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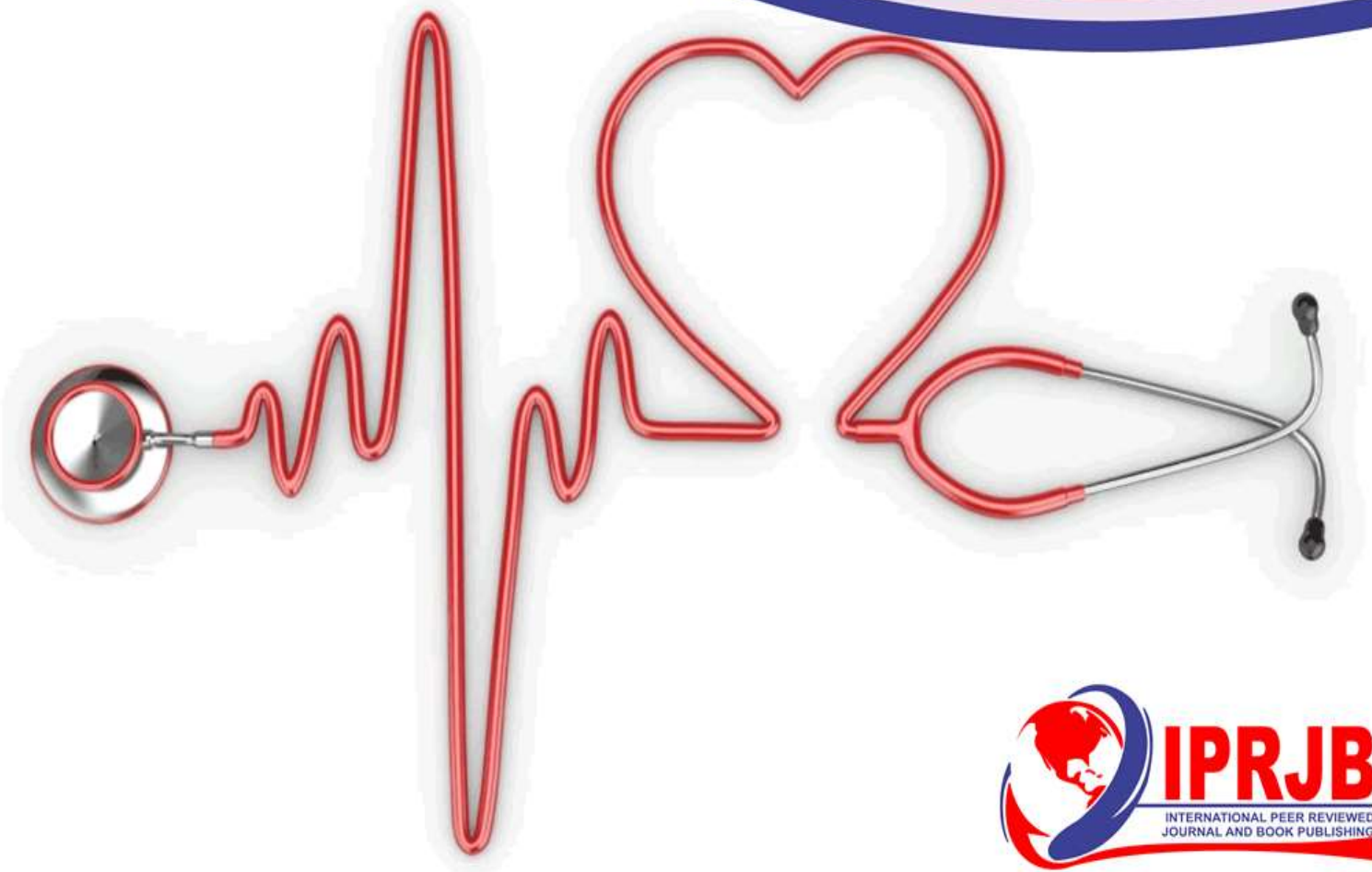

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Abstract

Purpose: The lack of an adequate number of registered midwives has resulted in a serious management and professional problem for labor and delivery units at maternity hospitals. In addition, the main issue examined in this working document concerns how insufficient staffing among registered midwives affects the quality of care in labor and delivery units, relative to patient safety, patient experience, and staff workload. This subject matter is important to address because maternity care is extremely time-sensitive, and unstaffed shifts or positions may adversely affect timely clinical observation, appropriate communication among caregivers, respectful care, and emergency preparedness.

Methodology: To examine this issue, this working document employed a qualitative evidence synthesis approach based on recent systematic review articles, multi-center observational study articles, qualitative research articles, and articles related to the midwifery workforce literature concerning staffing levels, workload, patient safety, patient satisfaction, and workforce retention. In addition, the working document applied Donabedian's (1966) structure-process outcome model to illustrate how structural weaknesses, such as midwife shortages, affected care processes and patient and workforce outcomes.

