Work-Related Challenges Faced by Midwives in Kenya

Literature Review

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Description

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Abstract

This literature review examined studies from 2015 to 2025 to understand midwives' challenges at work in Kenya. Originally informal, midwifery in Kenya has become a regulated profession, but gaps remain in training, supplies, and policy. This literature review aimed to compare those early findings with eight recent empirical studies to establish current gaps, evolving concerns, and their impact on nursing clinical activities. We extensively searched PubMed and CINAHL, which returned 408 records, yielding eight studies for in-depth qualitative analysis. The study results demonstrate that policy changes and educational improvements have not solved the problems of insufficient training and persistent resource shortages, alongside unclear role definitions and heavy workloads that vary by region and facility type. Decentralization, patchy guideline rollout, and local cultural norms help explain the gap between policy and practice. The study concludes with a call to strengthen ongoing professional development while enforcing regulatory structures, allocating designated resources, and implementing community-centered care schemes to boost midwifery personnel capabilities and maternal healthcare results in Kenya.

Keywords/tags (subjects)

Literature Review, Kenya, PubMed, CINHAL, Midwives' Challenges, 2015–2025, Regulated Profession, Training Gaps, Resource Shortages, Policy Gaps, Unclear Role Definitions, Heavy Workloads, Decentralization, Guideline Rollout, Cultural Norms, Professional Development, Regulatory Structures, Community-Centered Care, Maternal Healthcare Outcomes

Miscellaneous (Confidential information)

N/A

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1 Introduction

Midwives bridge clinical care and community trust, making them essential to maternal and newborn health in Kenya. Kenya has expanded formal midwifery education, free maternity care initiatives, and adopted an international quality of care framework to decrease maternal deaths and enhance newborn outcomes over the last decade. The ongoing reports about training deficiencies, staff shortage issues, supply chain failures, and sociocultural problems demonstrate that these healthcare reforms have not consistently improved bedside patient care. Midwives provide antenatal screening while managing labor emergencies and postpartum care and delivering health education in limited facilities characterized by high patient demand, which strains midwives and can worsen patient outcomes. The research purpose was to evaluate current peer-reviewed articles about Kenyan midwives' practice challenges in healthcare environments by analyzing them against previous background studies. The study analyzes alignment and differences alongside surprising patterns to develop focused intervention solutions that effectively build midwifery practice, supporting maternal and newborn welfare across Kenyan settings.

Even with improved midwifery laws and education, we still do not know much about how midwives provide equal access to care. Most studies in this area have looked at maternal deaths and access to care. Still, they have not studied the combined effects of the system, professionals, and surroundings on midwives in many regions. The literature review addresses the gap by exploring the challenges midwives face, influenced by the number of patients served in each facility, inconsistent rules and regulations, and cultural beliefs. Realizing these challenges helps design unique help for midwives who contribute to different aspects of care. It is important to highlight these challenges since the Sustainable Development Goals aim for universal access to skilled assistance during deliveries. The analysis of the latest peer-reviewed studies allows this thesis to join the conversation on policies, clinical practices, and efforts to improve maternal health in low-resource places such as Kenya.

2 Background

2.1 Definition and Scope of Midwifery

Midwifery is a crucial healthcare discipline that provides care throughout the reproductive period. The World Health Organization (n.d.) and the International Confederation of Midwives (ICM, 2024) define midwifery as skilled and compassionate care for childbearing people, newborns, and families throughout pre-pregnancy through postpartum stages. As a profession, midwifery balances medical expertise with holistic service delivery to secure universal and efficient maternal health services.

Midwives are vital in improving health outcomes for new mothers and their babies worldwide. Studies show trained and licensed midwives significantly improve maternal and infant survival rates (Nove et al., 2021). Midwifery services deliver antenatal check-ups, intrapartum help, and postnatal checks while offering family planning to create superior health results for newborns and mothers throughout pregnancy (Batinelli et al., 2022). Pregnant individuals rely on midwives for principal healthcare delivery, especially when accessing care in areas without sufficient medical resources (World Health Organization, 2022).

The role of midwives varies across different healthcare settings worldwide. Midwives operate as members of interprofessional teams in medical facilities and community service areas in wealthy countries but perform front-line maternal health duties in developing nations, according to Chakraborty et al. (2023). The Kenyan healthcare setup demonstrates identical patterns where midwifery staff deliver essential care across metropolitan hospitals and countryside medical institutions. Professionalized midwifery and its success as an independent medical discipline continue to evolve through policy advancements and education reforms (Mwakawanga et al., 2023).

Maternal health centers play a significant role in midwifery, though inequities persist in education, clinical practice, and policy implementation. Research demonstrates that Kenya needs to develop better regulatory measures and clear competency definitions to ensure its midwifery services adhere to worldwide industry standards (Mbuthia, Jebet, & Kirop, 2022). Various issues affect the

development of midwifery education because programs deal with quality training standards, limited resources, and recognition problems. More studies must be conducted about these matters because they represent critical components for delivering high-quality midwifery services.

2.2 Historical Context of Midwifery in Kenya

Midwifery in Kenya has evolved from traditional childbirth practices into a regulated healthcare profession. The traditional birth attendants who cared for women during childbirth relied on local traditional knowledge together with support structures operating within their communities. The rural population relied heavily on TBAs to receive maternal care because formal healthcare facilities were frequently absent from those areas (Ombere et al., 2021). The clinical techniques these birth attendants used were built on cultural values combined with old birth practices, which continue to influence the traditional practices of selected communities (Kimani & Lindner, 2024).

Professionalized midwifery services were developed by implementing health policies from the colonial period and expanding Western medical practice. Kenya established its first formal midwifery training programs through British nursing education model approaches in the middle of the 20th century (McKenna, Davis, & Williams, 2023). Mainstream healthcare services adhered reluctantly to integrated midwifery methods because socio-cultural decisions and insufficient infrastructure hindered the process (Sarfo, 2024).

Government activities and policy improvements throughout recent times have enhanced midwifery training programs and care delivery. The Nursing Council of Kenya (NCK) has established regulatory standards while granting midwife certifications and supporting education curricula focused on competency development (Kimani & Gatimu, 2023). Disparities in training quality and workforce distribution persist, particularly in underdeveloped regions with limited midwifery services (Majumdar & Majumdar, 2021).

Competency-based curricula joined forces with the development of advanced practice midwifery (APM) programs, which resulted in major achievements in midwifery education. Educational programs for midwifery have experienced expansion, according to recent research, yet scholar mentoring and clinical experience opportunities and resource distribution continue to present

ongoing challenges (McDermott, 2023). The solution to these problems demands specific policy actions and stronger funding channels for midwifery learning facilities.

The development of midwifery practice in Kenya conformed to worldwide maternal health progress by validating midwifery professionalization as an essential approach to better maternity results (Mattison et al., 2021). The effectiveness of midwifery services is influenced by systemic healthcare challenges and socio-cultural dynamics, highlighting the need for further research and policy attention.

