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Exploring Midwives' Experiences with Intrapartum Care in Health Facilities in Ankole Sub-region, South Western, Uganda

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Research Article

Keywords: Midwives, Health facilities, intrapartum care, experiences, Uganda

Posted Date: July 13th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10296307/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Although midwives are essential in providing intrapartum care, they frequently work in difficult environments that compromise the standard of care they deliver. To improve maternal and neonatal outcomes, care provision and intrapartum interventions must take into account the experiences of midwives during women's labour and birth. This research study aimed to explore midwives' experiences of providing intrapartum care in selected health facilities in the Ankole Sub-region of South Western Uganda.

Methods

A descriptive qualitative study design was used to collect data involving midwives working in the labour ward of selected health facilities. Purposive sampling was used to recruit 10 participants with at least one year of experience in intrapartum care. Thematic analysis was applied.

Results

Three main themes emerged. "Professional identity and satisfaction." This emerged from three subthemes: internal drive and pleasure in midwifery, emotional benefits of the career, and commitment to intrapartum care. "System and infrastructural limitations" emerged from three subthemes: Inadequate recognition and progress, limited resources, and non-evidence-based intrapartum practices. "Heavy workload consequences" emerged from three subthemes: Work burnout, emotional and physical burden, professional dissatisfaction and career reassessment.

Conclusion

From the midwives' point of view, intricate systemic and professional issues influence the delivery of intrapartum care and retention in practice; hence, policies aimed at improving midwives' welfare should be prioritised.

Background

The global midwifery workforce is experiencing a serious crisis marked by excessive occupational strain and burnout (1, 2). Midwives work in challenging settings worldwide to support women's health and provide positive experiences (1). In many African nations, maternal and neonatal morbidity and mortality rates are still significantly influenced by a lack of skilled birth attendants, despite advancements in healthcare (3–6). Uganda has a very high midwife shortage, despite government efforts to increase the number of health workers (7), and it is estimated that one midwife conducts between 350–500 births

annually, which is more than twice the World Health Organisation (WHO) recommended maximum of 175 births per midwife (8).

Numerous organizational and individual elements contributing to midwife attrition have been reported. These elements include high levels of stress at work, bullying experiences, structural barriers that prevent woman-centred care, professional responsibility emotions, post-traumatic stress disorder, social and professional isolation, and burnout (9–11).

Evidence indicates that appropriate and timely intrapartum practices save lives by preventing adverse outcomes, including obstructed labour, postpartum hemorrhage, stillbirths, and birth asphyxia (12). Inadequate access to high-quality healthcare contributes to maternal mortality, particularly in environments with limited resources (13).

The availability of educated, well-supported midwives working in an appropriate and safe environment is crucial to achieving maternal and newborn health and wellbeing goals (14–16).

Enrolled midwives (who have received training at a certificate level) and registered midwives (who have received training at a diploma or degree level) provide the majority of intrapartum care in Uganda (17). In rural areas like the Ankore Sub region, with health facility staff shortages and high and varied patient caseloads, midwives offer labor management care, early diagnosis of complications, emergency response, and psychosocial support (18). Research demonstrates that when high-quality midwifery care is given in a supportive setting with sufficient staffing and resources, this can avert more than 80% of maternal deaths, stillbirths, and newborn problems (19, 20).

In Uganda's health care systems, research reveals ongoing shortages of essential supplies, a lack of equipment, heavy workloads, poor documentation procedures, frequent out-of-stock replacement of resources, and few opportunities for supportive supervision (7, 21). These challenges affect midwives' clinical decisions, psychological well-being, and capability to offer compassionate, evidence-based care, which midwives recognize as vital contributors to disrespectful and abusive maternity practices (22, 23).The quality of intrapartum care and women's confidence and trust in healthcare facilities may be compromised by such systemic influences.

Research has examined the experiences of women giving birth and the maternity care provided by healthcare professionals in Uganda (24), however, limited research has focused on midwives' perspectives, particularly during intrapartum care in the Ankore sub-region. This current qualitative study explored the intrapartum care experiences of midwives in Ankore Sub-region, South Western Ugandan healthcare settings. It is envisaged that the findings for qualitative research will assist and guide future policy implementation and inform context-specific interventions to enhance maternal and newborn health and wellbeing outcomes in limited-resource settings.