Findings: The results indicate that midwife shortages were associated with longer times to receive care; higher rates of adverse events during care; higher rates of postpartum readmission; greater utilization of certain medical interventions; lower ratings from patients regarding their experiences; decreased access to respectful maternity care; and increased staff dissatisfaction and intentions to leave. An additional finding was that midwife shortages created a self-fulfilling cycle. When there were fewer midwives on duty, the workload per nurse increased, which in turn diminished the quality of care provided to women and negatively affected nurses' physical and mental wellbeing, reducing their capacity to continue providing high-quality care.

Unique Contribution to Theory, Practice and Policy: For both the midwifery profession and leaders of maternity hospitals, the implications of these findings are clear: workforce planning will need to focus on creating sustainable improvements rather than simply replacing personnel who are absent. Therefore, developing evidence-based staffing models, improving working conditions for registered midwives, fairly compensating them, providing continuing education opportunities, supporting them through effective leadership, and implementing retention-fostering policies to enable registered midwives to provide safe, respectful, and woman-centered care are essential.

Keywords: *Registered Midwife, Quality of Care, Maternity*

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INTRODUCTION

What ways can maternity hospital leaders ensure that all patients receive safe, respectful, and timely care when the number of registered midwives (RMs) on duty does not meet demand? Although fertility rates are decreasing globally, in numerous developed nations, there are still a significant number of deliveries annually. And as such, hospitals' maternity departments will likely experience varying degrees of volume for a considerable time into the future

(Fauser, B. C. J. M., 2024)

With increasing workload pressures, staff exhaustion, and demands for woman-centered care, the need for solutions to address the RM shortage has never been greater. The role of RMs in labor and delivery departments includes continuous assessment, clinical monitoring, emotional support, health education, documentation, and emergency response. All these activities occur in an extremely time-sensitive area of hospital-based care.

In this working paper, we explore the shortage of RMs from both managerially and professionally focused perspectives. We argue that RM shortage is not solely a human resources management issue but is also directly related to issues of quality and safety. As staffing levels decrease, RMs will spend less time on surveillance, communication with families, documentation, emotional support, and respectful care of their patients. Such decreased levels of process-related performance can increase the risk of adverse outcomes for mothers and babies, reduce maternal satisfaction, and increase burnout and turnover among remaining staff members.

This paper aims to contribute to practice by synthesizing current literature and organizing it into a practical guide or framework for Maternity Hospital Leaders. We use the Donabedian

Structure-Process-Outcomes model to illustrate how RMs shortages negatively impact care processes and ultimately lead to negative care outcomes. There are three major dimensions explored in this paper:

1. Patient Safety/ Clinical Outcomes
2. Patient Satisfaction/Respectful Maternal Care
3. Staff Workload/Well Being/Retention

Our primary finding is that RM shortages create a self-perpetuating cycle in which understaffed work environments lead to higher workloads, which in turn diminish the quality of care and reduce staff well-being, resulting in burnout and further loss of experienced staff. Thus, improving sustainability will require more than just hiring new staff. Workforce planning, retention initiatives, supportive work environment(s), equitable compensation, opportunities for continuing education/professional development, and improved visibility of the midwifery profession will be necessary.

Problem Statement and Identified Gaps

While there is an increasing body of evidence linking midwife staffing levels and workloads with clinical outcomes(such as the number of interventions performed, frequency of adverse events, post-discharge readmission rates and staff burn-out), many of these studies have been focused on identifying correlations rather than developing practical advice for maternity service providers about how they could effectively manage their services during ongoing shortfalls of midwife numbers and skill-mix (Bradley et al., 2015; Matlala & Lumadi, 2019;

Matthews et al., 2022; Turner et al., 2021; Turner et al., 2024; Creswell et al., 2023; Eggenschwiler et al., 2025; Matthews et al., 2023; Doherty & O'Brien, 2022).

Furthermore, much of this available evidence has concentrated upon different aspects of the maternal experience - particularly antenatal, intrapartum and postpartum - with little evidence being integrated that links these experiences together. Additionally, most of this existing literature provides limited information on integrating patient safety, respect, continuity of care, and sustainable workforce development into a coherent framework (Turner et al., 2021; Matthews et al., 2022; Moncrieff et al., 2023; Tilden et al., 2025).

This working paper aims to address some of these identified gaps:

By synthesising the existing literature on how shortages of registered midwives impact on clinical outcomes/patient safety, women's experience/satisfaction/respectful maternity care and the well-being/workload/retention of midwives/staff By utilising the Donabedian Structure-Process-Outcomes Model to illustrate how shortages in the structural components of midwife services (numbers, mix of skills, distribution) result in compromised processes and ultimately negatively impacted clinical outcomes.

By translating findings into a practical Problem Statement and identifying Gaps

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By utilizing the Donabedian Structure-Process-Outcomes Model to illustrate how shortages in the structural components of midwife services (numbers, mix of skills, distribution) result in compromised process and ultimately negatively impact clinical outcomes.

By translating findings into a practical resource/framework for maternity service providers/hospital leaders, providing useful strategies/tools for managing maternity staffing and workload issues during times when rapid recruitment cannot occur.