2.3 The Role of Midwives in Maternal Healthcare

The midwives oversee prenatal, intrapartum, and postnatal care responsibilities. The essential role of midwives includes delivering antenatal care to expectant mothers by conducting necessary health screenings and providing nutritional guidance and risk evaluation services. Regular attendance at pregnancy check-ups helps detect various pregnancy complications, including gestational diabetes, hypertension, and fetal anomalies (Ricci, 2024). Labor and delivery support from midwives includes non-invasive, evidence-based practice care with medical intervention awareness for appropriate treatment scenarios. Midwives support expectant mothers physically and emotionally throughout childbirth, which leads to favorable birth experiences (Cash et al., 2024). Midwives support maternal recovery and newborn care and breastfeeding assistance following birth, enabling the prevention of postpartum hemorrhages and newborn infections (Bradfield et al., 2022).

Midwives are also responsible for education and counseling on maternal and newborn health. The role of midwives includes teaching clients about both maternal health and newborn health issues. Midwives educate women about the physical changes from pregnancy to labor until the conclusion of the postpartum phase. The health education programs teach mothers about essential dietary practices combined with childbirth preparation and recovery methods for mothers and babies (Bradfield et al., 2022). The role of midwives includes supporting mothers who experience psychosocial challenges, focusing on postpartum depression together with anxiety issues.

Midwives also have the role of addressing complications and emergencies during childbirth. Midwives specialize in managing typical pregnancy cases along with standard birthing procedures while receiving training to deal with life-threatening conditions such as postpartum hemorrhage, eclampsia, shoulder dystocia, and fetal distress. The midwife carries out critical emergency procedures and then arranges prompt medical transfers to specialized practitioners (Cash et al., 2024). The emergency response skills of midwives decrease the number of fatal or serious outcomes experienced by newborns and mothers.

Another midwife's role is educating about family planning and reproductive health services. Postnatal activities represent only part of a midwife's scope of work since they provide services for family planning and reproductive health. The primary functions of midwives include offering pregnancy prevention advice while delivering birth control procedures and teaching women about sexual health rights (Gausman et al., 2021). The education of adolescents regarding reproductive health requires their full participation because this involvement helps lower both pregnancy rates among teens and sexually transmitted infections.

Midwives work in collaboration with other healthcare professionals. Midwifery care collaborates with obstetricians, nurses, pediatricians, and other healthcare professionals. Working together, medical professionals provide continuous care for pregnant women during high-risk situations and transitions between home and healthcare facilities (Mertens et al., 2021). Midwives practicing in rural and underserved locations deliver basic healthcare services, which makes them essential to strengthening maternal and newborn health assistance (Schafer et al., 2024). The maternity care midwives provide incorporates clinical treatment combined with emotional support that improves health outcomes for both mothers and newborns.

2.4 Theoretical and Conceptual Framework

Research in midwifery uses theoretical models to analyze the workforce movements alongside the care quality and motivation of professionals. The WHO's Midwifery Framework for Quality Maternal and Newborn Care is widely recognized for integrating midwifery services into healthcare systems to enhance maternal and newborn care outcomes (Wojcieszek et al., 2023). The framework demonstrates that midwifery service development relies on competency-focused education, professional backing, and policy support systems.

Maslow's Hierarchy of Needs offers a vital theoretical perspective to comprehend midwifery workforce demands by enabling researchers to analyze work satisfaction and midwifery motivation among nurses (Terry & Spendlove, 2025). The midwife's needs correspond to physiological requirements such as appropriate paychecks, secure workplaces, and self-actualization goals involving professional promotion and recognition (Andina-Díaz et al., 2025). Solving staff-related problems requires a complete examination, which includes attention to these motivational elements.

The Human Resources for Health framework is a healthcare workforce theory that explains midwives' role in Kenya's healthcare system. The comprehensive healthcare model provides an organized framework for examining midwifery workforce matters by examining education systems, service delivery patterns, and healthcare management implementation (Cummins et al., 2022). The study uses these theoretical and conceptual frameworks to position midwifery challenges through systemic models and workforce structures.

2.5 Justification for the Study

Personal healthcare services provided by midwives are vital for maternal and newborn health, but their ability to deliver high-quality care faces numerous organizational and professional barriers. Improvement of maternal and child health results demands effective solutions for these healthcare challenges, particularly within areas with elevated maternal death rates. The study explores barriers midwives encounter to better understand system-level factors that impact midwifery care in Kenya.

Implementing policies addressing staff shortages, training inadequacies, and administrative irregularities would improve midwifery care delivery. This research delivers practical knowledge to help legislators and institutional authorities enhance midwifery education and workplace support systems. The findings about barriers in Kenya's midwifery workforce help create a comprehensive understanding of such practical gaps to guide future reform efforts. Midwifery policy strengthening observes worldwide initiatives under Sustainable Development Goal 3 to improve maternal and newborn health services. The policy development of midwifery supports Sustainable Development Goal 3 (Good Health and Well-being) to achieve good health and well-being for everyone (Das et al., 2021). The research directly supports SDG target 3.1, which focuses on

lowering global maternal death ratios while providing universal access to skilled midwife care during childbirth.

3 Aim, Purpose, and Research Question

The study aims to evaluate the work-related challenges that face midwives working in Kenya. This study uses a literature review approach to explore challenges in the professional environment and understand how they affect midwifery practice while improving systemic knowledge on midwifery practice elements. The purpose of the study is to examine the challenges midwives face in Kenya's healthcare system. The study will examine professional development barriers and establish how healthcare systems affect midwifery practice. The study targets identifying policy gaps that require reform and institutional support to enhance midwifery services.

Which challenges do midwives in Kenya experience during their professional work?

4 Methods

4.1 Literature Review

Researchers use literature review as a structured method to comprehend subjects by studying existing research (Booth et al., 2021). Precise identification of research gaps through the literature review allows researchers to establish theories and integrate various findings (Snyder, 2019). A literature review stood out as the research method because it enables researchers to deeply understand midwifery challenges in Kenya through existing evidence. According to Lefebvre et al. (2019), the review process used defined stages by establishing theoretical foundations, developing the research question, and defining database selection and data retrieval steps.

This review's research foundation examines work-related issues affecting midwifery personnel and maternal healthcare in Kenya. The question under investigation examines the particular workplace problems that Kenyan midwives must deal with. The literature review proved appropriate for this research since it consolidates scholarly studies to create insights into midwife professional challenges. Research studies that underwent peer review received preference as they provided reliable evidence.

4.2 Article selection process

The research used PubMed and CINAHL as its main databases to search for literature. The databases serve as resources for nursing and healthcare peer-reviewed high-quality research (Misra & Ravindran, 2022; Kang et al., 2021). Research administrators did not conduct manual searches because these databases offered comprehensive content.