Methods

Study design, setting, and participants

This study was carried out as a component of a larger inquiry involving the practices of midwives and the experiences of mothers receiving intrapartum midwifery care (25). In order to explore midwives' experiences of providing intrapartum care, this current study used a qualitative descriptive design. This design was informed by the interpretivist research paradigm, which recognizes that reality is socially constructed and that people give meanings to their experiences based on their interactions and contexts (26).This paradigm was deemed appropriate for the study as it allowed for a thorough understanding of the subjective experiences and meanings that midwives attach to their provision of intrapartum care.

Three primary public health centers in Uganda-Bwizibwera Health Center IV (BHCIV) in Mbarara district, Kinoni Health Center IV (KHC-IV) in Rwampara District, and Mbarara City Health Center IV (MCHIV) in Mbarara City- were selected for the study, two of which were rural and one of which was urban. Three of the five Health Center IVs in these three districts were specifically selected because of the higher rates of birth-related complications. Ten (10) midwives worked at the maternity ward of MCHIV, where there are an average of ten (10) births per day. KHC-IV had four midwives who worked with an average of five births per day, while BHCIV had eight midwives who worked with an average of six births per day. Ten midwives were purposively selected from the three health facilities. Selection was based on midwives' years of experience and duration of practice in the health facilities. The sample size was determined using the data saturation principle, which asserts that no new information will surface from subsequent participants (27).

Data collection and analysis

Data collection was conducted utilising semi-structured interviews in private rooms within the health facilities to ensure confidentiality and privacy, and to promote open discussion. The lead researcher, with the assistance of an experienced qualitative researcher, used a semi-structured interview guide to conduct face-to-face, interviews with the participants. A participant information sheet was given to participants before being enrolled into the study, voluntary participation was emphasized, and a participant was informed that they could withdraw at any time from the study. Written informed consent was obtained.

To enhance the reliability of data collection, all interviews were audio-recorded with participant’s consent. To record contextual observations, nonverbal cues, and developing remarks that could improve data interpretation, were recorded via written field notes during and after the interviews. The duration of each interview was between 45 and 60 minutes.

As soon as the data was collected, audio recordings were transcribed verbatim. To ensure the transcripts were accurate and comprehensive, they were compared to the audio recordings. To protect participant privacy, all identifying information was de-identified and deleted from the transcripts. Thematic analysis was utilised to analyze the data in accordance with Braun and Clarke's six-stage

method (28). First, while listening to the audio recordings, the researchers repeatedly read and reread the transcripts to become familiar with the data. Immersion in the data and a greater comprehension of the experiences of the participants were made possible by this procedure.

Following familiarization, initial codes were generated inductively from the data. Due to the coding process being data-driven, codes and categories were not imposed from pre-existing theories or frameworks but rather emerged from participant narratives. Preliminary categories were created by grouping similar codes. Following this, the categories were examined and arranged into possible themes by looking for recurrent patterns and connections in the dataset. To guarantee coherence, consistency, and correct representation of participants' experiences, themes were developed through an iterative process that involved comparing coded excerpts with the original transcripts. To strengthen the trustworthiness and dependability of the findings, the final themes were precisely identified, defined, and supported with exact quotes.

Trustworthiness

Lincoln and Guba's criteria of credibility, dependability, confirmability, and transferability (29) were used to establish the study's reliability.

Long-term interaction with the data, iterative questioning during interviews, and the correct representation of participants' opinions through verbatim quotations all contributed to increased credibility. By keeping thorough records of the study process, including data collection methods, coding choices, and theme development, dependability was guaranteed. Recording and documenting an audit trail and using reflexive techniques to reduce researcher bias during data interpretation, confirmability was attained. Being open and transparent and providing good explanations of the study requirements, and research methods, transferability was enhanced, enabling researchers to evaluate how well the findings applied to comparable situations. Through in-person meetings, member checking was conducted with 7 out of 10 participants who reviewed their transcripts and the initial coding framework and findings were a true representation of what they discussed. This strengthened credibility and representation of the participants' experiences.

