BMC Nursing

RESEARCH

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Midwifery manager's experiences of knowledge and skills utilization by midwife specialists in the public health sector of South Africa

Kagiso P. Tukisi[1*], Zelda Janse van Rensburg[1] and Wanda Jacobs[1]

Abstract

Introduction Midwife specialists are trained professionals who render low and high-risk maternity and neonatal healthcare services across the globe. A workforce shortage of trained obstetricians and neonatologists in the rural parts of South Africa led to the rise of complicated births and neonatal conditions. Consequently, South Africa trained the registered midwives as midwife specialists to address the health needs of both mothers and neonates with life-threatening complications. While the country tried to train midwives, the existing literature proves that midwives are constrained to practice in the public health sector. This study is derived from a doctoral study in which midwife specialists' knowledge and skills utilization were explored and described through the lens of multivariate populations. This part of the study aims to explore and describe the experiences of midwifery managers in midwife specialists' utilization of knowledge and skills in the public health sector of South Africa.

Methods A qualitative, descriptive, explorative research design was followed. Twelve purposefully sampled midwifery managers participated in three focus group interviews. Data were analyzed using Collaizi's descriptive method based on the emerging themes and categories.

Results Midwifery managers recognize midwife specialists as knowledgeable and skilled professionals who lack professional autonomy to utilize their knowledge and skills. Consequently, the midwife specialists were inconsistent in their practice and demonstrated over-reliance on physicians and midwifery managers. The inconsistent practice led to potential knowledge and skills loss. Midwifery managers associated these with the lack of specific practice regulations to guide midwife specialist's practice regarding roles and responsibilities.

Discussion The study highlights midwife specialists in public health sectors cannot utilize their knowledge and skills optimally and cannot assume their specialist role in South Africa. The need to specify the roles and responsibilities of midwife specialists remains a challenge and call for revision of the practice regulations.

Keywords Midwife specialist, Professional autonomy, Professional practice, Scope of practice, Professional role, Clinical competence

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Introduction

The midwife specialists training program was designed and approved in South Africa in 1980 [1]. It aimed to expand the knowledge and skill set of the registered midwives who primarily cared for low-risk maternity and neonatal patients [2]. The South African midwife specialists training program is not the first of its kind; countries such as Liberia and Uganda follow the long-duration midwifery programs where advanced knowledge and skills are embedded [3, 4]. Therefore, a midwife specialist is referred to as a midwife with expanded knowledge and skills in maternal and neonatal care [5, 6].

The inception of the midwife specialists' programs was the response measure to the critical shortages in the maternal and neonatal care facilities amidst the accelerated maternal and neonatal mortalities [1, 5]. The responses to address the escalating maternal and neonatal mortalities align with the sustainable development goals (SDG) 3.1: to reduce maternal mortalities to less than 70 per 100,000 births [7]. Additionally, SDG 3.2 targets to reduce neonatal mortalities to at least less than 12 per 1000 births [7]. The midwife specialist training program also aimed to address the critical shortage of physicians interested in maternity and neonatal care [1]. According to the prior published literature, the expansion of midwife specialists' knowledge and skill set was aimed at permitting lawful and safe task-shifting of roles and responsibilities from physicians to midwife specialists [8, 9]. Lawful and safe task-shifting in midwifery and obstetrics is necessary to avert adverse patient outcomes [10].

The task shifting from physicians to midwives and specialists aligns with the midwifery models of care that place midwives at the forefront of maternity and neonatal healthcare [9]. The midwives-led models of care led to the inception of midwife-led obstetric units under the operational management of midwife specialists [11]. The operational managers are also trained midwife specialists with vast experience in maternal and neonatal care and are employed in management positions in terms of occupation-specific dispensation [12]. The operational managers are responsible for coordinating the midwife specialists' activities in maternity and neonatal care, including managing low-risk maternal and neonatal clients in the midwife-led obstetric units [13]. The emergence of severe maternal and neonatal complications requires midwife specialists to stabilize the patient's condition and involve a physician in interprofessional collaboration (IPC) in the management of complications [11]. A physician's involvement in managing a complicated situation occurs through the referral of a patient from the midwife-led obstetric units to the hospital, where both a physician and midwife specialists are employed to continue IPC [14].