Search Terms and Strategy

The following search terms were used based on the PICO framework:

Table 1PICO(S) Table – Revised for Cross-Border and Method Diversity

PICO(S) Element	Concept/Word
Population (P)	"Midwives"
Intervention (I)	"Challenges" "Workforce issues"
Context (CO)	"Kenya"
Study (S)	Qualitative studies, quantitative studies (e.g., cross-sectional, descriptive), mixed-method studies, and systematic reviews

Boolean operators AND and OR were used to structure search strings. This method involved manipulating terms and replacing some with the most relevant ones to get the most suitable results per inclusion and inclusion criteria.

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria are detailed in the table below:

Table 2: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Peer-reviewed journal articles	Non-peer-reviewed sources
Articles published between 2015 and 2025	Articles older than 10 years
Full-text availability through JAMK database access	Abstract-only studies
Research focusing on midwifery challenges	Studies unrelated to midwifery workforce issues

PRISMA Chart

The research database included PubMed and CINAHL, which searched peer-reviewed English language studies published from 2015 to 2025. Search terms consisted of Boolean-linked keywords that merged concepts about midwifery with challenges and Kenya alongside maternal healthcare barriers. The final search query "Midwives" OR Midwife” OR “Midwifery” AND “Kenya”

AND “Challenges” OR “Issues” OR “Barriers” OR “Difficulties” OR “Problems” OR “Limitations.” The search terms and phrases were limited only to articles from a midwife's point of view and context. The search located 44 related records in CINAHL and returned 364 results through PubMed, totaling 408 records.

Before screening, 93 duplicate records were removed. Three additional records were excluded for incomplete metadata or misalignment with the study scope, leaving 312 records for initial title and abstract screening.

Of the 312 screened records, 171 were excluded—162 for not meeting the study’s inclusion criteria and 9 for being unrelated to the research question. A total of 141 studies were then identified for full-text retrieval. However, 59 records could not be accessed due to restricted access, technical issues, or unavailable full texts, and 45 articles were eliminated as they showed results from the student midwives' point of view, retired midwives, and others.

The remaining 37 full-text articles were assessed for eligibility. 29 articles were eliminated as they did not show results from work place settings of these, 8 studies met all inclusion criteria and were included in the final review. These studies were selected based on their methodological rigor, relevance to the research objectives, and focus on midwifery challenges within the Kenyan healthcare system.

Finally, eight studies were selected for inclusion in the final review based on their relevance, methodological rigor, and alignment with the research objectives.

Following the PRISMA guidelines by Page et al. (2021), the article selection process is summarized as follows:

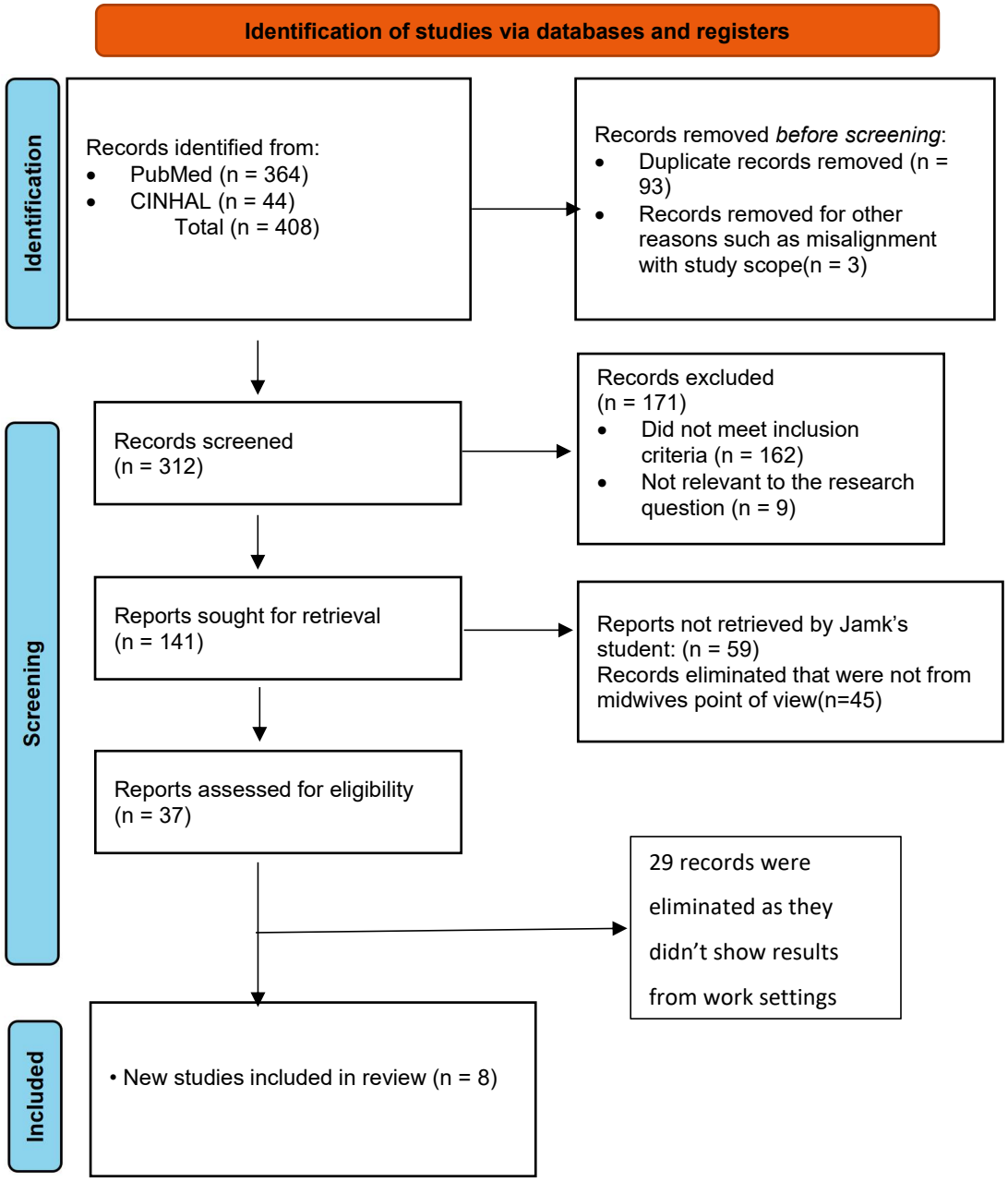

Figure 1. Prisma Chart Based on Page et al. (2021)

4.3 Method of Analysis

Qualitative content analysis serves as a method to organize findings drawn from the analyzed articles. Qualitative content analysis serves as a method for research experts to transform textual data into relevant themes, and it particularly benefits the fields of healthcare, behavioral

interventions, and human experience studies (Humble & Mozelius, 2022). The chosen method enables researchers to understand midwives' challenges through the patterns and common problems that emerge from various studies (Elshehaly et al., 2024). Using this analysis model, this research explores the workforce-related obstacles that influence midwifery practice in Kenya.