Results

Characteristics of participants

Of the 10 midwives, seven had a diploma in midwifery and were considered Assistant Nursing Officers as per the government structure, although among the seven midwives, only one midwife was officially promoted to the level of Assistant Nursing Officer; the rest were employed as Enrolled midwives (this is the current lowest level of Midwifery in Uganda), despite having upgraded their level of education. The highest years of experience ranged from 3 to 22 years. The respondents’ characteristics are presented in Table 1 below.

Table 1
Characteristics of the respondents

Pseudo name of respondents	Age	Participants' level of education	Cadre as per employment	Work experience (Years)	Marital status	Health Centre (HC) Level
Winfred	45	Diploma in midwifery	Enrolled midwife	8	Married	HC IV
Kate	49	Diploma in Environmental Health	Enrolled Midwife	14	Married	HC IV
Annette	32	Certificate in Midwifery	Enrolled midwife	9	Married	HC IV
Beatrice	54	Diploma in midwifery	Enrolled Midwife	22	Married	HC IV
Bridget	48	Diploma in Midwifery	Assistant Nursing officer, midwifery	17	Married	HC IV
Allen	28	Diploma in midwifery	Enrolled Midwife	9	Single	HC IV
Penelope	39	Diploma in Midwifery	Enrolled Midwife	15	Married	HC IV
Suzan	26	Certificate in midwifery	Enrolled Midwife	5	Single	HC IV
Deborah	28	Certificate in Midwifery	Enrolled midwife	3	Single	HC IV
Patience	42	Diploma in Midwifery	Enrolled Midwife	16	Married	HC IV

Findings are presented under three (3) themes: “Professional identity and satisfaction”, “system and infrastructure limitations”, “heavy workload consequences”. The interviews helped to explore midwives experiences while providing intrapartum care. Themes development are presented in Table 2 below

Table 2
Themes, subthemes and categories

Ser. No	Theme	Subtheme	Category
1.	Professional identity and satisfaction	Internal drive and pleasure in midwifery	• Persistent ambition to become a midwife • compassion for the midwifery profession
		Emotional benefits of the career	• Midwife witnessing birth • Sense of value from mothers
		Commitment to intrapartum Care	• Rebutting mistreatment of mothers • Defending the profession • Committing to care under poor environment
2.	System and infrastructural limitations during intrapartum care	Inadequate recognition and progress	• Promotions stagnating after upgrading • Denied uniform dress code changes after upgrading • Being ridiculed due to lack of promotion • Lacking access to incentive programs • Lacking respect from other health team cadres • Limited support
		Limited resources	• Limited physical space • Shortage of equipment • Referral cost barriers • Limited human resource • Long shifts • Unnecessary referrals • Low pay
		Non evidence based intrapartum practices	• Contradictory drug administration

			• Maintaining lithotomy position in second stage • Filling the labour care guide (LCG)/partograph after birth • Ensuring admission of few mothers • Inconsistent immediate postpartum follow-up • Applying selective consent • Use of traditional herbs on labour ward
3.	Heavy work load consequences	Work burnout	• Feeling exhausted due to inadequate workforce • Difficulty in having quality time with family
		Emotional and physical burden	• Verbal abuse from mothers and attendants • Carrying unresolved trauma • Fore seeing long-term health issues, • The physical toll of midwifery
		Professional dissatisfaction and career reassessment	• Contemplating to leave the profession • Diverting to other courses during upgrading • Lacking professional protection

Professional identity and satisfaction is the first theme that emerged from three subthemes: (1) internal drive and pleasure in midwifery, (2) Emotional benefits of the career, and (3) Commitment to intrapartum Care.

Most midwives felt happy about being midwives despite the challenges encountered while providing care. Some of the midwives expressed joy at becoming a midwife, voicing a desire they had since childhood, as quoted below.

"I am genuinely pleased to be a midwife, as I have aspired to this profession since my high school years."

Others expressed gratitude for being the first person to see a baby being born. While others defended the profession, voicing that none of the midwives studied the course to mistreat women, and claimed that

poor working conditions and the environment may trigger negative behavior.