While there are expectations of various roles and responsibilities of midwife specialists in managing complicated maternal and neonatal conditions, the existing literature found that the competencies available do not provide the legal protection for the midwife specialist's actions without the scope of practice [15]. The lack of relevant guidelines to support the independent and interdependent functions of midwife specialists is a universal concern even in countries with expanded midwifery training programs, such as Liberia, Uganda, and Japan [3, 4]. This part of the study is derived from the original doctoral study which examines the utilization of the knowledge and skills through the experiences of the multivariate populations. The study's objective is to explore midwifery managers' experiences regarding how midwife specialists apply their advanced knowledge and skills within South Africa's public health sectors, focusing on factors that enable or hinder optimal utilization of these specialized capabilities.

Setting

South Africa consists of nine provinces. The study took place in public health facilities of seven of the nine provinces that offer maternal and neonatal healthcare in midwife-led obstetric units rendered by midwives to majority of the South African population.

Methods

Aim

The aim of the study is to explore and describe midwifery managers' experiences regarding how midwife specialists utilize their knowledge and skills in the public health sector of South Africa.

Research design

We employed a qualitative, explorative, descriptive research design to explore and describe the experiences of the midwifery managers regarding the utilization of midwife specialists' knowledge and skills in the public sector of South Africa [16]. The study took place in the public health sector of South Africa after the approval of the research proposal by the University of Johannesburg Research Ethics Committee and Higher Degrees Committee (REC-1279-2021; HDC-01-154-2021). The study forms part of health science research, and it was therefore registered in the National Health Research database to facilitate the National Department of Health approval.

Recruitment and sample

The midwife managers were recruited via their nursing services managers, who acted as gatekeepers [17]. A purposive sampling method was used to select twelve participants who met the inclusion criteria [17]. The participants needed to be midwife specialists with

undergraduate and postgraduate qualifications in midwifery and registered as such by the South African Nursing Council. Furthermore, they needed to be employed by the public health sector of South Africa as a manager for a minimum of three years in the midwifery discipline. At the time of data collection in 2022, the midwifery managers' experience in midwifery management ranged between six and fifteen years.

The informed consent for participation and recording of the interview were sought from all the participants [18]. Data was collected using focus group interviews (FGI) on Microsoft Teams' application to limit the cost implications to the participants as the study covered a large geographical area [19]. The participants were recruited telephonically and by email. However, the patients contact details were accessible only to the researcher and were used strictly to communicate the research information to adhere to protection of personal information act. The participants' demographic data is summarized in Table 1.

Data collection

Three FGI comprising four participants each were conducted and lasted between 70 and 90 min by the researcher [20]. The interview guide developed for the purpose of the study comprising of a central and probing questions (Annexure A) was followed. The FGI commenced with a central question: *What is your experience as a midwifery manager regarding midwife specialists optimally utilizing their knowledge and skills in the public*

Table 1 Demographic characteristics of midwifery managers

Participants code: MM	Qualifications	Years of experience	Public facility	Province
Focus group 1				
1.	• Bachelor of Nursing and Midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**08**	**midwife-led obstetric units**	**North-west**
2.	• Bachelor of Nursing and Midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**10**	**Hospital**	**Eastern Cape**
3.	• Bachelor of Nursing and Midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**11**	**midwife-led obstetric units**	**Gauteng**
4.	• Diploma in nursing and midwifery (R.425) • Bachelor of Nursing education and administration with Post-basic midwifery and neonatal nursing (R.212)	**07**	**Hospital**	**Limpopo**
Focus group 2				
5.	• Bachelor of Nursing and Midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**09**	**Hospital**	**Limpopo**
6.	• Diploma in nursing and midwifery (R.425) • Bachelor of Nursing education and administration with Post-basic midwifery and neonatal nursing (R.212)	**11**	**Hospital**	**Free State**
7.	• Diploma in nursing and midwifery (R.425) • Bachelor of, Nursing education and administration with Post-basic midwifery and neonatal nursing (R.212)	**08**	**Hospital**	**KwaZulu Natal**
8.	• Diploma in nursing and midwifery (R.425) • Bachelor of Nursing education and administration with Post-basic midwifery and neonatal nursing (R.212)	**06**	**midwife-led obstetric units**	**Northern Cape**
Focus group 3				
9.	• Bachelor of Nursing and Midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**15**	**midwife-led obstetric units**	**North-west**
10.	• Diploma in nursing and midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**11**	**Hospital**	**Eastern Cape**
11.	• Diploma in nursing and midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**13**	**midwife-led obstetric units**	**Gauteng**
12.	• Bachelor of Nursing and Midwifery (R.425) • Diploma in post-basic midwifery and neonatal nursing (R.212)	**09**	**midwife-led obstetric units**	**Limpopo**