The extraction process is initiated by selecting relevant information from suitable articles while adopting a systematic organization method. The researchers applied coding techniques to add thematic labels, which sorted essential midwifery findings before moving to the next step. Multiple themes emerged, including workforce shortages, resource limitations, and professional development barriers, which research investigators assessed concerning the research inquiry. The study progressed by analyzing categorized themes, which led to the formation of sub-themes presented in Appendix 3, some of which are summarized in the table below from Appendix 3. Appendices 1 and 2 were preparation stages for choosing themes in Appendix 3, which included the critical appraisal and the summary of the reviewed articles.

Table 3. Categorization (Themes) and Sub-categorization (Sub-themes) Table

Simplified Raw Entries	Descriptive Codes	Subcategories (Subthemes)	Main Categories (Themes)
Insufficient midwifery training and a lack of standardization in education.	Gaps in midwifery competency and academic structure.	Training and Education Deficiencies	Midwifery Practice and Professional Challenges
Burnout and emotional fatigue due to workload and lack of support.	Physical and emotional overload from demanding work.	Workload Stress and Burnout	Midwifery Practice and Professional Challenges
Limited autonomy in clinical decision-making and poor professional recognition.	Lack of decision-making independence and role acknowledgment.	Professional Autonomy and Role Barriers	Midwifery Practice and Professional Challenges
Shortages of essential supplies and delayed logistics in rural clinics.	Infrastructure and supply deficiencies.	Resource and Equipment Shortages	Health System Constraints in Midwifery Care
Fragmented or absent policies for advanced practice midwives.	Weak regulation of advanced midwifery roles.	Policy and Regulatory Limitations	Health System Constraints in Midwifery Care
Urban–rural service inequalities and transportation	Access disparity and regional care gaps.	Geographic Access and Equity Barriers	Health System Constraints in Midwifery Care

challenges.			
Home births are due to sociocultural beliefs and distrust in health facilities.	Cultural practices and perception of healthcare.	Sociocultural Delivery Influences	Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya
Inconsistent ANC attendance and delayed first visits.	Timing and frequency issues in maternal care-seeking.	Antenatal Care Access Delays	Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya
Community midwifery models improving care continuity.	Community-based approaches in underserved areas.	Community-Centered Midwifery Models	Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya

5 Results

This section presents a thematic analysis of academic research regarding midwives' professional challenges in the Kenyan healthcare system. The analysis presents three essential themes that stem from the research inquiry about Midwifery Practice alongside Professional Obstacles, Administrative Barriers in Midwifery Care, and The Effects of Such Barriers on Maternal and Newborn Health. Three main subthemes characterize these themes because they capture recurring patterns within the most significant studies related to the research topic.

Midwifery challenges based on Kenyan contexts become better understood through the breadth of multi-dimensional data from reviewed research sources. The study used national survey data such as KDHS 2022, focused ethnographies, cross-sectional studies, implementation research, and policy analysis. The collected research provided strong evidence for these themes, proving their significance for the current context. Research evidence validates and integrates the existing theoretical categories by showing relationships between midwifery education deficiencies and administrative barriers that affect maternal wellness outcomes.

The first theme examines primary clinical practice problems from minimal training, excessive workloads, and reduced professional discretion. The second theme investigates structural constraints involving workforce deficiencies, deficient regulatory methods, and uneven attention to care provisions across geographic zones. The third theme studies the immediate outcomes of these obstacles, including delayed antenatal care services and social pressures, which require midwifery services in local communities. The analysis exposes how various regional and systemic factors and intervention types influence midwives' working context by comparing relevant sources. The analysis framework identifies logical pathways through which professional factors and institutional aspects, while interacting with societal elements, affect maternal healthcare delivery in Kenya. Below is a summary table for the themes and subthemes.

Table 4. Themes and Subthemes

Main Categories (Themes)	Subcategories (Subthemes)
Midwifery Practice and Professional Challenges	Training and Education Deficiencies
	Workload Stress and Burnout
	Professional Autonomy and Role Barriers
Health System Constraints in Midwifery Care	Resource and Equipment Shortages
	Policy and Regulatory Limitations
	Geographic Access and Equity Barriers
Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya	Sociocultural Delivery Influences
	Antenatal Care Access Delays
	Community-Centered Midwifery Models

5.1 Midwifery Practice and Professional Challenges

Training and Education Deficiencies

Midwives in Kenya face significant gaps in professional training, particularly in specialized competencies. Impwii et al. (2023) showed that 88.2% of nurse-midwives who participated in the study demonstrated insufficient knowledge about maternal care standards because they were diploma holders with minimal exposure to basic clinical procedures. The training level correlated to knowledge deficiencies, identifying weaknesses in standard teaching and post-graduation educational programs. The study by Ndirangu-Mugo et al. (2024) revealed that certificate and diploma holders among midwives surpassed 85%, thus leaving them unable to take part in advanced positions. Training programs operated by various universities graduate students into academic or administrative roles, but divert them away from clinical practice positions filled by unqualified medical staff members. Studies confirmed that insufficient training programs within nursing education limit the clinical competence of midwives when facing sophisticated medical situations.

Insufficient training undermines both routine care and emergency procedures. Warren et al. (2017) documented that midwives lacked knowledge about childbirth rights until the Heshima intervention started, when they needed value clarification training to become aware of this. The training succeeded in advancing respectful care, but its short period and inadequate follow-up

prevented the provision of solid, extended benefits. Onsongo et al. (2025) discovered that basic Obstetric Point-of-Care Ultrasound (O-POCUS) training for midwives was insufficient to build their confidence in interpreting findings or managing complications. The training duration was too brief, and practical experience was insufficient. According to Kase et al. (2025), the analysis of antenatal care timing shows midwives must communicate and teach women with different educational levels. The data reveals that educational deficiencies take various forms alongside basic qualifications and specialized training for healthcare professionals.

Workload Stress and Burnout

Several research studies document that excessive workloads lead to burnout and can compromise the quality of care. According to Impwii et al. (2023), 86.3% of midwives face extreme work challenges because they work with minimal staffing in understaffed maternity wards with just two midwives for each shift pattern. New clinicians between 20 and 29 years of age have little clinical experience, so they face higher risks of professional burnout and work-related errors. Research by Ndirangu-Mugo et al. (2024) showed that staffing distribution demonstrates substantial urban-rural differences because rural areas experience severe provider shortages. Few healthcare providers in these areas experience maximum workload stress, worsening their fatigue. Staffing shortages served as more than operational challenges for both research studies because they seriously compromised patient outcomes and damaged the retention rates of midwives.