It is exciting to be the first person to witness an individual entering the world, seeing that baby cry, and the mother giving a sigh of relief and joy. I really love being a midwife

“Nobody studied midwifery to mistreat mothers, it’s because of these challenges…."

Some of the midwives felt that their work had to go on despite the challenging circumstances because they loved helping people, especially saving the lives of mothers and newborns.

"We cannot lay down tools to let mothers die...even when you decide to remain home, the thought of complications that will occur without a midwife can haunt a midwife”.

The theme system and infrastructural limitations during intrapartum care emerged from three sub-themes: (1) inadequate recognition and progress, (2) limited resources, and (3) non-evidence-based intrapartum practices.

The theme, inadequate recognition and progress, emerged from three sub-themes: (1) “Promotions stagnating despite qualifications”, (2) “perceived government indifference,” and (3) “Lack of access to incentives”

Some of the respondents expressed disappointment at not receiving promotions after upgrading; some had been at their current level of study for nearly seven years without receiving any consideration for a promotion from the government. Midwives believed that the government devalued their knowledge and experience and viewed them as cheap labour, especially when a promotion would increase their pay.

"You spend a lot of money studying, but you never get promoted. Now, what is the reason for going back to study the government is only to exploit us for cheap labour."

I am now forty-five years old. My hopes of getting promoted are decreasing…….

The respondents claimed that because they were aware that promotions are extremely rare, their colleagues lacked the motivation to progress. It was highlighted that those who had continued with their studies and gained further qualifications without being promoted were subjected to ridicule by those who haven't upgraded. It is noteworthy, that only one midwife with a diploma qualification was promoted, and paid as an assistant nursing officer, the other midwives were not. Interestingly, some participants discussed how they wished to wear uniforms based on their educational attainment as a form of motivation for going back to upgrade, even in the absence of a professional promotion.

“After earning a midwifery diploma, we asked the doctor in charge to let us wear the white uniform, but he refused, saying that we should stay in the pink uniform because that is the cadre we work for. I would be inspired by a white uniform and a yellow belt”.

Some of our colleagues refused to go back to study, they usually laugh at us since we are never promoted after spending money and time during the course of study…….

Others felt that midwives have no one who cares and values them, saying that they appear like orphans in the system.

“We work really hard, yet no one notices or cares. Midwives in the government are like orphans”.

The sub-theme of limited resources arose from categories of limited physical space, shortage of equipment, referral cost barriers, limited human resources, long shifts, unnecessary referrals, and low wages. Respondents voiced that the maternity space is limited, and sometimes they are forced to tell some of the labouring women to remain outside the labour wards as they wait for mothers to give birth and get beds. Unfortunately, some of the women end up giving birth outside the labour ward unattended by midwives. Sometimes, midwives are forced by the conditions to put the polythene paper (commonly known as kaveera) on the floor and conduct the birth.

We occasionally tell the mothers to wait outside while we wait for others to give birth, since there is not enough room in the labor ward for all of them. Unfortunately, some end up giving birth outside the ward, which is not good, of course.

For referral cost barriers, respondents voiced that in case of an emergency that needed referral, the mothers have to fuel the ambulance, and however, most of these mothers are too poor to fuel the ambulance. This delays referral, often increasing midwives’ tension and fear of the consequences, and occasionally midwives end up fueling the ambulance from their hard-earned low salaries.

"The majority of these women are poor, but they still have to pay for the ambulance's fuel before referral……"

“I sometimes buy fuel to transfer the mother because I know if she delays, complications will occur while I am on duty… I fear maternal audit…if death occurs, it is when you will see double cabins of our bosses looking for answers to what went wrong… it is not easy”.

Respondents mentioned a shortage of drugs and equipment, where major obstetric emergency drugs were out of stock, and the respondents reported being forced by circumstances to send mothers and companions to buy out-of-stock drugs and sundries. Additionally, blood pressure machines were faulty or, at times, lacked batteries. These affected intrapartum care management.

“For example, we do not currently have injectable tranexamic acid or magnesium sulphate, but yesterday I instructed an attendant to purchase two ampoules of magnesium sulphate, keeping one for emergencies. I understand that it costs him money, but it will shortly save a life”.

