported study recruitment and contributed to writing the final draft of the paper. TG, YM, TD, MY, ND and, AA conceptualized, acquired funding, and led protocol development for the study, co-led study implementation and data analysis/interpretation, and was a major contributor in writing and revising all drafts

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Data availability
All the datasets for this study are available from the corresponding author upon request.

Declarations

Ethics approval and consent to participate
All methods were followed in accordance with relevant guidelines and regulations. The institutional review board of Dire Dawa University has also examined and evaluated it for its methodological approach and ethical concerns. Ethical clearance was obtained from Dire Dawa University Institutional Review Board and an official letter from research affairs directorate office of Dire Dawa University was submitted to Dire Dawa health office and it was distributed to selected health institutions. Voluntary informed written consent was obtained from the study participant's right after the objectives of the study were explained to the study participants and confidentiality of the study participants was assured throughout the study period. Participants were informed that they have the right to terminate the discussion (interview) or they can't answer any questions they didn't want to answer.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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