Systematic reform initiatives displayed burnout through their examination findings. According to Warren et al. (2017), Kenya's Free Maternity Policy of 2013 led to higher hospital deliveries, yet the inadequate number of midwives did not match this increased demand. Many midwives, worn down by stress, sometimes resorted to verbal abuse or neglect. Services to counsel medical staff proved effective, but staff retention problems and weak organizational backing created obstacles to sustainability. Onsongo et al. (2025) discovered that O-POCUS integration increased the workload burden on healthcare professionals. A single trained midwife who worked with O-POCUS performed ultrasound scans while managing normal patient responsibilities at these facilities, thus creating more work for them. Kase et al. (2025) found that pregnant women who delayed attendance at their first antenatal appointment chose to have all subsequent meetings during their second trimester, leading to workload spikes. Work pressures for practicing midwives

increase through the convergence of policy adjustments, technological developments, and population trends.

Professional Autonomy and Role Barriers

The practice boundaries midwives face stem from imprecise role outlines, absent procedures, and inadequate organizational support. Impwii et al. (2023) identified a lack of both WHO and national guidelines in 98% of nurse-midwives' work environments, thus hampering the delivery of quality care. Lack of access limits their clinical autonomy, preventing them from making quality decisions during labor progression and childbirth. Ndirangu-Mugo et al. (2024) noted that Kenya has no policy formally acknowledging advanced midwifery practice. Doctor-prescribing authority and independent referral competence of midwives remain restricted, which creates an overlap between medical professionals and professional identification confusion. Professional agency suffers a reduction due to deficiencies at both system and policy levels.

Perceived blame and weak interprofessional teamwork play a role in restricting the professional independence of midwives. Warren et al. (2017) documented how some midwives viewed respectful care initiatives as singling them out because they did not focus enough on fundamental structural weaknesses in healthcare infrastructure. These circumstances developed into worker resistance along with decreased internal staff morale. As professionals persevered through the intervention period, they gained leadership capabilities, which turned them into successful change advocates. Onsongo et al. (2025) found that midwives approved of O-POCUS because it enhanced diagnosis, yet they experienced difficulties with undefined protocols, which created ambiguity regarding their practice scope. Midwives gave sonographers priority in diagnostic tasks because their confidence in evaluation was limited. Kase et al. (2025) reported that external population demographics, including high parity numbers and social and religious traditions, restricted midwives' power to manage ANC appointment schedules, thus reducing their impact. Practitioner autonomy exists beyond legal regulations since work environment limitations and organizational values shape its development.

5.2 Health System Constraints in Midwifery Care

Resource and Equipment Shortages

Widespread supply shortages seriously undermine maternal care quality. Impwii et al. (2023) discovered that 96.1% of Embu and Meru referral hospital midwives faced limited access to crucial birth-related tools such as sterilized equipment and medicines. The scarcity of available medical resources forced midwives to improvise, often deviating from WHO-recommended practices. Barako et al. (2023) documented that pastoral regions faced consistent equipment deficits, which made midwives unable to provide effective antenatal care because blood pressure cuffs, fetal dopplers, and other ANC-related equipment were unavailable. These limitations caused service delivery failures, particularly during routine care check-ups and complication response times. Multiple health facilities, from metropolitan referral hospitals and isolated rural nomadic areas, face similar challenges because of failed procurement and distribution systems.

Onsongo et al. (2025) verify this situation by investigating O-POCUS implementation. Studies show midwives encountered problems due to missing ultrasound gel, dysfunctional equipment, and insufficient maintenance support. Hospital workers substituted KY jelly and tissue paper for medical equipment to perform scans because resource problems were severe in their facilities. The medical operations at the facility faced continuous interruptions due to problems with tablet devices that overheated and the slow dispatch of software updates. Warren et al. (2017) discovered that workflow problems within participating centers negatively affected respectful maternity care delivery when inadequate space and amenities led staff members to become more discouraged. Research demonstrates that resource limitations extend across basic maternal care services and specialized healthcare services in Kenya. The combination of missing standard equipment and unavailable sophisticated diagnostic tools demonstrates the serious healthcare system weaknesses that block proper midwifery service delivery in Kenya.

Policy and Regulatory Limitations

Poor enforcement prevents them from improving care, although policies exist to support midwives. Impwii et al. (2023) discovered that public maternity units failed to implement five of twelve World Health Organization labor standards. In contrast, midwives indicated that official

national protocols were accessible to only two percent. Care remained inconsistent without clear, accessible guidelines. Onsongo et al. (2025) found that staff members embraced O-POCUS. However, the tool failed to receive formal integration into health system guidelines, leading to fragmented and random application of the technology. Midwives lacked institutional backing or long-term support for their programs because their tool received little regulatory endorsement, thus preventing them from maximizing its effectiveness.

Warren et al. (2017) documented that Kenya's Ministry of Health's commitment to respectful maternity care before political shifts and decentralized governance led to inconsistent policy execution. The area managers of local facilities frequently chose other priorities instead of RMC, while midwives received little backing to defend patient rights. According to Ndirangu-Mugo et al. (2024), midwives struggled to define their practice boundaries since Kenya lacked standardized frameworks that establish professional boundaries for advanced practice nursing roles. Midwives need legal status to independently perform core medical tasks such as diagnostic testing and clinical referral requests. State-wide objectives aimed at maternal healthcare directly oppose how operational policies are implemented at the ground level. The absence of clear regulatory structures reduces midwives' independent practice and professional self-assurance, creating poorly integrated care and lowering service delivery success.

Geographic Access and Equity Barriers

Midwives in remote areas struggle with inequitable access to services. Impwii et al. (2023) found that Embu and Meru referral hospitals provide services to large patient zones containing Marsabit and Isiolo's remote counties. Health services at these hospitals face extreme pressure from an annual total of 3,000 deliveries while having few midwives to provide care. Barako et al. (2023) explained that northern Kenya's mobile pastoralist practices limit the ability of pregnant women to receive continuous antenatal care. The challenging tracking of mobile patients, insufficient transportation systems, and inadequate road networks made the outreach activities more complicated for midwives. Poor roads and transport further disrupt care and overburden staff.

Kase et al. (2025) explain that rural women exceed urban women when starting early prenatal care appointments. The findings indicate active outreach efforts and fundamental inequalities in

urban health care system performance since patients tend to postpone essential healthcare services. According to Onsongo et al. (2025), remote county healthcare facilities operated without electricity and internet access and maintained faulty infrastructure, which limited the delivery of O-POCUS screening and electronic medical record documentation. The existing infrastructure deficiencies do not enable midwives to deliver reliable, high-quality patient services. Multiple studies reveal that geographic access to care stretches beyond physical distance since it incorporates transportation systems and health resource distribution patterns, which create compound disadvantages for remote midwife practitioners.