Limited human resources were frequently echoed by the respondents, where the number of midwives at the facilities was limited, and this affected the number of midwives per shift, yet the procedures and

activities expected to be undertaken were many, and this affected their performance. Respondents voiced having one anaesthetic officer for the facility, which significantly affects the quality of care.

"There aren't many midwives here; I know that there are only nine of us to manage the maternity, postnatal ward, maternal and child health clinics. It's extremely hectic, and it affects the quality of care we provide!"

Respondents voiced that due to the limited number of midwives, usually referred mothers are not escorted by midwives, which they regarded as a bad practice.

When I am alone on duty, and I have a referral, it might be difficult at times to escort the mother, therefore I let the mother leave with the ambulance driver and continue praying that nothing goes wrong while in transit…

Due to the limited number of midwives at the health facilities, respondents narrated having only two long shifts: day duty, which commences at 08:00AM to 08:00PM, and night duty, which commences at 08:00PM to 08:00AM. The respondents found these long shifts exhausting and described how this affected their performance.

"This facility has only two shifts with limited off-duty days. A midwife works 12 hours; by the time I finish giving the report, it is 9:00pm. I go back home exhausted like garbage... "

Unnecessary referrals to the main regional referral hospital were discussed, where the respondents voiced that their managers advised them to admit a few mothers and refer the rest, since most of the time we have one doctor, and by 5:00pm, he/she is exhausted. Additionally, it was discussed that since a health facility has one anaesthetic officer who works on alternate weeks, mothers are referred to the week when the anaesthetic officer is off, and no cesarean operations are performed during that week.

We have one anaesthetist, and he cannot work every day without an off-duty, the week he is off, we refer all the high-risk mothers and emergencies…

Low pay was frequently mentioned by the respondents, who claimed that they do a lot of hectic work, yet the salary they are paid was low, which cannot cover their personal expenses and they cannot save for old age and retirement.

Our salary is very little compared to the work we do, it is like out of pocket. I am paid 1.2M Uganda Shillings(333USD), on this I pay rent, school fees, medical bills for me and my family among other expenses, for sure this is low pay (emotions observed as she voices this).

Under the sub-theme, non-evidence-based intrapartum practices arose from three categories: Practices not based on current evidence, selective intrapartum care monitoring, and the use of traditional herbs by mothers on the labor ward.

The respondents voiced that all mothers are directed to give birth in lithotomy position to some, it was the only position they knew, others claimed that it was a comfortable position for them to facilitate birth

and some said that the delivery beds and the labour suite environment in the facilities were not suitable for other positions and avoid labour ward accidents

We occasionally tell them to be in lithotomy position and many of them know that it is the position we want as midwives

In my midwifery practice, I have not tried any other position apart from lithotomy position which I am used to, our delivery beds are small, and the environment in our labour ward is not conducive for other positions

Respondents claimed that after birth, they only undertake immediate postnatal follow-up for mothers who have experienced complications during birth; the rest of the mothers are not closely monitored, and the midwives rely on the attendants who report in case a complication develops. This practice is deemed harmful as waiting for a complication to occur instead of performing preventive measures puts both the mother and baby at high risk. This is not in alignment with WHO postnatal care recommendations

"On the postnatal ward, we usually follow closely only those mothers who get complications during birth... the rest we wait for attendants to report when a problem arises."

Insufficient updates on new evidence-based practices and a lack of ongoing professional development were evident in several of the midwives' responses. Some participants were unsure when to use uterotonics to prevent postpartum hemorrhage. Some midwives brought up the outdated approach of preventing postpartum hemorrhage, voiced giving an oxytocin injection at the time of anterior shoulder delivery. Others mentioned completing the labor care guide after mothers gave birth so that mothers have good records after giving birth.

"I give oxytocin when the anterior shoulder is delivered……."