Source: Tukisi, K. P., Janse van Rensburg, Z., & Jacobs, W. (2024). South African midwife specialists' experiences in the utilisation of their knowledge and skills. Health SA Gesondheid, 29, 2444

Table 2 The list of probing questions

The list of probing questions
• You mentioned that there are midwives who are beyond others, please elaborate on that statement
• You mentioned that there is usually a conflict between obstetricians and midwife specialists, may you please elaborate?
• You mentioned that you do have absolute belief and trust in the advanced midwives, may you please explain that further?
• I heard you say a policy change is necessary, what might change be?
• May you please elaborate more on the statement "They are overlooked in your policies?

Table 3 Summary of themes and categories

Themes	Categories
• Suboptimal practice of midwife specialists	• Suboptimal utilization of knowledge and skills
	• Midwife specialists' dependent function.
• Diminishing midwife specialists' profession	• Midwife specialists' knowledge and skills loss
	• Midwife specialists' inconsistent Practice
• Midwife specialist's professional legal framework.	• Limiting the scope of practice
	• Limiting job description

health sector in South Africa? Each participant had an opportunity to share their experience through the assistance of the moderator, who ensured each participant got a fair chance [20]. The researcher used probing questions, enabling the participants to clarify and elaborate on their experiences, and in turn, rich data was gained [20]. The following are examples of probing questions that were asked detailed in Table 2.

The participants were requested to activate their camera and video mode to enable the researcher to observe non-verbal cues as field notes [19]. The silence was also noted to probe the participants to elaborate on their responses.

Although the Microsoft Soft team has an in-built and automatic voice transcription system, the researcher took time to read and validate the transcriptions against the recordings. This exercise aided the researcher in immersing self in data. Subsequently, the seven steps of Collaizi's qualitative data analysis method were used to analyze the data [17]. The researcher read the transcriptions and listened to the audio recordings to make sense of the data in line with the guidelines for reporting a qualitative data. The researcher extracted statements from each focus group interview related directly to the midwife specialist's experience with the phenomenon. The meanings from the participants' statements were drawn into significant statements that were used to formulate clustered themes with meanings. Lastly, the themes were clustered into meanings, which provided an exhaustive description of MM's experience in MS's utilization of knowledge and skills.

Trustworthiness

A code-recode method was applied, and an independent was employed, strengthening the study's dependability. The participants' demographics presented in Table 1 prove that the inclusion criteria were met. Therefore, the transferability and generalizability of the study's findings to the population with similar characteristics were ensured. The researcher used direct, verbatim quotations from the transcriptions to present the participant's experiences and emotions, increasing the study's confirmability and authenticity.

Ethical considerations

The researchers were cognisant that the study involved human participants and adhered ethical considerations detailed in Declaration of Helsinki for health science research. The participants who met the inclusion criteria were recruited and invited to participate. Informed consent was obtained from the participants, which assured voluntary participation [18]. Furthermore, the participants were informed of their rights to withdraw from the study at any point. The researcher generated codes specifically for the data discussion to ensure the anonymity of the participants [18].