Target Group for the Study

a. Hospital Leaders and Unit Managers - who are looking for evidence-based resources to assist them in making decisions related to staffing levels and workload allocation, and in establishing contingency plans for escalating demand
b. Registered Midwives/Maternity Staff - who may find value in suggestions related to improving their workload/culture and reducing attrition.
c. Women/Newborn/Families - who will benefit from strategies designed to protect quality, safe, respectful, and continuous care while addressing shortages
d. Makers/Workforce Planners - who will gain insight into ways that local organization strategies can be aligned more closely with national workforce policies

This paper is structured as follows: Section 2 presents our study design. Section 3 describes the background/theoretical underpinnings. Section 4 outlines the literature/evidence/key findings. Section 5 provides an overview of potential causes/interventions/policy implications. Section 6 addresses managerial implications. Section 7 highlights limitations/future research directions. Finally, Section 8 provides conclusions regarding what this means for Maternity Hospital Managers/Midwifery Profession/Researchers

Study Approach

The structured search used to guide this evidence synthesis was conducted between [2016] and [2025]. Databases searched include [e.g., PubMed, CINAHL, Scopus, Web of Science]. The literature searches used a combination of keywords and phrases related to "Registered

Midwives", "Midwifery Staffing, "Quality Maternal Health Care", "Patient Safety," "Patient Satisfaction," "Respectful Maternity Care," and "Workforce Retention." Articles were eligible if they were peer-reviewed articles, policy documents relevant to the research question, and written in the English language from [start year] forward. The included study types were Systematic Reviews, Multi-Center Observational Studies, Cross-Sectional Studies, Qualitative Studies, Doctoral Theses, and Workforce Policy Documents examining midwifery staffing in hospital-based maternity units. Types of studies NOT included are those focused on non-midwifery cadres, community-only services, or non-maternal health care services. In addition, reference lists of key study findings were also reviewed to ensure all relevant studies were identified.

This working document has been developed using a narrative evidence synthesis that examined recent literature on registered midwifery staffing, maternal health care quality, patient safety, patient satisfaction, respectful maternity care, and registered midwives' workforce retention.

Literature from systematic reviews, multi-center observational studies, cross-sectional studies, qualitative studies, doctoral research, and workforce policy literature has informed the development of this paper.

Several key concepts guided the selection and interpretation of the evidence used for developing this working document.

These were:

1. How does a registered midwife shortage impact patient safety and clinical outcomes in maternity hospitals?

2. How does a registered midwife shortage influence patient satisfaction and respectful maternity care?
3. How does a registered midwife shortage impact staff workload, well-being, and retention?

This working document uses the Donabedian (1966) structure-process-outcome model to inform its approach. Midwife staffing levels are considered to represent a 'structural' element. Process elements include care delivery practices such as monitoring, communication, emotional support, care documentation, timely escalation of concerns, and respectful care. Outcome elements include maternal and newborn health outcomes, patients' perceptions of their hospital experience, harmful incidents, readmission rates, staff perceptions of job dissatisfaction, and staff intentions to leave.

Since this working document represents an intermediate stage of analysis before the completion of primary data collection and analysis, it is appropriate to interpret the findings reported here as 'evidence-informed perspectives', rather than as statistically derived outcomes from new research.

Theoretical Framework

The global Context of Midwifery

International organizations, such as the International Confederation of Midwives, have formally identified midwives as a distinct group of professionals, separate from other healthcare providers. A midwife is defined by the International Confederation of Midwives as an individual who has graduated from an approved midwifery education program, is qualified for registration or licensure in their jurisdiction to practice midwifery, and can demonstrate competence in practicing midwifery (International Confederation of Midwives, 2017).

Universal health coverage will depend on the effective use of midwives, according to the World Health Organization. Furthermore, the World Health Organization emphasizes that improving maternal and newborn health outcomes will require the effective and safe utilization of midwives (World Health Organization, 2021). According to the United Nations Population Fund (UNFPA) et al. (2021), there were significant gaps between the number of midwives required to provide universal access to all essential maternal and newborn health interventions and the number working. These gaps existed across high-, middle-, and lowincome countries. However, while low and middle-income countries lacked sufficient numbers of midwives, they faced additional challenges, including maldistribution, retention issues, workload issues, and aging of the midwifery workforce.

In addition to identifying the need to increase the number of midwives globally (Nove et al., 2024), recent studies have confirmed that increasing the number of midwives alone is insufficient to address the service gap. Rather than focusing solely on workforce supply, it is equally important to ensure that the environment in which midwives work is conducive to their practicing effectively and safely.

To better understand how these workforce and practice-environment problems influence both quality and safety in the delivery of maternity care, the Working Paper uses the Donabedian (1966) structure–process–outcome model as its conceptual framework.

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The Donabedian Model

This paper uses the structure-process-outcome model developed by Donabedian (1966) to examine how shortages of registered midwives affect the quality of care in Maternity Hospitals. The paper will apply each component of the structure-process-outcome model to provide an overview of how shortages of registered midwives affect the quality of care in maternity hospital settings.

