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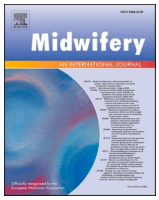

Stakeholders' expectations and experiences of being involved with a global accreditation process for midwifery centres in LMICs: a rapid ethnography

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ABSTRACT

Background: This study explored the expectations and experiences of stakeholders involved in the accreditation of midwifery centres (MCs) in low- and middle-income countries (LMICs). With increasing evidence that MCs provide safe, respectful, and evidence-based care that improves maternal and neonatal outcomes, accreditation may serve as a mechanism to bridge quality gaps in maternal health systems, particularly in regions with high maternal and neonatal mortality.

Methods: A rapid ethnographic approach, combining participant observation and semi-structured interviews, was conducted in partnership with the GoodBirth Network (GBN), which identified six pilot midwifery centres in Haiti, Uganda, and South Africa. Convenience sampling was applied, and qualitative data was thematically analyzed using NVivo software. Ethical approval was granted by City St. George's, University of London.

Results: Findings suggest that the accreditation process fostered a culture of co-production and continuous quality improvement. Four key themes emerged: the value of accreditation, enablers and barriers of the process, and future expectations. The participatory approach was identified as a self-reflexive tool supporting an evolving culture of quality, an enabling environment and embedding the principles of continuous improvement. However, structural and cultural barriers varied across contexts, potentially influencing stakeholder engagement and implementation.

Conclusion: A participatory approach to accreditation may facilitate MC implementation, integration, and sustainability in LMICs, contributing to quality care and enabling environments for midwives. Further research is needed to explore the short- and long-term benefits of accreditation, as well as macro- and micro-level enablers and barriers to its adoption.

Introduction

Low- and middle-income countries (LMICs) continue to bear the global burden of preventable maternal and infant deaths, despite decades of interventions targeted to increase access to skilled care and facility delivery (WHO, 2023). As the global call for a shift in approach grows, from increased access to care to increased access to *quality* care, one possible evidence-based solution is scaling the midwifery model of care provided at midwifery centres (MCs) (Kruk et al., 2018; Nove et al., 2023; Renfrew et al., 2014; Stevens & Alonso, 2020; UN, 2015).

Midwifery centres (MCs) are defined as primary care facilities that provide midwifery-led, comprehensive, respectful, and evidence-based maternal and neonatal care for women with low-risk pregnancies (Rocca-Ihenacho et al., 2018; Stevens & Alonso, 2020). Services include basic emergency care and timely referrals when higher-level interventions are required (Rocca-Ihenacho et al., 2018). MCs provide safe, cost-effective, and human rights-centred care, enhancing maternal and neonatal outcomes (Kruk et al., 2018; WHO, 2023a). Additionally, they create an enabling environment where midwives can deliver individualized, holistic care within their full scope of practice (ICM, 2021; Stevens & Alonso, 2020; Stevens et al., 2022). Such environments are crucial for maintaining high-quality care and patient safety (ICM, 2021).

Midwifery centres (MCs) currently operate in 57 LMICs, with varying degrees of community and health system integration (Nove et al., 2023). As evidence for midwifery-led care grows (Renfrew et al., 2014; ICM, 2021), the number of MCs is expected to rise. The World Health

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Organization (WHO) recognizes midwifery-led models as key to improving maternal and newborn outcomes and advancing Universal Health Coverage (UHC) (WHO, 2024). Maximizing their impact requires effective implementation, scale-up, and integration within national health systems.

Health service accreditation may be one tool to do so. Accreditation is a globally recognized policy tool for improving healthcare quality, safety, and patient experience (Nicklin et al., 2017; Mitchell et al., 2020). It enhances efficiency, service integration, stakeholder engagement, and the implementation of evidence-based care (Mitchell et al., 2020; Tabrizi et al., 2011; Allen et al., 2019). In recent decades, many LMICs have adopted accreditation to achieve UHC and enhance healthcare quality (Mansour et al., 2020; Mate et al., 2014).

Accreditation may also facilitate the integration of MCs into national health systems, particularly in LMICs where they are often operated by non-governmental organizations (NGOs) (GoodBirth Network, 2023). In these settings, accreditation provides a formal mechanism for ensuring adherence to quality standards and best practices, benefiting service users, communities, and funders (GoodBirth Network, 2023). To address this need, the GoodBirth Network (GBN), an international research-based NGO supporting over 100 MCs in 25 countries, developed a global accreditation framework for MCs in LMICs (Stevens & Alonso, 2021; GBN, 2023).

The GBN accreditation pathway evaluates MCs against 43 globally validated operational standards, developed by multidisciplinary stakeholders and piloted in eight LMICs (Stevens & Alonso, 2021). These standards are grouped into three themes—Dignity (woman-focused), Quality (provider-focused), and Community (administration-focused)—to ensure high-quality, rights-based care. The accreditation process (detailed in Figure 1) follows a participatory Human Rights-Based (HRB) approach, incorporating stakeholder input to enhance care quality, gender equality, accountability and community engagement (Kruk et al., 2018; ICM, 2021; McTaggart, 1994; Oladapo et al., 2018). Accreditation is granted for three years, with future plans for program expansion across additional regions and languages.

No prior studies have examined the accreditation of MCs in LMICs. This study aimed to explore stakeholders' expectations and experiences of accreditation, with particular attention to its perceived impact on operational standards, the enabling environment, and the process itself. The study is grounded in the recognition that stakeholder engagement is critical to advancing healthcare quality through mechanisms of co-production, accountability, and system responsiveness (Freedman, 2001; Kruk et al., 2018).