Results

The midwifery managers experienced sub-optimal utilization of midwife specialists' knowledge and skills, which limited their practice and increased their dependability on the obstetricians. Consequently, there was a concern about diminishing the potential of the midwife specialists' profession because there were no specific practice regulations to standardize midwife specialists' MS' roles and responsibilities. The findings of the study are summarized in Table 3.

Theme 1: Suboptimal practice of midwife specialists

Midwifery managers recognize midwife specialists as specialized practitioners with extensive knowledge and skills who can positively contribute to patients' health. However, the midwife specialists were troubled by their' suboptimal utilization of knowledge and skills, as evidenced by their' exaggerated dependence on the midwifery managers and obstetricians.

Category 1: Suboptimal utilization of knowledge and skills

The midwifery managers acknowledge the midwife specialists as knowledgeable and skilled practitioners who underwent training to expand their midwifery knowledge and skill set. In addition, the midwife specialist's knowledge and skills are necessary to improve patients' outcomes.

> *Midwifery specialists program taps more into obstetrics. This places midwife specialists in a better posi-*

tion to have discussions with obstetricians at that level. Even in clinical, we [the Midwife Specialists' team] belong to the same group as ESMOE [Essential Steps in Management of Obstetric Emergencies]. Midwifery manager 11; midwife-led obstetric units

The Midwifery managers highlighted that applying the knowledge and skills assumed to be in place is challenging as the interventions that require Midwife specialists' knowledge and skills are regarded as obstetricians' responsibility.

The conflict arises when we must work on a real-life patient. Midwifery manager 9; midwife-led obstetric units

It was mandatory to do breech deliveries and forceps deliveries and vacuums. In a tertiary hospital like this, no policy allows you to do all those things, even as managers do not get to do it; such procedures are reserved for doctors. Midwifery manager 10; midwife-led obstetric units

Category 2: Midwife specialists' dependent function

Although the midwife specialists are knowledgeable and skilled, the midwifery managers were concerned that the midwife specialists were demonstrating more dependence on the obstetricians than on the independent and interdependent functions expected from the specialists.

The midwife specialists confidently call the doctor to come and see the patient, knowing very well that they are going to manage the patient. " Midwifery manager 7; Hospital

Then, the patient will deliver in admission while the midwife specialist runs after the doctor in the ward, forgetting that she is an independent practitioner. " Midwifery manager 4; Hospital

The Midwifery managers advocated for the interprofessional collaboration between the Midwife specialists and obstetricians. However, the Midwifery managers seemed to limit their contributions to the patient's care plans and related interventions.

As a midwife specialist, I should work very closely with the doctor in a clinic or hospital. The presence of a doctor in the delivery room is not supposed to render me unskilled, but it should be to strengthen the multidisciplinary team. Midwifery manager 7; Hospital

According to the Midwifery managers, the Midwife specialists heightened dependent function also limited the Midwife specialist's leadership role in healthcare facilities. Consequently, the midwifery managers were required to take over the midwife specialist's leadership function from MS, which was an added responsibility for the midwifery managers.

To them, a manager is a problem solver! Even if a person is a shift leader, they will come to the office and say we do not have an indwelling urinary. Midwifery manager 5; Hospital

So, now it is confusing because, as a manager, I expect a person to deal with certain issues in the ward, even if they are clinical issues because they are leading shifts. You would wonder if we had advanced midwives? Midwifery manager 10; Hospital

Theme 2: Diminishing midwife specialists' profession

The Midwifery managers were concerned about the future of the midwife specialists' profession because of the evident loss of the Midwife specialist's invaluable knowledge and skill set. In addition, there needed to be more consistency in MS' practice.

Category 1: Midwife specialists' knowledge and skills loss

The midwifery managers reiterated the value of the midwife specialist's knowledge and skills, which are necessary to prevent adverse patient outcomes. However, the midwifery managers were concerned that the midwife specialist's sub-optimal practice may contribute to losing knowledge and skills. The midwife specialists argued that they would gradually be out of practice without continued practice. The Midwifery managers reiterated.