Registered Midwife staffing levels are identified as one of the fundamental structural elements of quality of care, along with the skill mix of staff, access to required equipment, and organizational policies. The absence of sufficient Registered Midwives creates a structural constraint on the type of care that can be delivered.

The shortage of Registered Midwives will affect many aspects of providing intrapartum and postnatal care to women and their infants. Examples of processes affected by the number of Registered Midwives include ongoing labor support, timely assessment of both mother and fetus, effective communication among disciplines, escalating concerns about patient safety, completing all necessary documentation, and providing respectful, woman-centered care. When there are insufficient numbers of registered midwives, these care processes will be delayed, incomplete, or completed in a task-focused manner rather than a relational one.

Variations in processes will ultimately lead to changes in outcomes for individuals (women and their newborns), groups (families), and organizations (staff). Variations in outcomes for individuals may include an increased incidence of preventable morbidity/mortality, greater utilization of obstetrical interventions, a higher frequency of adverse events, and a greater need for hospital readmissions. Families may experience decreased satisfaction with the care received and perceive less respect, dignity, and emotional support during interactions with healthcare providers. Organizations may also experience variations in outcomes related to sustained exposure to high workloads and moral distress among staff. Sustained exposure to high workloads and moral distress has been shown to contribute to burnout, job dissatisfaction, and intentions to leave employment, which can add to the already existing shortage of registered midwives.

Using the Donabedian structure-process-outcome model enables identification of the causal pathway from Registered Midwife staffing numbers (structure) to the quality/reliability of care delivered (process), and ultimately to clinical, experiential, and workforce outcomes. This model provides the conceptual framework for organizing the remainder of this paper and provides a foundation for interpreting the results of the narrative evidence synthesis.

The Vicious Cycle of Midwife Shortages

Registered midwife shortage creates a self-enforcing cycle. The cycle starts when there are insufficient registered midwives relative to the number of patients seeking maternity services.

As a result, there will be an increased workload on those registered midwives who do exist. Increased workload results in less time being available to provide ongoing labour support to women, communicate with the woman and her family, carry out appropriate levels of surveillance, document appropriately, and make appropriate decisions regarding the care of the woman and baby. Compromise to these care processes could lead to a range of negative health outcomes for mothers and babies e.g. Delays in recognising problems, incidence of harm during or after birth, unnecessary admissions back into hospital, dissatisfaction from the mother, and poor experience by the mother and her family (mattock et al., 2025; Turner, Ball,

Meredith, Kitson-Reynolds, & Griffiths, 2024; Turner, Saville, Ball, Culliford, & dall'ora, 2024). The cycle becomes even worse as the workforce shrinks due to burnout, dissatisfaction, and a desire to cease working as a registered midwife (Deresa et al., 2023; Neiterman et al., 2024).

- A vicious cycle of registered midwife shortages can occur.
- The increased workload associated with a shortage of registered midwives leads to reduced monitoring, communication, and respectful care for patients.
- Increased stress and burnout among staff result from a shortage of registered midwives.
- As a result of higher workloads, lower patient safety and experience occur as well. Intention to leave and attrition are also cons worsens as the workforce shrinks due to burnout, dissatisfaction, and a desire to cease practicing sequences of the registered midwife shortage.
- Comprehensive interventions addressing the need for recruiting more midwives while retaining existing staff.

Equity and Human Rights Dimensions

Shortages of midwives affect access to skilled birth attendants for the delivery process. As a basic right to health, there should be no barriers to obtaining care. Limitations to access to adequate maternity care due to shortages of midwives can limit women's rights to their own health, dignity, make informed decisions about themselves, and be treated fairly. Midwife shortages affect different groups differently. Some of these groups include rural women, low-income women, minority/ethnic women, migrant women, and women who need more specialized services. These groups will face greater hardships than others because they already suffer from inequities in accessing healthcare. In addition to inequitable access to resources, evidence from vulnerable countries such as Ituri Province in the Democratic Republic of Congo indicates that some regions have severe shortages of midwives despite an abundance of other providers, underscoring the importance of ensuring a fair distribution of health workers (Baba, 2021).

In terms of gender equality, midwifery is a job almost entirely performed by women. Therefore, the devaluation of the contributions made by midwives represents a broader pattern of gender-based inequalities present within labor markets. Addressing shortfalls of midwives through both practical solutions addressing technical aspects of the workforce, as well as equal pay, safe working conditions, and professional recognition for midwives.

Evidence and Key Findings

Evidence from the research presented in this working paper illustrates that the shortage of registered midwives affects maternity services in three ways: (1) to patients' safety and the quality of clinical care; (2) to patients' experiences; and (3) to workloads and staffing levels.

Table 1: Summary of Key Evidence and Managerial Meaning

Evidence Main Finding Area

Understaffing is associated with harmful Patient safety incidents, care delays, and readmissions.

Clinical outcomes	Better staffing may reduce some unnecessary interventions.
Patient experience	High workload reduces respectful and responsive care.
Staff wellbeing	Workload contributes to dissatisfaction and intention to leave.