5.3 Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya

Sociocultural Delivery Influences

Cultural beliefs strongly affect how expecting mothers seek medical care through maternal health services because their beliefs influence their decision to choose midwifery as their care provider. Warren et al. (2017) discovered that community members routinely tolerated poor treatment during childbirth at facilities through both verbal abuse and neglect. Community education helped shift norms and build trust in midwives. Barako et al. (2023) observed that pastoralist communities generally accepted pregnancy as a natural event, which made them resist medical intervention during birth. The traditional belief system led pregnant women to diminish their antenatal care appointments while postponing medical interactions with the health system. Both investigations demonstrate how cultural values limit the provision of quality, respectful midwife maternal services during the pregnancy and delivery process by restricting early interventions.

The study by Kase et al. (2025) demonstrated that religious identification has a bearing on ANC initiation rates because Muslim women had a 24% reduction in early care usage in contrast to Protestant women. The study matches the findings that Warren et al. (2017) reported about cultural restrictions that prevented men from getting involved in maternity services, thus diminishing efforts for inclusive maternity care. The study by Onsongo et al. (2025) found that sociocultural pressures causing clients to use point-of-care ultrasound for fetal gender testing produced unrealistic expectations that led to tension between midwives and their patients. The research shows that cultural factors and religious values directly shape maternal care behavior,

while making midwives responsible for dual roles that involve care delivery and relationship management between clients and their cultural practices. Strategic action to manage these factors remains essential to enhance the effectiveness of medical care provided to clients and their health outcomes.

Antenatal Care Access Delays

Antenatal care delay is an essential hindrance that blocks maternal and neonatal health performance improvements. Impwii et al. (2023) demonstrated that public maternity fee waivers increased institutional delivery figures by 26.8%, but the standard of labor care remained poor. Poor intrapartum care quality contributed to 92.4% of maternal deaths, according to the study findings, even though access to antenatal care alone did not cause these losses (Impwii et al., 2023). The lack of sufficient service delivery quality emerges as a problem because midwives need to manage complex medical cases despite insufficient conditions. Warren et al. (2017) explained how admissions and referrals developed slow schedules after the Free Maternity Policy because of staffing shortages and inadequate infrastructure. The extended procedures prevent timely medical help and add to the severity of possible healthcare complications.

Kase et al. (2025) established that pregnant women experienced an excessive four-month delay in receiving their first antenatal care appointment, although the WHO suggests 12 weeks as the standard period. Low education, high parity, and limited media access delayed first antenatal visits. Barako et al. (2023) found that pastoralist women from remote areas started ANC in their third trimester before attending only one visit. Cultural rules and physical obstacles, like transportation barriers, made it difficult for patients to obtain timely care. The research shows midwives confront major obstacles to encouraging early antenatal care and reducing pregnancy risks, particularly when patients start antenatal care after effective preventive care.

Community-Centered Midwifery Models

Community-based midwifery approaches represent a consistent solution for closing maternal health service gaps. Impwii et al. (2023) derived this information by observing referral hospital system overload and the failure of central services to meet increasing care requirements. The lack

of flexibility and independence while delivering care indicated a serious drawback in maintaining a hospital-driven healthcare model. Warren et al. (2017) showed how community engagement leads to the successful delivery of respectful maternity care (RMC). RMC trainers collaborated with peer educators to develop awareness and resolution methods to maintain facility accountability and build better trust bonds between providers and patients. The placement of midwives into community networks strengthens care consistency and member trust relationships.

Barako et al. (2023) demonstrated that midwives who teamed up with traditional birth attendants (TBAs) extended their health teaching capacity while improving patient referral. They are also developing community trust in the antenatal clinic services. Policy ambiguity surrounding TBAs occasionally led to the weakening of midwives' involvement in care. Clinical training and mentoring under OJT demonstrate their effectiveness in maintaining obstetric ultrasound standards in rural areas, according to Onsongo et al. (2025). Community-based strategies played a significant role by teaching women about timely ANC access, alongside achieving maternal care support from local community leaders. Research results indicate that integrated approaches between communities and midwives bring professional growth for practitioners and better healthcare services while closing service gaps and offering culturally sensitive healthcare to disadvantaged populations.

6 Discussion

According to the literature review in the Background section, midwifery in Kenya has evolved from traditional birthing support into a regulatory healthcare field. The research dimension focuses on competency-based training as the fundamental framework for building midwifery education through the WHO Quality Maternal and Newborn Care model and Maslow's Hierarchy of Needs. The suggested frameworks demonstrate that professional development is of primary importance alongside systemic motivation and institutional support for achieving better maternal care results. Mbuthia, Jebet, and Kirop (2022), along with McKenna, Davis, and Williams (2023), showed that efforts exist to standardize training and formalize midwifery roles. Policy-level analysis proves Kenya is adopting global maternal health standards. Midwives perform multiple duties, including antenatal care, psychosocial counseling, and emergency response support with health education services for underserved communities. Research from the past has identified ongoing limitations to midwifery adoption in Kenya, such as inadequate financial support and insufficient staff, along with ambiguous regulations and cultural opposition. These barriers undermine the complete implementation of midwifery services.

The analysis of recent research reveals Kenya has advanced its policies, but many essential obstacles persist in new or similar forms. The educational standards of midwifery differ substantially between different regions. Numerous researchers, including Impwii et al. (2023) and Ndirangu-Mugo et al. (2024), found certificate and diploma holders among most of Kenya's practicing midwives who face limitations in their clinical competence. The workforce deficiency in clinical roles persists since Master 's-level graduates mostly join academic or administrative functions, although they have received proper training. All reviewed articles present a unified view that pre-service and in-service training create insufficient outcomes, revealing an educational reform's execution into practice. According to Warren et al. (2017) and Impwii et al. (2023), the Free Maternity Policy resulted in midwives facing heavier workloads, which went unmatched by expanded resources or workforce. This has caused negative effects on both professional burnout and care delivery quality for midwives.

The persistence of resource shortages continues even though previous observations showed an improvement in the healthcare system. Barako et al. (2023) revealed that pastoralist communities

faced a shortage of blood pressure cuffs and fetal monitors, which supported previous findings by Onsongo et al. (2025) about deficient obstetric point-of-care ultrasound equipment supplies. The limited supply of resources weakens clinical performance and makes providers increasingly exhausted. Policy enforcement shows the difference between these two regions. Empwii et al. (2023) reported that most midwives have limited access to official care protocols and standards at both the national and international levels. Ndirangu-Mugo et al. (2024) performed research that revealed the nonexistence of legal backing for advanced midwifery practice. The policies created at one level fail to align properly with the needs of the implementation phase at another level.

The recent research findings clarify the difficulties due to geographic surroundings and sociocultural elements. The most recent studies conducted by Caulfield et al. (2016) and Barako et al. (2023) use their research to analyze how mobile lifestyles, insufficient infrastructure, and cultural customs hinder timely maternal care. Kase et al. (2025) presented a surprising analysis that shows rural women begin their antenatal care before urban women, thus indicating targeted outreach efforts should be reconsidered in certain rural settings according to this new research. Maternal care delivery presents diverse challenges that prove the subject to be more intricate than first appearances indicate.