Laughs… we sometimes fill the labour care guide after birth to have proper records, you know, when the maternal audit is done, we are answerable

The theme, heavy workload consequences, emerged from three sub-themes: (1) Work burnout, (2) Emotional and physical burden, and (3) Professional dissatisfaction and career reassessment. The respondents attributed heavy workload to limited staff numbers, this led to overworking and exhaustion since it was common to find only one midwife on duty yet she had a variety of tasks including admitting new mothers, monitoring more than three mothers in labor, facilitating births, managing mothers and babies during the immediate postpartum period, going to theatre to receive the babies and sometimes escorting referrals in case of an emergency. The respondents experienced burnout, contributing to inefficient performance.

I'm fatigued when I leave work, and the only time off I get is to clean and wash…

Respondents frequently described how they go home exhausted and find it difficult to spend time with their family members, indicating that work burnout adds to emotional stress.

“I also find it difficult to spend quality time with my spouse and kids; they are eager to chat with me, but with all the stress and tiredness, I do not give them time”.

According to the midwives’ voices, mothers and attendants occasionally verbally attack them, particularly when there is only one midwife on duty, and mothers feel abandoned.

“Sometimes we are abused by the mothers and their companions, especially when they feel we have not offered the care they expected from us…there can be like three mothers in the second stage, and I cannot care for them at once”.

Dissatisfaction and career reassessment sub-theme arose from three categories, where respondents **c**ontemplated quitting the midwifery profession, diverting to other courses during upgrading, and claimed a lack of professional protection. These were attributed to the heavy workload, long duty shifts, low pay, and lack of protection in case of maternal or fetal death while working under poor health facility conditions.

"I have a backup plan already. I'm taking a different course (environmental health) right now that will probably lead to a promotion outside of midwifery, so this workplace isn't ideal for me.

……..the conditions are unfavorable, and the workload is excessive, and when a mother dies in such conditions, no one defends you.

Discussion

Professional identity and satisfaction,

Many midwives saw their work as a lifelong goal and a source of emotional fulfillment, especially when it came to being the first to see a new life coming into the world and getting praise from mothers. Midwives also expressed a high level of intrinsic motivation and pride in their job. This is in line with other studies conducted in Northern Nigeria and Senegal, which showed midwives' strong sense of purpose and dedication to their work in spite of unfavorable working conditions (1, 2). Even in the face of enormous job obstacles, midwives who have reported feeling proud and satisfied with their career frequently find inspiration in the personal fulfillment and emotional reward that come with helping women give birth(3). Contentment in the face of hardship, however, can also indicate a deep-seated tolerance for unfavorable working conditions, which could deter support for improved working conditions or legislative changes (4). This contentment implies that policy changes are required to match the commitment of midwives to their profession with favorable workplace environments.

System and infrastructural limitations during intrapartum care

The current study findings revealed inadequate recognition and progress; the midwives felt generally underappreciated and devalued by the healthcare system and Government. They voiced frustration with job advancement stagnation, pointing out lack of opportunities for promotions after upgrading. In many African contexts, the absence of possibilities for professional growth and recognition has been identified as a demotivating factor (30). Thus, retention is weakened, and additional training and professional growth are discouraged when qualified midwives are not promoted. Additionally, lack of opportunities and promotion can lower job satisfaction and impact self-esteem, which might result in discontent with what midwives do. Therefore, it is recommended that health systems establish clear, transparent promotion pathways and ensure timely implementation. Midwives should also be included in health sector incentive schemes, and professional associations should raise awareness and fight for their involvement in health policy forums.

The findings showed limited resources in terms of equipment, drugs, and sundries, plus serious space constraints in the labor ward, which resulted in overcrowding and, occasionally, births that took place outside the approved birthing zones. These findings are consistent with earlier studies where lack of resources and space for providing high-quality maternity care have been identified as physical infrastructure constraints (22, 31, 32). Research conducted in Uganda and other Sub-Saharan African countries has also shown that inadequate infrastructure leads to unsafe and disrespectful treatment and care (33). This implies that space constraints make it more difficult to follow advised healthcare procedures, including ongoing observation, privacy, and prompt emergency treatment. Healthcare professionals experience moral discomfort as a result of being compelled to offer substandard care against their professional judgment (34). Therefore, the authors recommend that infrastructure development for maternal health care should be a high priority for local governments and health ministries. This entails investment and building new labor wards and enlarging current maternity units, especially in these facilities with high patient volumes. Data on service consumption should also be used by policymakers to efficiently direct resource allocation.