The fact we are limited to do everything, irrespective of how educated you are, you remain a midwife like everyone else. So, even the knowledge and skills that one has diminished. I mean, we are not practicing. Midwifery manager 3; midwife-led obstetric units

Category 2: Midwife specialists' inconsistent practice

The participants shared that the Midwife specialists needed to be more consistent in their practice as each Midwife specialists used their discretion when applying knowledge and skills, making it challenging for the Midwife specialist's practice to be standardized. The Midwifery managers explained:

We have watched her [Midwife specialist] perform breech deliveries in the presence of doctors, and she would do it even better skilfully than doctors. The

registrars relied on her because she knew all the manoeuvres and did that very diligently. Midwifery manager 5; Hospital

It depends on individuals! Some sisters are above others in terms of qualification, but most of the time, they are very qualified, such as the midwife specialists in the case of my ward. They [Midwife specialist] don't want to take initiative … they do not want to act whenever something is happening with a patient. Midwifery manager 2; Hospital

Although some Midwife specialists attempted to practice to the best of their abilities, they were concerned that some practice was not at the standard expected from the registered midwives. Consequently, the Midwifery managers were disappointed by such occurrences. The Midwifery managers elaborated:

I have often seen a midwife who has yet to attempt the midwife specialists' course but is experienced and performing far better than the midwife specialists. Midwifery manager 7; Hospital

If the person goes for midwife specialist training, you expect them to come back and practice even better than before their training. Midwifery manager 10; Hospital

Theme 3: Midwife specialist's professional legal framework

The midwife specialists highlighted a need for a more relevant and specific legislative framework midwife specialist regarding the scope of practice and job description to guide the midwife specialist's practice, making it challenging to draw professional boundaries for midwife specialists' practice.

Category 1: Limiting scope of practice

The Midwifery managers associated the Midwife specialists' suboptimal and inconsistent practices with the scope of practice. The Midwifery managers explained that according to SANC documentation, there is no specific scope of practice to guide the Midwife specialist's practice. The Midwife specialists explained:

There is no scope of practice in place for midwife specialists, but in terms of training according to the Midwifery curriculum then, the skills and knowledge are advanced. Midwifery manager 3; midwife-led obstetric units

The midwife specialists explained that the SOPs currently available in the SANC database are the regulations regarding the practice of nurses and midwives, and the conditions for midwives' practice are similar.

I have visited SANC regulations and have noted that we are still regulated by the same regulations as midwives. Midwifery manager 4; Hospital

SANC has no scope of practice for midwife specialists. We are all practicing under the regulation R.2488 [Conditions under which midwives carry out their profession]. Midwifery manager 9 midwife-led obstetric units

The Midwife specialists expressed that it was even more challenging to draw job descriptions without the relevant SOP to serve as a framework of reference. Consequently, midwives need help to draw a distinct SOP to categorize them. Midwife specialists are specialists with expanded roles and responsibilities.

If you design a job description, you should base it on the scope of practice to cover the professional legally. Only then can we have the roles and responsibilities of midwife specialists different from those of ordinary midwives. Midwifery manager 1; midwife-led obstetric units

Category 2: Limiting job descriptions

The Midwifery managers explained that the Midwife specialists seemed not to be aware of what was expected of them during the execution of the clinical intervention.

Mostly, what is seen is that they do not know what is expected of them; they are only reminded when something is wrong. Midwifery manager 11; midwife-led obstetric units

The midwifery managers associated with the midwife specialists needed to be made aware of the health team members' expectations of the limiting job descriptions, like those of registered midwives. The midwifery managers reiterated that the legislative framework did not provide midwife specialists' professional autonomy. The Midwifery manager elaborated:

The Job description, policies, and protocols do not give us the freedom to practice. So, we are skilled but cannot do it; you must watch when the doctor is doing it. So, they are just witnessing and not performing as midwife specialists but as essential midwives. Midwifery manager 12; midwife-led obstetric units

The Midwifery managers highlighted that the absence of relevant job descriptions was challenging as they often needed a basis to hold the Midwife specialists accountable for suboptimal practice. Midwife manager explained,

> *So, that is affecting us because we do not know what we are doing. We do not know how and when to hold them accountable if we also need to know exactly what we are expecting from them and when we expect it. Midwifery manager 4; Hospital*