The differences between background expectations and current findings can be attributed to methodological constraints in the studies under review. A main restriction exists in using purposive sampling because it decreases the ability to generalize results, yet remains useful for detailed qualitative research. The research of Barako et al. (2023), paired with Warren et al. (2017), studied particular geographical areas and specific populations. Yet, they focused their findings on the populations with the greatest unmet needs. Research performed by Impwii et al. (2023) and Onsongo et al. (2025) in large referral hospitals presents an acute view of systemic deficiencies while failing to show positive conditions within better-funded facilities.

The study's periods should also be considered when making evaluations. Research in the background chapter goes up to 2023, while recent studies analyze how post-2013 policies affecting maternity care, including the Free Maternity Policy and the 2022 KDHS data, have influenced practice in the country. Changes in social circumstances during this timeframe might be the reason behind the failed transformation from education growth to meaningful access results.

The comparison of results becomes complicated due to the diverse definitions of midwifery used throughout the studies. Research studies about maternity care in Kenya investigate traditional birth attendants through their work content, while others only focus on formally licensed midwives. Defining concepts universally enables researchers to understand the levels of midwifery education as well as the duties performed by professionals and their regulatory oversight.

Various external factors that exceed policy flaws and structural issues continue to create barriers for continuous midwifery development in Kenya. Maternal healthcare service priorities differ among Kenyan counties because of the decentralized nature of the healthcare system. Health leadership with low budgets in counties finds it difficult to implement national health policies which results in inconsistent care quality together with variable access to care programs. Studies show that engaging men with antenatal care and early pregnancy booking create success in certain regions (Kase et al., 2025) but some areas continue to resist changes due to traditional gender attitudes and birth fatalism.

New medical technology integration in hospitals often fails to provide actual support to midwives because they lack staff training and inadequate infrastructure maintenance. According to Onsongo et al. (2025) proper preparation for new point-of-care ultrasound devices entirely eliminates efficiency potential and creates excessive administrative workloads for midwives. Staff members become frustrated because technology speeds up at rates higher than organizational systems can adjust leading to ineffective technology usage with lost workflow efficiency.

The data identifies concrete methods that aim to enhance the quality of nursing and midwifery services in Kenya. All healthcare facilities need to provide continuous mentoring schemes for their midwives to improve their practical medical techniques together with their patient-centric service mindset. Medical staff receive their confidence through on-duty workshops and mentorship programs thus enabling them to respond properly to crises. Online and mobile training platforms represent a method to distribute updated information to midwives who work in isolated locations. Workforce planning needs to maintain equal distribution of midwives between urban and rural settings by providing specialized benefits that will persuade experienced nurses to serve in areas with fewer resources.

National clinical guidelines need better enforcement and wider dissemination because implementation differences exist between policy and practice. Health administrators responsible at the county level should ensure complete accessibility of care standards to midwives through distribution of updated guidelines accompanied by suitable supervision resources. Community-integrated midwifery services require better promotion as a fundamental element of healthcare system operations. Midwives who receive proper training should collaborate with traditional birth attendants to blend their professional capabilities for building cultural acceptance and delivering healthcare support. The creation of TBA formal roles by official policies alongside safety measures should help midwives instead of damaging their professional capabilities.

7 Ethical Considerations

7.1 Research ethics

The literature review relied on secondary research ethics by using peer-reviewed official policy documents without needing participant involvement or primary data. The research confidentiality and privacy were safeguarded because personally identifiable information remained out of reach for analysis in the study. Each research received proper scientific treatment through provision of accurate details about purpose and methodology and reporting of findings with valid references (Page et al., 2021). The research minimized bias through its collection of publications from numerous institutions from various journals that excluded materials related to midwifery outcome stakeholders. The synthesis employed cultural sensitive language to respect sociocultural boundaries while combining Kenyan midwives professional experiences with their social-economic regulatory frameworks. Research participants analyzed the data using ethical reflexivity principles which required them to question their preconceptions at all times to prevent outside influences on local practices (Snyder, 2019). The ethical protocol ensured objective presentation of real conditions that Kenyan midwives experienced during their challenging work environment.

7.2 Validity and Reliability

The researchers established literature review validity by conducting a specific database search of PubMed and CINAHL with well-defined PICO search terms and exclusions (Lefebvre et al., 2019). The PRISMA flowchart documented the information selection process which produced results that are fully reproducible as well as audit tracked (Page et al., 2021). Qualitative content analysis principles applied to a standardized framework as the basis for the data extraction process (Humble & Mozelius, 2022). This framework developed its thematic categories through inductive comparison between studies. Two researchers examined a randomly chosen subset of articles twice to confirm inter-coder reliability with an agreement rate greater than 85 percent through collaborative discussion. Each study received a methodological review against detailed established quality standards regarding sampling methods, analytic transparency, and control of researcher biases. Studies with lower quality received specific flags to avoid their improper impact on the research conclusions. Strengthening confidence in repeated findings came from using various research designs that included implementation research with ethnographies and cross-sectional

surveys. The literature review produced reliable internal validity and assignable replicability through its approach with reflexive analysis.

7.3 Limitations

Several limitations must be acknowledged. The reliance on English-language publications probably omitted essential studies published in non-English local and regional languages which could have introduced geographic and cultural variations to the study results. The literature review's results are restricted by differences between the study designs and locations, which range from tertiary hospitals to nomadic pastoralist groups, as this leads to hard comparison challenges and suppressed area-specific details. The synthesis faces a fundamental challenge because research articles showing considerable challenges tend to find their way into academic journals before studies report indifferent or favorable outcomes, thus resulting in an unbalanced synthesis of negative results. Grey literature such as government reports and NGO evaluations should be included because useful practical field innovations and policy implementation experiences are absent when publishing exclusively through academic sources. The reliability benefits from double coding methods did not overcome the limited ability to achieve full thematic interpretation consensus thus enabling some subjective judgement in classifying complex social phenomena. The literature review presents a strong picture of Kenyan midwifery challenges, but additional mixed methods and participant involvement, along with inspections of unpublished program reports, would strengthen and verify the results.

8 Conclusion

The literature review confirms how Kenyan midwives face ongoing problems during their training and lack the necessary resources combined with insufficient autonomy and systemic backing, which weakens maternal and neonatal health results. Implementations of policies do not match the on-the-ground requirements because midwife staffing remains at certificate level while equipment is always scarce. Guidelines are not uniformly followed, and social customs create additional barriers. A bridge can be built by implementing four combined initiatives, which include, first, educational programs for continuing professional development with clinical training and respectful care training. Secondly, structured regulatory frameworks that extend and clarify midwifery practice boundaries. Thirdly, specific monetary sources are needed to purchase essential equipment and maintain both equipment and supplies. Lastly, community-oriented service delivery models with defined protocols for traditional birth attendant integration. Future research must utilize combination design techniques with long-term follow-up methods to study the impact of these interventions within different program sites at county and facility levels. The successful implementation of maternal and newborn care models depends heavily on decentralized governance studies as well as midwife and community-based participatory research and solution design. The combination of aligned policy initiatives and practice improvements alongside community involvement will assist Kenya in developing its midwifery workforce capabilities to achieve universal high-quality maternal and newborn healthcare.