Midwives also reported work overload, irregular postpartum follow-up, and admission procedures that were impacted by capacity constraints. Some mothers were either turned away or only followed up when complications occurred. These results corroborate earlier research on maternity care that was rationed because of capacity and workload concerns (34, 35). This damages public confidence in the healthcare system and helps to normalize and accept poor treatment and care (36). The researchers recommend that health care facilities, involve key stakeholders, to create and standardize postnatal monitoring procedures in alignment with WHO recommendations (37) and increase maternity staff to cover the workload sufficiently (38).

Non-evidence-based intrapartum practices came forth, where several respondents emphasized the frequent usage of the supine-lithotomy positions during labour, frequently without clinical indication or informed consent. This approach is not in alignment with the WHO's current recommendations for a positive birth experience and recent research that suggests enabling women to get into comfortable positions like lateral or upright positions, which are linked to shorter labor times, fewer instrumental

deliveries, and higher levels of maternal satisfaction (39, 40). The supine position is often imposed upon women, which is indicative of a provider-centered style of care that prioritizes convenience over the autonomy of the mother and physiological birth. Additionally, outdated practices indicate that the WHO guidelines that promote evidence-based intrapartum care are not being adequately implemented.

Furthermore, respondents mentioned the use of an oxytocin intramuscular injection during an anterior shoulder birth. This practice deviates from the standard protocol of active management of the third stage of labour, where oxytocin use is recommended within one minute of the birth of the baby (41). This lack of knowledge indicates the need for continuous professional education emphasizing updates with clinical guidelines and regular support and supervision of care providers, specifically those in primary health facilities, is critical. Reliance on outdated approaches may be decreased by including behavior change communication techniques and training on evidence-based practices into standard maternal health services.

The fact that midwives completed the labour care guide (LCG) after the infant is born, instead of during labor, raises questions about the standard of intrapartum monitoring and clinical protocol adherence. This issue is analogous to earlier studies conducted in Ethiopia and South Asia that documented both retrospective completion and formality of labor monitoring instrument completion (42, 43). This retrospective recording also aligns with earlier research conducted in Burkina Faso and Uganda, where medical professionals reported that partographs were completed postpartum in order to satisfy administrators' and direct supervisors' expectations (44, 45). This retrospective record keeping may be attributable to a possible absence of an accountability culture, where documentation is viewed as an unusual duty rather than an essential part of care (43). Therefore, education and training programs need to emphasize the LCG's clinical value as a tool for decision-making rather than just a documentation necessity.

Midwives also reported work overload, irregular postpartum follow-up, and admission procedures that were impacted by capacity constraints. Some mothers were either turned away or only followed up when problems occurred. These results corroborate earlier research on maternity care that was rationed because of capacity and workload concerns (34, 35). This lack of follow-up care damages public confidence in the healthcare system and helps to normalize and accept poor treatment(36). It is recommended that health care facilities, through key stakeholders, create standardized postnatal monitoring procedures and increase maternity staff to cover the workload sufficiently.

Heavy workload consequences

Respondents voiced work burnout, emotional and physical burden as consequences of heavy workload, which they attributed to the shortage of midwives in health facilities, long working hours, and lack of adequate system support. This is consistent with the notion put forth, which states that the challenges midwives encounter lead to moral distress and burnout, which is typified by emotions of guilt, rage, depersonalization, and demoralization (46). Burnout can lower a midwife's drive, capacity for emotion

control, and ability to deliver patient-centered, compassionate care. Ultimately, burnout, could have an impact on maternal satisfaction, the safety of mothers and newborns, and the standard of intrapartum care. Burnout may worsen the performance and sustainability over time of the maternity care workforce if left neglected. Strategies to lessen midwife burnout should be implemented by health systems and facility administrators. These could include employing enough midwives to fill staffing gaps, distributing workloads fairly, limiting duty hours, and enhancing the overall working conditions in maternity wards. Additionally, to support midwives' well-being and improve the standard of intrapartum care, supportive supervision, stress management programs, professional support, and recognition should be enhanced.

