

REVIEW ARTICLE

Bridging the Policy and Practice Gap in Midwifery: Pathways to Professional Autonomy: A Systematic Review

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ABSTRACT

Background: Despite progressive maternal health policies, midwives globally continue to experience a gap between policy intentions and actual clinical practice. Professional autonomy remains constrained by regulatory, institutional, and sociocultural barriers.

Objective: To systematically review evidence on factors contributing to the policy and practice gap in midwifery and to identify pathways that strengthen professional autonomy.

Methods: A systematic review of qualitative, quantitative, and mixed-method studies published between 2016 to 2025 was conducted. Databases searched included PubMed, Scopus, CINAHL, and Web of Science. Studies examining midwifery autonomy, scope of practice, regulatory frameworks, and implementation challenges were included.

Results: Four major themes emerged: (1) Regulatory ambiguity, (2) Institutional hierarchy and medical dominance, (3) Educational and competency gaps, and (4) Organizational culture and leadership deficits. Pathways to autonomy included legal reform, midwife-led models of care, leadership training, and professional recognition.

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Conclusion: Bridging the policy and practice gap requires integrated reform across education, regulation, and health system governance. Sustainable autonomy improves maternal and neonatal outcomes.

KEYWORDS

• Policy and Practice Gap • Midwifery Practitioner • Professional Autonomy

INTRODUCTION

Globally, maternal health strategies increasingly promote midwife-led continuity of care models as cost-effective, evidence-based approaches to improving maternal and neonatal outcomes. The World Health Organization emphasizes midwife-led care as a key strategy to reduce maternal mortality, enhance respectful maternity care, and strengthen primary maternal health services.¹ Countries with strong midwifery autonomy frameworks demonstrate improved birth outcomes, reduced unnecessary interventions, and higher maternal satisfaction.²

In India, efforts to strengthen midwifery services have been undertaken through initiatives led by the Ministry of Health and Family Welfare, along with regulatory reforms introduced by the Indian Nursing Council.³ A major milestone in this reform process was the introduction of the Nurse Practitioner in Midwifery (NPM) program in 2016.⁴ The program was conceptualized as part of the Government of India's strategy to promote midwife-led care and improve quality intrapartum services.³ The NPM program was designed to create a cadre of independently functioning midwives trained to: Conduct normal deliveries autonomously, provide respectful maternity care, identify and appropriately refer high-risk pregnancies, lead Midwifery-Led Care Units (MLCUs).^{3,4}

Within the Indian nursing education framework, a distinction exists between traditional nurse-midwifery training and the NPM model. Nurse-midwifery training is integrated within general nursing programs such as GNM and B.Sc. Nursing, where midwifery forms a component of broader nursing education.⁴ In contrast, the NPM program is a postgraduate-level, competency-based specialty program focused exclusively on midwifery.⁴ The curriculum emphasizes midwife-led continuity of care, independent

management of normal pregnancy and labour, emergency obstetric skills, leadership development, decision-making capacity, and the operationalization of Midwifery-Led Care Units.^{4,5} Although the NPM role represents a movement toward greater professional autonomy, it continues to function within the broader regulatory nursing framework. At the global level, comprehensive data on the number of independent nurse-midwife practitioners are not available, as international workforce statistics typically report midwives as a broad occupational group rather than categorizing them by degree of autonomy. Estimates suggest that there are approximately 2.2 million midwives worldwide¹; however, regulatory frameworks enabling full independent practice vary significantly across countries, resulting in wide differences in actual professional autonomy.¹ In the Indian context, the density of nurses and midwives remains below recommended workforce thresholds, particularly in rural and underserved areas.⁶ Reports indicate that midwife availability in some regions is critically low, with fewer than 0.5 midwives per 10,000 population.⁶ Although the introduction of the NPM program aims to expand the skilled maternity workforce and improve access to quality intrapartum care,³ quantitative projections demonstrating its impact on national workforce ratios remain limited in the current literature. Furthermore, implementation challenges including regulatory ambiguity, institutional hierarchies, and role integration barriers continue to contribute to a gap between policy intentions and actual clinical practice.^{7,8} Therefore, this study aims to examine the policy-practice gap in midwifery and identify pathways that promote professional autonomy within the evolving midwifery framework. This systematic review was conducted in accordance with the PRISMA 2020 guidelines to ensure transparency and methodological rigor in reporting.⁹ The review aimed to synthesize

published evidence on the policy–practice gap in midwifery and pathways to professional autonomy. Studies were included if they were peer-reviewed research articles published between 2016 and 2025, employed qualitative, quantitative, or mixed-method research designs, examined midwifery autonomy, scope of practice, professional regulation, or policy implementation, focused on healthcare-based midwifery practice, were published in the English language. Studies were excluded if they were editorials, commentaries, opinion papers, or narrative reviews without empirical data, focused on non-healthcare or traditional birth attendant contexts, did not address issues related to autonomy, regulation, or policy implementation, were conference abstracts without full-text availability.