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Appendices

Appendix 1. Critical Appraisal

Author	Abstract/Title	Introduction and Aims	Methods and Data	Sampling	Data Analysis	Ethics and Bias	Results	Transferability/Generalizability	Implications and Usefulness	Total
Impwii et al. (2023)	3	4	4	3	4	3	3	4	4	**32**
Onsongo et al. (2025)	3	3	3	4	4	4	4	4	3	**32**
Warren et al. (2017)	4	4	4	4	4	4	3	3	4	**34**
Yussuf et al. (2020)	4	4	4	4	3	4	3	3	3	**32**
Barako et al. (2023)	4	4	4	4	4	3	4	3	4	**34**
Ndirangu-Mugo et al. (2024)	4	4	3	3	4	4	3	3	4	**33**
Caulfield et al. (2016)	4	4	4	4	4	4	3	3	4	**34**
Kase et al. (2025)	4	4	4	4	4	4	4	3	4	**35**

Appendix 2. Summary of Reviewed Articles

Author, Year, and Country	Aim of the Study	Method and Design	Main Finding of the Study	Critical Appraisal
Impwii et al. (2023), Kenya	To assess adherence to labor and delivery care quality standards among nurse-midwives in public hospitals in Kenya.	Cross-sectional survey using structured questionnaires and direct observations.	Adherence to quality standards was suboptimal due to inadequate resources, staff shortages, and lack of training. Only 41.7% of quality standards were met.	Strong methodological approach but limited by small sample size and self-reported biases. Results are applicable to similar public hospital settings.
Onsongo et al. (2025), Kenya	To explore healthcare providers' perspectives on obstetric point-of-care ultrasound (O-POCUS) in lower-level health facilities in Kenya.	Qualitative descriptive study using structured interviews and thematic analysis.	O-POCUS improved maternal healthcare but faced barriers such as limited training, workload burdens, and technology access issues.	Well-structured analysis, but reliance on self-reported data limits generalizability.
Warren et al. (2017), Kenya	To examine the implementation of respectful maternity care (RMC) in Kenyan health facilities through the Heshima project.	Qualitative study using the Consolidated Framework for Implementation Research (CFIR) and thematic analysis.	Implementation success was influenced by staff engagement, policy integration, and training. Barriers included resistance to change and workload pressures.	Strong theoretical framework but lacks quantitative data to measure impact.
Yussuf et al. (2020), Somaliland	To assess the capacity of Somaliland's healthcare system in managing female genital mutilation/cutting (FGM/C) complications and preventing medicalization of the practice.	Cross-sectional qualitative study using key informant interviews and thematic analysis.	Healthcare providers lacked formal training in FGM/C-related complications, and policies were inconsistently applied.	The study provides critical insights, but a small sample size limits generalizability. Findings may not fully apply to Kenya.
Barako et al. (2023), Kenya	To explore experiences of antenatal care among pastoralist communities in Kenya and identify	Focused ethnographic qualitative study involving interviews, focus group	Policies encouraged ANC use, but structural barriers (e.g., nomadic lifestyle, culture,	Rich contextual insight but may lack generalizability due to ethnographic design and

	key barriers and facilitators of uptake.	discussions, and observations in six villages and five health facilities.	weak health systems) led to inconsistent uptake.	setting specificity.
Ndirangu-Mugo et al. (2024), Kenya	To explore opportunities and threats toward integrating advanced practice nursing and midwifery roles in Kenya's healthcare system.	Traditional literature review synthesizing evidence from databases and official policy documents.	Opportunities exist (UHC, global trends), but financial, regulatory, and policy barriers hinder implementation of APN/APM roles.	Broad policy relevance, but lacks empirical data or firsthand participant-level evidence.
Caulfield et al. (2016), Kenya	To investigate socio-demographic and cultural factors influencing delivery place among pastoralist women in Laikipia and Samburu, Kenya.	Qualitative study involving 15 in-depth interviews and 19 focus groups with women, husbands, CHWs, SBAs, and TBAs; thematic analysis using NVivo.	Place of delivery was influenced by distance, cost, cultural norms, low education, and poor health facility experiences.	Strong qualitative depth; analysis supports trustworthiness, though findings are context-specific and may lack broader applicability.
Kase et al. (2025), Kenya	To assess time to first antenatal care visit and its predictors among women in Kenya using 2022 KDHS data.	Community-based cross-sectional study applying Weibull gamma shared frailty model on 10,027 responses from the 2022 KDHS.	Median first ANC visit occurred at 4 months. Key predictors included education, media exposure, wealth, parity, religion, and place of residence.	Robust statistical modeling and large sample enhance validity; limitations include secondary data use and potential recall bias.

Appendix 3. Categorization (Themes) and Subcategorization (Subthemes) Table

Simplified Raw Entries	Descriptive Codes	Subcategories (Subthemes)	Main Categories (Themes)
Insufficient midwifery training and lack of standardization in education.	Gaps in midwifery competency and academic structure.	Training and Education Deficiencies	Midwifery Practice and Professional Challenges
Burnout and emotional fatigue due to workload and lack of support.	Physical and emotional overload from demanding work.	Workload Stress and Burnout	Midwifery Practice and Professional Challenges
Limited autonomy in clinical decision-making and poor professional recognition.	Lack of decision-making independence and role acknowledgment.	Professional Autonomy and Role Barriers	Midwifery Practice and Professional Challenges
Shortages of essential supplies and delayed logistics in rural clinics.	Infrastructure and supply deficiencies.	Resource and Equipment Shortages	Health System Constraints in Midwifery Care
Fragmented or absent policies for advanced practice midwives.	Weak regulation of advanced midwifery roles.	Policy and Regulatory Limitations	Health System Constraints in Midwifery Care
Urban–rural service inequalities and transportation challenges.	Access disparity and regional care gaps.	Geographic Access and Equity Barriers	Health System Constraints in Midwifery Care
Home births due to sociocultural beliefs and distrust in health facilities.	Cultural practices and perception of healthcare.	Sociocultural Delivery Influences	Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya
Inconsistent ANC attendance and delayed first visits.	Timing and frequency issues in maternal care-seeking.	Antenatal Care Access Delays	Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya
Community midwifery models improving care continuity.	Community-based approaches in underserved areas.	Community-Centered Midwifery Models	Midwifery Challenges and Their Impact on Maternal and Neonatal Health in Kenya