Category 3: Undefined professional boundaries

The midwifery managers were concerned that the absence of specific SOP and the job descriptions made it challenging to define the professional boundaries for the Midwife specialists. Consequently, the midwife specialists were disadvantaged because there were often clinical orders from physicians that may exceed the scope of function of the Midwife specialists. The Midwifery managers elaborated:

> *I see a midwife specialist being abused because the midwives may be performing the same midwifery duties as an advanced. However, there are instances where a midwife specialist will go beyond regular midwifery duties and take control of the situation in the ward. We also see doctors shifting responsibility to the midwife specialists; they will say because you are midwife specialists, please deal with those patients. Midwifery manager 7; Hospital*

The midwifery managers reiterated that the lack of professional boundaries makes it difficult for the Midwife specialists to exercise their advocacy role when care plans for patients are designed, which usually results in conflicts.

> *Teaming up with doctors is sometimes very difficult because our doctors are overwhelmed by the workload and shortage! Moreover, sometimes, when they must decide, they decide aggressively, especially when the midwife specialist is in the picture with the advice and all! They will immediately see it as though the midwife specialist is trying to micromanage them. Midwifery manager 2; Hospital*

Some midwifery managers would avoid causing conflicts by avoiding raising their concerns and opinions during clinical discussions, which may disadvantage some patients. The Midwifery managers explained:

> *So, this is trouble for us as managers, especially with the case of midwives who are not bold enough to say something to the doctors or even to their subordinates…then the obstetrician's decision stands even when a certain patient could have been prioritized. Midwifery manager 10, Hospital*

Discussion

The study sought to explore and describe the midwifery manager's experiences with midwife specialists' utilization of knowledge and skills in the public sectors of South Africa. The midwifery managers demonstrated their value for the midwife specialist's knowledge and skills and their potential contribution to improving maternal and neonatal outcomes. This finding coincides with the studies on the roles of midwife specialists in managing complicated births. The midwife specialists trained in vaginal breech births handled such deliveries with great caution resulting in positive outcomes for both mother and their neonates in an era where a caesarean section is a plan of choice for breech presentations [21]. This finding suggests that, given an opportunity, the midwife specialists may demonstrate their knowledge and skills optimally for the benefit of the patients.

The midwife specialists echoed that although the Midwife specialists undoubtedly have the specialist's knowledge and skills, the limited utilization of such knowledge and skills may diminish when not practiced. This finding supports the studies on clinical training and skills, which recommend that there should be continuous practice to retain the skills [22]. The knowledge and skills loss are reported in the emergency medical care field, where the health personnel previously trained on basic life support score low in pre-test when they undergo a retraining [23]. The knowledge and skills are gained when they are continuously applied [23].

The midwife specialists were troubled by their suboptimal utilization of their specialized knowledge and skills in managing patients in their care. The existing literature suggests that the midwife specialist's training has expanded their knowledge and skill set, inadvertently raising their independent and interdependent functions [24]. The heightened independent and interdependent functions suggest that knowledge and skills should be utilized to the maximum. Unfortunately, this was not the case according to the Midwifery managers in the public sector. Midwife specialists seemed inconsistent in their practice and relied more on obstetricians for patient care. The midwifery managers value the interprofessional collaboration between the midwife specialists and obstetricians despite the marked Midwife specialist's dependence on the obstetricians. This finding supports a strengthened IPC between the Midwife specialists and obstetricians to improve patient outcomes [25, 26].

The study found that the midwife specialist's suboptimal utilization and the diminishing Midwife specialists' professional status may be due to the need for a relevant

legislative framework, such as the SOP and job descriptions, to guide the midwife specialist's practice. This finding is consistent with studies in other countries that found it challenging to establish the professional status of Midwife specialists without the relevant regulations [27, 28]. Accordingly, the need for a specific and legislative framework limits the midwife specialist's powers and discretions in drawing clinical decisions and judgments when executing clinical responsibilities [29]. Consequently, the midwife specialists need more professional autonomy. The midwifery managers argued that the lack of relevant legislative frameworks made defining professional boundaries challenging for midwife specialists. The midwife specialists are in interprofessional collaborations with the obstetricians because of the similarities to a certain extent in their training and the patients in their care [30]. Consequently, the obstetricians may shift some tasks through the clinical orders.