System resilience	Crises such as COVID-19 intensify staffing pressure.

Managerial Meaning

- Staffing should be treated as a safety indicator.
- Staffing affects the type and quality of care delivered.
- Managers must protect time for communication and support.
- Retention must be treated as a strategic priority.
- Emergency planning must include workforce protection.

Patient Safety and Clinical Outcomes

The most affected area by Registered Midwife Shortages is Patient Safety. Labour and Delivery Units depend on Continuous Observation, Timely Response, Accurate Documentation, and Rapid Escalation in cases where complications occur. All of these functions are undermined if there are not sufficient staff to manage them.

Research has demonstrated that high workloads among midwives in Maternity Settings lead to Care Delays and adverse childbirth outcomes. For example, Mattock et al. (2025) conducted a Systematic Review of Maternity Environments in OECD Countries and identified that High Midwife Workloads were associated with Delayed Care and Increased Risk of Adverse Perinatal Outcomes (including Perineal Trauma).

Another Research Study (a Scoping Review) investigating In-Patient Maternity Staffing

Levels found that an Increase in Staffing Levels for Midwives resulted in Improved Health Outcomes (reduced maternal readmission and decreased rates of certain interventions); however, the evidence base was inconsistent across studies. (Turner, Griffiths, & Kitson-Reynolds, 2021)

It is generally accepted that Multicentre Studies are Strong Evidence Sources for determining the association between Midwifery Staffing and Clinical Safety. For Example, Turner, Ball, Meredith, Kitson-Reynolds, and Griffiths (2024) identified that understaffing of Registered

Midwives resulted in an increase in reported Harmful Incidents. Additionally, Turner, Saville, Ball, Culliford, and Dall'Ora (2024) identified that Below-Average Midwifery Staffing resulted in increased Post-Partum Readmissions.

There is also evidence from China indicating that improvements in Midwife Staffing are associated with Reduced Rates of Instrumental Vaginal Deliveries and Episiotomies (Zhu et al., 2024). The implications of this study suggest that Adequate Staffing will contribute not only to reducing unsafe practices during birth, but also to improving the Type and Quality of Care Women Receive during Birth.

From a Managerial Perspective, the Findings above indicate that the Registered Nurse/Midwife Shortage should be treated as a Clinical Risk Factor. Hospitals providing maternity services should monitor their Staffing Levels (alongside incident reports, readmission rates, complaint rates, and Patient Outcomes).

Patient Experience and Respectful Maternity Care

Staff Shortages and Overwork

Several studies show that short staffing of registered midwives creates workloads that are stressful for both patients and health workers. The literature suggests that if there are

insufficient numbers of midwives available to carry out the work of a hospital or community midwifery unit, it will inevitably increase the workload of each remaining midwife. As a consequence, the individual midwife's ability to communicate effectively with her clients, provide them with emotional support, explain their treatment options clearly, enable them to make informed choices about how they want to receive care, and respond quickly to their requests for assistance will all deteriorate.

It has been suggested that the negative impact of work overload on maternal experiences of care is independent of whether the technical quality of the care provided is compromised. In other words, women may still perceive their care as being rushed, impersonal, and/or lacking respect, even though clinically the care was 'safe.'

Pokharel et al. (2023) found that in Nepal, high client-to-midwife ratios were significantly associated with lower levels of respectfulness shown towards women in maternity care settings, particularly so during the COVID-19 pandemic. Similarly, Turner et al. (2022) investigated the relationship between midwifery staffing levels and women's experiences of care after birth in England. They found that areas with better staffing ratios tended to have higher levels of positive post-natal care experiences.

In addition to its potential negative effects on the way in which pregnant women experience maternity services, the research described above also suggests that work overload may compromise the physical and mental health and well-being of health service providers. Wibbelink et al. (2022) conducted qualitative interviews with a sample of midwives working in South African public sector facilities. Their results suggest that both the clinical effectiveness of care provided by midwives and the way pregnant women experienced that care were affected by work-related challenges, such as shortages of qualified personnel and inadequate resources.

Health Service Managers and Work Load

The implications of this body of research for health service managers are clear. While communication skills training, patient experience surveys, and other approaches to improving the patient experience are certainly valuable tools for managers concerned with the quality of care delivered by midwives, they will always have a limited effect unless managers first address workload issues.

Discussion

A concern for many maternity hospitals is the shortage of registered midwives. The shortage of registered midwives can create several interconnected problems. One of the initial impacts of a shortage of registered midwives is an overall increase in the workload expected of each individual registered midwife. As there is less time available to attend to every aspect of care delivery due to an increase in the total amount of work each registered midwife performs, this can result in inadequate monitoring of patients, reduced opportunity for effective communication with other health-care providers or the family members of patients, poor care treatment, and/or inadequate documentation of all aspects of patient care. Therefore, a reduction in the standard of care delivered may increase risks associated with pregnancy and childbirth for mothers and infants. In addition to placing mothers and infants at a higher risk for adverse outcomes, a higher workload can also place additional stress and burnout on registered midwives. Additional stress and burnout may lead registered midwives to become dissatisfied with their jobs and possibly leave. Ultimately, this will add to the existing shortage of registered midwives willing or able to work full-time. Thus, this will once again create

another cycle of fewer registered midwives, resulting in a heavier workload for those who remain registered. These two cycles will ultimately result in a much greater deficit in the number of registered midwives.

