



MAKING CONTINUITY OF MIDWIFE CARE IMPLEMENTABLE ACROSS HEALTH SYSTEMS: A GLOBAL QUALITATIVE STUDY USING THE CONTEXT AND IMPLEMENTATION OF COMPLEX INTERVENTIONS FRAMEWORK



Authors

Gila Zarbiv [1,6], Rebecca R. S. Clark [2,3,4], Moriah E. Ellen [1,5,6]

BACKGROUND

Continuity of midwife care (CoMC) is associated with improved maternal and neonatal outcomes, reduced intervention, and better care experiences, yet implementation across health systems remains uneven. Existing literature has largely described barriers and facilitators to implementation, offering limited understanding of how CoMC is pragmatically implemented across diverse global systems. This study aimed to examine how CoMC was implemented across diverse health systems using the Context and Implementation of Complex Interventions (CICI) framework.

AIM

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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. Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing, Philadelphia, Pennsylvania
3. Pennsylvania Hospital, Philadelphia, PA
4. Leonard Davis Institute of Health Economics, Philadelphia, Pennsylvania
5. Institute of Health Policy Management and Evaluation, University of Toronto Dalla Lana School of Public Health, Toronto, Ontario, Canada
6. Israel Implementation Science and Policy Engagement Centre (IS-PEC), Ben-Gurion University of the Negev, Beer-Sheva, Israel

METHODOLOGY

A global qualitative study was conducted guided by the CICI framework. Semi-structured interviews were conducted with 22 participants across all six World Health Organization regions, including midwives and participants with implementation science (IS) or knowledge translation (KT) expertise. Data were coded deductively to CICI domains and macro, meso, and micro levels, followed by inductive analysis to identify recurring patterns and mechanisms.

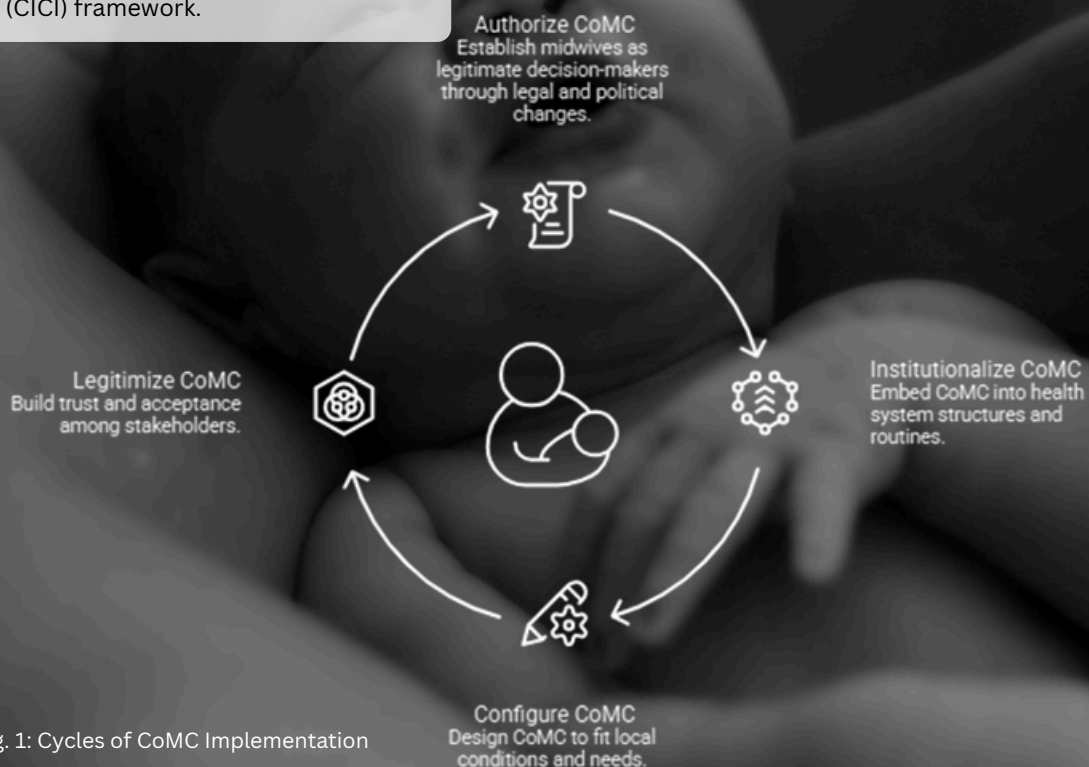


Fig. 1: Cycles of CoMC Implementation

RESULTS

CoMC was not implemented as a standard model transferred into practice. Instead, it was made implementable through four recurring forms of implementation work: authorizing midwifery authority, institutionalizing continuity within stable structures, configuring the model to local conditions, and legitimizing and negotiating contested change. These forms of work were overlapping rather than sequential and involved continual interaction among legal, political, socioeconomic, sociocultural, ethical, geographical, and epidemiological factors across system levels. A cross cutting finding was a gap between experiential implementation practice and formal IS, with much implementation work carried out through tacit, relational, and intuitive strategies rather than explicit frameworks or tools.

CONCLUSION

CoMC was not implemented as a standard model transferred into practice. Instead, it was made implementable through four recurring forms of implementation work: authorizing midwifery authority, institutionalizing continuity within stable structures, configuring the model to local conditions, and legitimizing and negotiating contested change. These forms of work were overlapping rather than sequential and involved continual interaction among legal, political, socioeconomic, sociocultural, ethical, geographical, and epidemiological factors across system levels. A cross cutting finding was a gap between experiential implementation practice and formal IS, with much implementation work carried out through tacit, relational, and intuitive strategies rather than explicit frameworks or tools.