Implications for practice

The study reveals the misalignment between Midwife specialists' education regulations and the practice regulations. There was evidence that the midwife specialists received extensive training in midwifery studies, which expanded their knowledge and skill set. The existing practice regulations hindered the Midwife specialists from practicing autonomously and independently. The regulatory bodies should provide the specific scope of practice to guide and legalize the Midwife specialist's practice. The provision of the scope of practice in South Africa is the role and responsibility of South African Nursing Council in terms of the Nursing Act 33 of 2005 [31]. The job descriptions were reported as limiting and need to be revised. The job descriptions are derived from the SOP to ensure a proper alignment so that a professional may practice within the prescribed boundaries [32]. The autonomy, independence, and optimal practice of Midwife specialists and the utilization of their knowledge and skills will require an enabling professional practice environment [33]. The professional practice environment can only be achieved by modifying practice regulations guiding Midwife specialists' practice.

Strengths and limitations

This study's strength lies in the generalizability of findings to South Africa, as the participants were recruited from seven of nine provinces. The study provides opportunities for the review and evaluation of Midwife specialists professional practice through the lens of midwife managers, which limits the bias that could have been present in the self-evaluation by the midwife specialists. The study's limitations are evidenced by the involvement of only the Midwifery managers as participants, which narrows the Midwife specialist's utilization of knowledge and skills to the Midwifery manager's experience. However, the experiences of midwife specialists, obstetricians, and medico-legal experts regarding Midwife specialists practice are also explored in separate studies attached to the main doctoral study. The study focuses on the Midwifery managers in the public health sector. It excludes the Midwifery managers in the private health sector who may also provide invaluable input on Midwife specialists utilization of knowledge and skills. A part of the study linked to the main doctoral study looks at midwifery managers 'experiences in the private sector.

Conclusions

In conclusion, the Midwife specialists could not optimally utilize their knowledge and skills, which resulted in inconsistent practices among MS. The primary concern was the potential knowledge and skills loss as Midwife specialists was seen as dormant in their practice. Our study identified the misalignment between the education, training, and practice regulations of MS, which was associated with the midwife specialist's sub-optimal practice. There needs to be a specific SOP and job descriptions to permit the independent and autonomous practice of midwife specialists in the midwife-led obstetric units. Consequently, the Midwife specialist's practice professional boundaries are difficult to define, and the Midwife specialist's practice cannot be standardized. Our study concludes that practice regulations should be revised to enable midwife specialists to fully utilize their knowledge and skills autonomously in midwife-led obstetric units, with appropriate protective protocols and equipment in place to ensure both provider and patient safety during independent practice.

Abbreviations

IPC	Interprofessional collaboration
PPE	Professional practice environment
SDG	Sustainable developmental goal
SOP	Scope of Practice

Acknowledgements

The researchers wish to express their immense gratitude to all the Midwifery managers who took time from managing demanding midwifery units to contribute to the study. Your voices signify your concerns for the Midwifery profession and the need for reforms, which might even contribute to our goal of reducing maternal and neonatal mortalities.

Author contributions

KPT conducted the research and drafted and designed the article. ZJVR and WJ supervised the study, revised the draft and approved the themes. All authors proofread, corrected and made suggestions for the article.

Funding

The study is derived from self-funded major doctoral study.

Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethical approval

The study adhered to the Declaration of Helsinki for health science research with human participants. The University of Johannesburg Research Ethics Committee and Higher Degrees Committee (REC-1279-2021; HDC-01-154-2021) granted permission to conduct the study. Further approval was obtained from the National Department of Health to conduct the health science related research. Clinical trial number not applicable to this study. All the participants granted informed voluntary verbal and written consent. Codes were generated specifically for data collection to ensure anonymity among the participants.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Received: 12 December 2024 / Accepted: 24 April 2025
Published online: 29 April 2025

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