As previously mentioned, the cycles described above have significant implications for how maternity hospitals develop strategies to address their staffing needs. First, these cycles illustrate that relying solely on headcounts in developing staffing plans overlooks multiple factors that influence a hospital's capacity to deliver safe and effective care.

Quality of care will depend on many factors, including patient acuity, birth volume per hour, skill mix of employees, employee scheduling/shifts, number of support staff, and level of service offered. Higher patient acuity and a faster birth rate increase staff workload, creating time pressure that increases the likelihood of missed assessments and delays in responding to potential complications, and decreases patient satisfaction. A poor skill mix or ill-designed shifts result in fewer staff with the necessary skills to effectively monitor patients, respond to issues appropriately, and provide emotional support to women, resulting in less safe care and decreased respect for women. In addition to being an inefficient use of resources, having too few support staff and offering overly complex services will divert RMs from direct clinical care, potentially leading to additional adverse events, increased readmission rates, and/or staff burnout.

Therefore, when implementing quality improvement initiatives in maternity hospitals aimed at increasing patient safety and satisfaction, it is essential that the initiative addresses whether and how it improves the workforce and working conditions. It is unrealistic to anticipate significant, sustained improvements in either safety or patient experience without simultaneously addressing the foundational deficits in the hospital's staffing levels, skill mix, and workload organization.

In this regard, maintaining experienced Registered Midwives (RMs) as a top strategic goal for improving the quality of care is essential. The most critical factor contributing to improved clinical outcomes and enhanced patient satisfaction is RMs' use of their specialized expertise to recognize risk, provide appropriate intrapartum support, and escalate care when indicated. Additionally, RMs play a key role in mentoring new graduates through on-the-job training, which ultimately contributes to the consistent application of standards of practice and reduces variability in care. Finally, maintaining RMs results in continuity of care along the maternity pathway, establishes trusting relationships with women and families, and provides a stable team environment that supports both safety and respectful maternity care.

Although increasing the availability of registered midwives through recruitment efforts is crucial, Nove et al. (2024) stated that "strengthening" the workforce depends not only on recruitment but also on creating an "enabling environment." Creating an enabling environment helps healthcare systems and hospitals establish conditions in which registered midwives can carry out their duties safely and effectively.

Conditions that support safe and effective practice by registered midwives include fair compensation for services performed by registered midwives; supportive management/leadership at all organizational levels; access to necessary equipment/technology; autonomous practice for registered midwives; safe practice environments; opportunities for advancement/career development; and manageable workloads.

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Causes of Midwife Shortages

The current shortage of midwives is attributable to three categories: supply-side, organizational, and policy. The main contributors are a limited number of places for training, retention issues, wage disparities, limited professional career development options, working environment-related violence against midwives, migration of midwives, and aging of the midwife workforce.

One of the factors limiting the supply of new midwives entering practice is the shortage of training sites. Countries face challenges associated with having inadequate numbers of instructors, insufficient availability of clinical placement experiences for students, and/or funding to support students. Additionally, educators are often distributed inequitably throughout a country's geography, leaving vulnerable and rural communities without access to adequate training pipelines (Baba, 2021).

Poor working conditions also play a significant role in increasing turnover among midwives. Long work days and weeks, inability to take scheduled breaks, lack of adequate equipment/resources, and psychological distress have been identified by studies as correlates of midwives' intent to leave employment (Neiterman et al., 2024; Wibbelink et al., 2022).

Underpayment of midwives can negatively impact job satisfaction and retention. When midwives perceive that their pay does not reflect their responsibilities for patient/student care, the stress they experience while performing those duties, and the value of their contributions to the field of midwifery, they become less likely to remain employed. Other ways in which midwives lose motivation and loyalty to the profession include a lack of opportunities for professional advancement and a lack of recognition of their professional status. In addition to these factors, both the migration of midwives and the aging of the midwife workforce present added pressure. For example, some midwives may move from a rural to an urban setting or from the public to the private sector. Others may migrate from lower-income countries to higher-income countries. Additionally, some countries will experience large numbers of experienced midwives approaching retirement age and therefore need to develop succession plans for this generation of midwives.

Proposed Action Plans and Interventions

Addressing the shortage of registered midwives is multifaceted, recruiting additional candidates will require a combination of recruitment and retention strategies, along with a workforce plan to meet future needs through professional development and by creating an environment of job satisfaction.

To increase the number of available positions for registered midwives within health systems, there should be increased opportunities for growth in the number of places for training to address the demand for services, supporting educators' development, providing more opportunities for students to gain experience within clinical settings, and scholarship funding opportunities for students from underrepresented areas. To improve the work environment for newly graduated registered midwives during the transition-to-practice process, hospitals should develop programs to help new graduates successfully transition into clinical practice and avoid feeling overwhelmed.

