BARRIERS AND FACILITATORS FOR IMPLEMENTATION OF CONTINUITY OF MIDWIFE CARE: A REVIEW OF REVIEWS

Authors

Gila Zarbiv [1,3], Saritte Perlman [1,3], Moriah E Ellen [1,2,3]

Affiliations

1. Department of Health Policy and Management, Guilford Glazer Faculty of Business and Management and Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel
2. Institute of Health Policy Management and Evaluation, University of Toronto Dalla Lana School of Public Health, Toronto, Ontario, Canada
3. Israel Implementation Science and Policy Engagement Centre (IS-PEC), Ben-Gurion University of the Negev, Beer-Sheva, Israel

BACKGROUND

Continuity of Midwife Care (CoMC) is a model in which women are cared for by the same midwife or small team of midwives throughout pregnancy, birth, and the postnatal period. A midwife is a health professional trained to provide comprehensive medical care to women and newborns. Global evidence and WHO policy state that midwives, working to their full professional scope, could provide up to 90% of essential sexual, reproductive, maternal, and newborn health services (SRMNAH). CoMC not only reduces unnecessary interventions, cesarean sections, and maternal and neonatal mortality, but also strengthens trust, satisfaction, and supports midwives in delivering evidence-based, woman-centred care. Despite the overwhelming evidence, CoMC remains under-implemented across health systems, highlighting the urgent need to understand what enables or prevents its global integration.

OBJECTIVE

A review of reviews to synthesize the evidence on barriers and facilitators to CoMC implementation using the Consolidated Framework for Implementation Research (CFIR).

METHODOLOGY

Following the Joanna Briggs Institute methodology, a review of reviews was conducted. Comprehensive searches of Embase, Medline, CINAHL, and grey literature identified reviews published between 2013 to 2024 that addressed CoMC implementation. Data were categorized by CFIR 2.0 domains: innovation characteristics, outer setting, inner setting, characteristics of individuals, and implementation processes.

RESULTS

Six reviews met inclusion criteria. Barriers to CoMC were globally systemic and included hierarchical power dynamics, limited midwife autonomy, workforce shortages, and inadequate policy support. Facilitators were more context-specific, influenced by healthcare infrastructure and resources, supportive leadership, collaborative care models, and national guidelines promoting CoMC. Midwifery education and community trust were also noted as essential for successful implementation.

CONCLUSION

Unlike many areas of healthcare where conclusions call for further research, the evidence for continuity of midwife care (CoMC) is already robust, comprehensive, and universal. The challenge is no longer generating knowledge, but acting on it. Harnessing implementation science and cross-country collaboration can drive the integration of CoMC into diverse health systems. Without decisive implementation, the impact of CoMC will remain unrealized and the gap between evidence and policy will persist.

DISCUSSION

Barriers to implementing CoMC are globally systemic, embedded in policies, funding models, workforce shortages, and healthcare systems. Facilitators, however, tend to be highly context-specific, shaped by local cultures, leadership, and community engagement. The evidence highlights that while CoMC is universally beneficial, its uptake requires deliberate system-level adaptation rather than isolated interventions. Implementation science frameworks, such as CFIR, provide valuable tools to identify challenges and guide strategies across settings.

SIGNIFICANCE

The evidence base for CoMC is rigorous and global. To translate evidence into practice, implementation science is needed to dismantle structural barriers, foster cross-country collaboration, and adapt proven CoMC models to diverse health systems. Embedding frameworks such as CFIR can guide policymakers and practitioners in developing context-specific solutions. This will accelerate integration and deliver lasting improvements in maternal and newborn health.

Fig. 1: Distribution of countries included in the studies according to income levels (according to World Bank classifications)

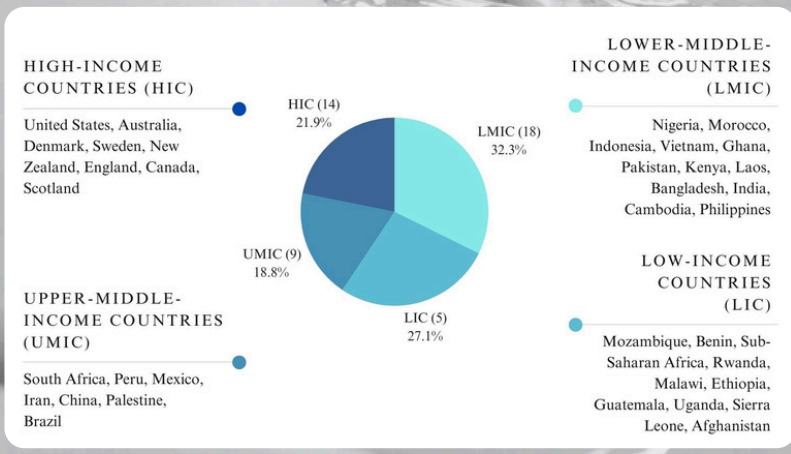

Fig. 2: Recurring barriers and facilitators across the six regions of the WHO