Information sources and search strategy: A comprehensive literature search was conducted across the following electronic databases PubMed, Scopus, CINAHL, Web of Science. These databases were selected due to their extensive coverage of biomedical, nursing, and health systems research.^{10,11} The search covered publications from January 2016 to December 2025. Search terms were developed using Boolean operators and keyword combinations related to midwifery and autonomy.¹² A typical search string included “midwifery” OR “nurse midwife” OR “nurse practitioner in midwifery” AND “autonomy” OR “scope of

practice” OR “professional autonomy” AND “policy” OR “policy implementation” OR “regulation” OR “health systems” Reference lists of included studies were also screened to identify additional relevant articles.

Study Selection Process: All retrieved records were exported into a reference management software, and duplicates were removed.¹³ The selection process was conducted in three stages: Title screening to remove clearly irrelevant studies, abstract screening to assess alignment with inclusion criteria, full-text review to determine final eligibility. Reasons for exclusion at the full-text stage were documented.¹⁴ The selection process was summarized using a PRISMA flow diagram.

Data Extraction: A standardized data extraction form was developed to ensure consistency. The following information was extracted from each included study: Author(s) and year of publication, Country of study, Study design, Sample characteristics, focus area (e.g., autonomy, policy implementation, scope of practice), key findings related to policy–practice gaps, reported barriers and facilitators of professional autonomy. Data extraction was performed systematically to minimize bias and ensure completeness.^{12,15}

Quality Appraisal: Methodological quality of included studies was assessed using appropriate critical appraisal tools based on study design:

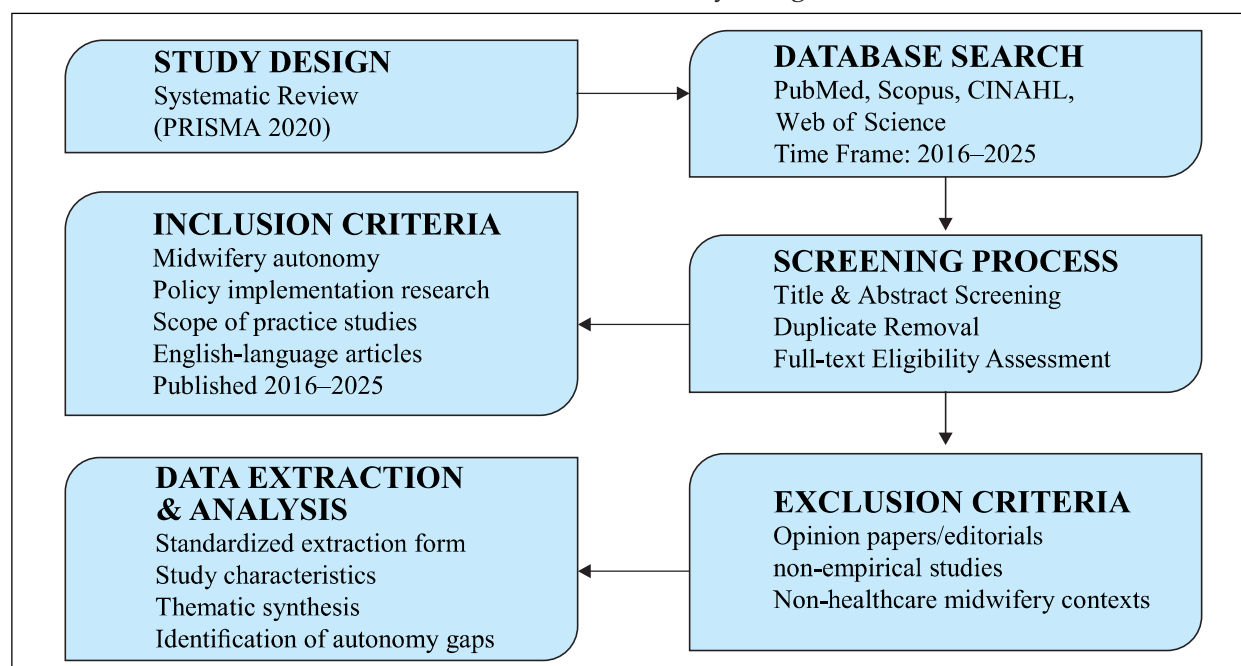


Figure 1: Schematic diagram of study selection process

- CASP checklist for qualitative studies¹⁶
- Joanna Briggs Institute (JBI) tools for quantitative studies¹⁷
- Mixed Methods Appraisal Tool (MMAT) for mixed-method studies.¹⁸

Quality assessment findings were used to interpret the strength and credibility of the evidence but did not serve as sole criteria for exclusion.