The study findings revealed professional dissatisfaction and career reassessment among midwives.

This indicates low career motivation and discontent with working conditions. This dissatisfaction could exacerbate the current midwife scarcity in maternity care and constitute a serious danger to the retention of qualified birth attendants. Losing experienced midwives can have a detrimental impact on mother and newborn outcomes, interfere with continuity of care, and increase the workload for the remaining staff. According to studies, midwives' intentions to quit their jobs are influenced by unfavorable working conditions, little opportunity for career advancement, and a heavy workload (47–49). Research shows that the mental and emotional health of midwives influences the standard of care they deliver. For instance, midwives who have a heavy workload become frustrated, which results in poor care interactions (50).

The study showed that midwives perceived that the salary they receive is low compared to the work they do in the maternity care setting. This is consistent with a systematic mapping of barriers low and middle income countries findings where it was noted that wages were low and were paid in arrears (46). Midwives may experience job discontent, burnout, decreased motivation, and more intentions to quit their jobs if they believe their pay is insufficient and out of proportion to their working hours. Ultimately, persistent complaints with pay can jeopardize the quality and continuity of maternity and newborn care, worsen the current lack of skilled birth attendants, and threaten workforce retention (51, 52). Therefore, to increase midwives' job satisfaction and retention, policymakers and healthcare administrators should think about enacting fair compensation packages, workload redistribution strategies, and supporting workforce standards and regulations. Additionally, enhance better emergency transfer systems and investment into proper ambulance services and not expect mothers to fuel the ambulance when they have limited funds and midwives having to personally help fund for fuel to prevent a maternal and neonatal bad outcome.

Conclusion

From the midwives' point of view, intricate systemic and professional issues influence the delivery of intrapartum care. Inadequate recognition, limited career advancement, and infrastructure limitations coexisted with themes like professional identity and contentment. The continuation of non-evidence-based procedures was a result of heavy workloads and a lack of resources, which further compromised

the quality of care. These difficulties not only have an impact on the quality of care provided but also lead to professional discontent and, in certain situations, career reevaluation among midwives. Therefore, policies aimed at improving midwives' welfare, including remuneration, recognition, and career progression pathways, should be prioritized to enhance motivation and retention. In order to lessen workload tasks and avoid midwife burnout, facility administrators should put more emphasis on increasing sufficient personnel numbers and resources. Increasing awareness of the need to invest in more midwives can save lives.

Abbreviations

LCG
Labour Care Guide
WHO
World Health Organization
ICM
International confederation for midwives
UNCST
Uganda National Council for Science and Technology

Declarations

Ethics approval and consent to participate

Ethical approval for the study was obtained from the relevant Research Ethics Committee prior to commencement of data collection. Bishop Stuart University in Southwestern Uganda was the supervising institution (BSU-REC-2024-325), the Uganda National Council for Science and Technology (UNCST) granted ethical approval UNCST- HS5048ES, and the University of Port Harcourt Research Ethics Committee in Nigeria also granted ethical approval (UPH/CEREMAD/REC/MM94/045) as the first author was completing a professional doctorate which included the undertaking of this study. This study complied with the Declaration of Helsinki's principles and regulations for upholding participants' safety and health (53).

Administrative permission was obtained from the study sites. Before each interview, participants provided written informed consent and were assured of anonymity, confidentiality, voluntary participation, and their right to withdraw from the study at any time without consequences. Each participant was given a unique identification code to safeguard their identity, and neither the transcripts nor the study reports contained any personal information. Only the research team had access to password-protected computer files containing audio recordings, transcripts, and field notes.

Consent for publication

Not applicable.

Availability of data and materials

All data generated during this study are included in this article

Competing interests

The authors declare no competing interest.

Funding

This research received no funding

Authors' contributions

EK conceived and designed the study. EK, MS and AM implemented the study and conducted data analysis. EK, MS and AM interpreted study results: EK wrote the first draft of the manuscript. EK, MS and AM reviewed and corrected the draft manuscript. All authors read and approved the final manuscript.

Acknowledgements

We acknowledge all the study respondents

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