The most critical component in retaining registered midwives is improving their work environment. Hospital maternity units should create evidence-based staffing guidelines to ensure adequate staffing levels, limit excessive overtime, protect their rest periods, ensure

timely access to the supplies and equipment needed to perform their duties, and provide mental health support. Additional personnel, such as support staff, can help alleviate some of the non-clinical workload associated with providing patient care, thereby enabling registered midwives to focus on clinical and relational aspects of patient care.

There should be a review of compensation and benefits for registered midwives to ensure they receive fair compensation based on their level of expertise and responsibility. Additionally, career paths should be developed for registered midwives in clinical practice, education, leadership, research, and advanced practice. Ongoing professional development and mentorship can enhance both the competency and commitment of registered midwives.

Workforce innovations can support recruitment and retention. Examples of workforce innovations include team-based care; midwife-led continuity models, where possible; pathways for students to become employed while attending school or participating in a postgraduation employment program; and hybrid models that allow for continuity of care while maintaining workforce capacity (Geraghty et al., 2025; Mumford et al., 2023).

Policy Implications

Responsibilities of Hospitals and Health Systems

Data collected specifically from certain maternity hospitals for use in this working paper indicate that hospitals must address their staffing policies before anything else is done at those locations. Regional health authority managers and hospital administrators must prioritize safe midwife-to-patient ratios in labor and delivery units, taking into consideration (1) the number of births during defined time frames, and (2) the degree of complexity and acuity present with each woman's care requirements. The local planning process for workforce development must consider validated, reliable, and current information regarding staffing vacancies, employee turnover, demographic characteristics of employees, the average amount of workload each midwife has, the diversity of skill sets among members of each team providing services, and the number of women and newborns being cared for. Regional- and hospital-level maternity service plans should support:

Appropriate numbers of personnel to provide safe, uninterrupted intrapartum care;

Women's rights to receive safe and respectful care throughout pregnancy, childbirth, and postpartum; Midwives' opportunities to function in leadership positions when clinically indicated.

Additionally, organizations must implement strategies that will help to promote fairness in pay, to create workplaces free of violence and harassment, to safeguard employees from both physical and emotional harm, while preventing workplace violence and harassment, and to allow employees to perform duties in a work environment that allows them to work reasonable hours. To improve retention rates and sustain the quality of care, creating a workplace culture that promotes safety and provides adequate resources for employees is critical to enabling midwives to deliver consistent, safe, and respectful care.

National Workforce Strategies

Although these problems occur locally within maternity hospitals, they are influenced by larger national workforce strategies. As such, national health authorities have a duty to prioritize midwifery staffing in maternal and newborn health policy. Agencies responsible for national workforce development must develop quantifiable objectives for the education, recruitment,

retention, and equitable distribution of midwives, based on data from individual maternity hospitals and maternity care quality measures.

Creating a sustainable and healthy midwifery workforce requires not only increasing the supply of midwives but also developing policy structures that support midwives' ability to provide quality patient-centered care in safe working environments. Ethically based recruitment and deployment policies are especially important in contexts with regional shortages or internal maldistribution, so that maternity hospitals already struggling to maintain safe staffing levels do not face additional challenges.

By clearly connecting regional and national workforce strategies to hospital-based evidence on workload, safety, and satisfaction, these policy interventions may more effectively support both the midwives delivering care and the women and families receiving it.

Managerial Implications

Maternity hospital managers, nursing and midwifery directors, human resources departments, quality and safety departments, as well as policymakers are impacted by these results. Maternity hospital managers, nursing and midwifery directors, human resource departments, quality and safety departments, as well as policymakers are impacted by these results.

Treat Staffing as a Patient Safety Priority

The leaders of maternity hospitals are obligated to view registered midwives as a critical component of their hospital's ability to ensure patient safety through appropriate staffing. To assess this, the managers of maternity hospitals will need to compare the R.M. staffing reports with incident reports, postpartum readmission data, obstetric intervention rates, patient complaints, and patient satisfaction surveys. Managers should also examine whether there is a relationship between adverse events and the hospital's employee count, employees' workload, or the mix of skills within the workforce.

Move from Reactive Staffing to Workforce Planning

Hospitals have been responding to their labor shortage by utilizing overtime, hiring temporary personnel and deploying existing staff as needed. While these alternatives can provide immediate relief from a labor shortage; however, there is no long-term solution to the shortage.

Managers need to create a workforce plan that takes into consideration the number of births projected for an area, the level of care (acuity) expected for patients, employee turnover, leave patterns, and the risk of employees retiring.

Prioritize Retention, Not Only Recruitment

Although recruiting new midwives is a major concern, retaining experienced midwives is also critical. Experienced midwives are critical for providing clinical judgment, managing emergencies, mentoring, and ensuring consistency in standards of practice. Therefore, managers should identify why they are losing experienced staff and address modifiable factors such as excessive workload, inadequate supervision, lack of acknowledgment/recognition, limited opportunities for career development, and/or inadequate compensation.