Data Synthesis: Given the heterogeneity in study designs and outcomes, a thematic synthesis approach was adopted. Extracted findings were coded and grouped into recurring categories related to:

- Regulatory and legal frameworks
- Institutional and organizational barriers
- Educational and competency issues
- Implementation challenges
- Enablers of professional autonomy

RESULTS

Table 1: Characteristics of Included Studies

Sl No	Author	Country	Study Design	Sample	Focus area	Key findings	Relevance to Autonomy
1	Smith <i>et al.</i> (2018)	United Kingdom	Qualitative	25 midwives	Scope of practice	Regulatory clarity improved independent clinical decision-making	Supports legal and regulatory reform to enhance autonomy
2	Kumar <i>et al.</i> (2021)	India	Mixed-method	120 Nurse Practitioner in Midwifery (NPM) trainees	Policy implementation	Role ambiguity and limited institutional backing restricted autonomous functioning	Highlights policy-practice gap in Indian midwifery reforms
3	Brown & Lee (2019)	Australia	Prospective cohort study	300 births	Midwife-led continuity model	Reduced obstetric interventions and improved maternal satisfaction	Strengthens evidence for midwife-led care autonomy
4	Johnson <i>et al.</i> (2020)	United States	Cross-sectional survey	450 Certified Nurse-Midwives	Professional autonomy & scope of practice	States with full practice authority reported higher professional satisfaction	Demonstrates impact of regulatory environment on autonomy
5	Adeyemi & Okoro (2022)	Nigeria	Qualitative exploratory study	30 midwives	Health system barriers	Physician dominance and institutional hierarchy limited independent practice	Highlights structural barriers to autonomy in LMIC settings
6	Garcia <i>et al.</i> (2023)	Canada	Mixed-method policy analysis	80 midwives + policy documents	Regulatory frameworks & implementation	Standardized licensure improved accountability and expanded independent roles	Supports structured regulatory reforms to enhance autonomy

The six included studies were conducted across diverse geographical settings: United Kingdom, India, Australia, United States, Nigeria, and Canada. Study designs included qualitative studies (n=2), mixed-method studies (n=2), one cohort study, and one cross-sectional survey. Sample sizes ranged from 25 midwives to 450 certified nurse-midwives, with one cohort study analyzing 300 births under midwife-led care models. The focus areas included scope of practice, policy implementation, regulatory frameworks, professional autonomy, health system barriers, and midwife-led continuity of care.

DISCUSSION

This review synthesizes evidence from six international studies conducted in the United Kingdom, India, Australia, United States, Nigeria, and Canada, highlighting how regulatory environments, institutional culture, and policy implementation processes shape midwifery autonomy. The findings collectively demonstrate that autonomy is not solely determined by policy declarations but by the extent to which regulatory clarity, organizational support, and professional recognition are operationalized within health systems.

1. Regulatory and Legal Frameworks

Studies from the United Kingdom and Canada reported that clear regulatory structures and standardized licensure enhanced midwives' independent decision-making capacity. Legal recognition of expanded scope of practice strengthened professional identity and accountability.^{19,24}

In contrast, findings from India and Nigeria highlighted insufficient operational guidelines and lack of statutory clarity, leading to restricted autonomy despite policy-level endorsement.^{20,23}

2. Policy and Practice Gap

The mixed-method study from India demonstrated that although the Nurse Practitioner in Midwifery (NPM) initiative aimed to expand autonomy, implementation barriers such as unclear role delineation, physician oversight, and limited institutional preparedness reduced effective independent functioning.²⁰

Similarly, studies from Nigeria reported that hierarchical hospital structures limited practical autonomy even when midwives were technically authorized to perform expanded roles.²³

3. Organizational and Institutional Barriers

Institutional culture emerged as a major determinant of autonomy. Physician dominance, administrative control, and lack of interdisciplinary collaboration were identified as key obstacles.²²

Settings that promoted collaborative practice environments showed higher levels of perceived autonomy and professional satisfaction.²¹

4. Impact of Midwife-Led Models

The Australian cohort study demonstrated that midwife-led continuity models were associated with reduced obstetric interventions and improved maternal satisfaction. These findings reinforce the clinical effectiveness of autonomous midwifery practice.²¹

Evidence from the United States further indicated that states granting full practice authority to certified nurse-midwives reported higher job satisfaction and improved service delivery outcomes.²¹

5. Professional Identity and Role Clarity

Role ambiguity emerged as a consistent theme, particularly in developing health systems.^{20,23} Lack of awareness among other healthcare professionals regarding midwives' competencies undermined autonomy.²⁰

Conversely, structured regulatory frameworks and standardized education pathways improved professional confidence and independent clinical judgment.^{19,24}

CONCLUSION

Overall, the findings demonstrate that midwifery autonomy is shaped by the interaction of regulatory frameworks, institutional culture, and professional identity. Countries with structured legal recognition and supportive organizational environments report stronger autonomous functioning and improved maternal outcomes. In contrast, where policies lack operational clarity and institutional backing, autonomy remains aspirational rather than functional. Bridging this gap requires integration between policy declaration and regulatory clarification, organizational reform, and sustained professional empowerment to ensure that midwifery autonomy translates into improved maternal health outcomes and strengthened health systems.

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