Protect Time for Respectful and Woman-Centered Care

Midwives need ample time to care for their patients respectfully. Midwives have to spend time listening to their patients; explaining things to them; comforting them (when they are scared or

upset); monitoring them; writing down what is happening with them; and getting input from the woman about how she wants her labor to go.

The way hospitals currently organize their staff does not recognize that the non-technical aspects of midwifery contribute to the quality of the patient experience.

Strengthen Leadership and Supportive Supervision

The actions of midwifery managers may reduce job-related stress among their employees and employee turnover. Midwives need positive and continuous communication with their manager (e.g., regular feedback). Managers also have control over how shifts are assigned, providing some control and predictability. Providing emotional or psychological support to employees is another important way that managers can help reduce stress. In addition, when midwives participate in decision-making (involvement), they feel a sense of ownership and investment, which may positively affect both job satisfaction and burnout.

Use Data for Continuous Improvement

Managers need to establish a dashboard with metrics for staffing, workload, patient safety, patient experience, and employee wellness. The dashboard will provide managers with an early warning system and data to make informed, evidence-based decisions.

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Table 2: Recommended Management Dashboard for Maternity Hospitals

Indicator	Example Measures	Purpose
Staffing	Midwife-to-patient ratio, vacancies, agency use, overtime hours	Monitor workforce adequacy
Workload	Birth volume, acuity, missed breaks, extra shifts	Identify pressure points
Patient safety	Harmful incidents, readmissions, postpartum haemorrhage, neonatal resuscitation	Detect safety risks.
Patient experience	Complaints, satisfaction scores, and respectful care feedback	Monitor service quality.
Staff well-being	Sickness absence, burnout survey, intention to leave	Track retention risk.
Care processes	Delayed observations, documentation delays, escalation delays	Identify process failures before they affect outcomes.

Limitations and Future Research Directions

This report is limited. The first limitation is that this is a narrative evidence synthesis; all the results must be viewed as "evidence-informed" rather than measured directly through local measurement.

The second limitation is that many of the stronger studies were conducted within highincome countries (especially the U.K.), although studies from China, Nepal, Ethiopia, South Africa, and the D.R. Congo can help increase the breadth of understanding required; more research will need to be conducted across diverse health systems. The third limitation is that staffing-outcome associations are complex: while the number of midwives can influence outcomes, so

too can other factors such as skill mix, leadership, organizational culture, patient acuity, equipment/infrastructure, and clinical protocols. Thus, future studies may wish to study these factors simultaneously.

Finally, we require more evaluation research. There is considerable evidence that staffing levels matter for quality of care and patient safety; fewer studies have investigated which interventions are most likely to reduce shortages and improve retention. Future research needs to be focused towards multicentre studies where staff numbers relate to both patient experience and patient safety outcomes; mixed-methods studies investigating how shortages of midwifery staff impact daily clinical practices; studies investigating the cost effectiveness of various retention strategies and staffing models; evaluations of student employed models, mentorship programs and midwife led continuity models; studies conducted in low/middle income countries and/or in rural or fragile settings; and studies determining minimum staffing thresholds for providing safe maternal care in each type of maternity unit.

Conclusion and Managerial Implications

This report will improve understanding of registered midwife shortages and demonstrate that these shortages are both a workforce problem and a quality-of-care problem.

Using the Donabedian structure-process-outcome (SPO) framework, we show that insufficient staffing of registered midwives is not merely a one-dimensional human resource issue.

Rather, it represents a structural weakness that has direct implications for all aspects of the care process, patient safety, patient experience, and workforce sustainability.

These study results provide maternity hospital managers with compelling arguments for framing their staffing decision-making through a quality/safety lens. While managers have traditionally used reactive strategies, including overtime, temporary agency use, and shortterm redeployment, the findings suggest they should adopt proactive, dynamic workforce planning methods. These should be designed using three dimensions of each maternity unit's characteristics: birth volume, patient acuity, and staff skill mix. In addition, each maternity unit should consider monitoring two types of indicators: those related to patient safety and quality, and those related to patient satisfaction, readmission rates, and staff well-being.

Further, the study indicates that managing turnover or "turnover prevention" may be a major managerial responsibility. To manage turnover effectively, hospitals may use strategies that increase employee job satisfaction through improved compensation packages, better schedules, enhanced supervisory practices, increased opportunities for professional growth and education, enhanced psychological support, and an improved physical work environment. Furthermore, effective management practices would require protecting midwives' time devoted to communicating with patients, providing emotional support, and delivering respectful care. These are critical elements in the delivery of high-quality maternal/child health care.

Finally, for the midwifery profession at large, this study provides strong evidence of the need for more formalized national professional recognition and defined career ladders. Additionally, there is a clear indication that midwives must participate directly in developing workforce policies and workforce plans.

Future empirical research needs to build upon the synthesis presented within this report. Specifically, future research requires multicentre empirical studies to test various staffing thresholds, evaluate the effectiveness of retention interventions, and identify which workforce models produce the most positive outcomes across a variety of hospital settings.

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