Participants, ethics, and methods

Study design

This study employs post-critical realism as its ontological stance and constructivism as its epistemological foundation. Post-critical realism acknowledges objective causal mechanisms while recognizing individual knowledge construction (Geertz, 1973), making it well-suited for exploring both structural and experiential dimensions of midwifery research (Guba & Lincoln, 1994; Walsh & Evans, 2014). The term "post-critical" reflects a commitment to examining power imbalances, social injustices, and researcher positionality (Noblit et al., 2004). Reflexivity is integral to post-critical ethnography, and a reflexive diary was maintained throughout fieldwork to document positionality (Noblit et al., 2004).

A rapid ethnography was conducted, incorporating participant observation in stakeholder meetings and semi-structured, one-to-one interviews before and after accreditation. Ethnography was selected for its capacity to capture individual and collective experiences within their cultural contexts, providing a nuanced understanding of stakeholder interactions throughout the accreditation process (Bryman, 2016; Denzin & Lincoln, 2017). Participant observation offers immersive insights into implicit meanings and cultural nuances by placing the researcher "inside" the experience (Hammersley & Atkinson, 2019; Emerson et al., 2011). Pre- and post-accreditation interviews enabled longitudinal comparisons of evolving stakeholder perspectives (Creswell & Creswell, 2017; Flick, 2013).

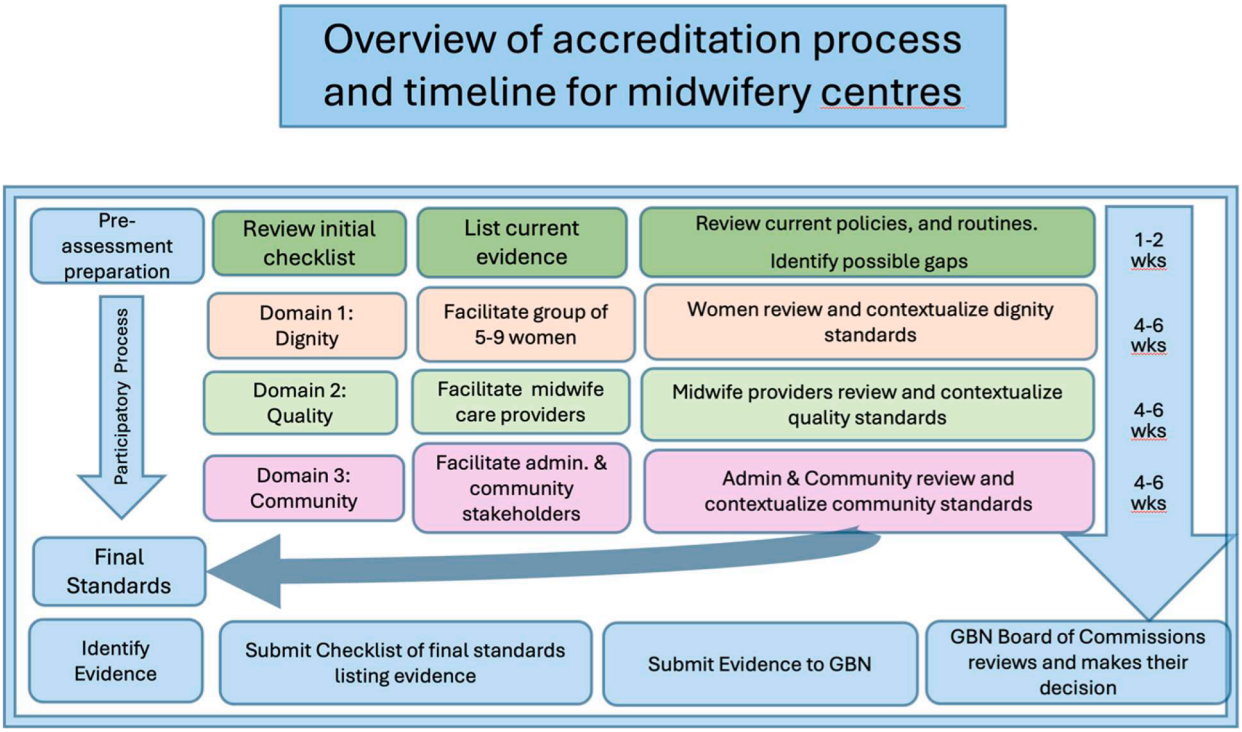

Fig. 1. Accreditation process and timeline (Source: GBN, 2023).

Recruitment and sampling

Before the study commenced, GBN identified MCs interested in the pilot project. Six MCs from three LMICs (Haiti, Uganda, South Africa) were invited to participate, and all accepted. As participants were pre-identified, convenience sampling was applied for interviews. Each MC was informed of the study's aims and process, met the inclusion criteria (Table 1) and consented to participation. Meetings were conducted in English and attended by designated Accreditation Leads (ALs), who could invite additional stakeholders, including management, staff, and midwives. One MC designated two accreditation co-leads.

Setting and process

All meetings and interviews were conducted virtually via Zoom and Microsoft Teams. Monthly stakeholder meetings, facilitated by a GBN co-founder, occurred from March to July 2023, with a concluding session in October 2023. Group sizes ranged from four to ten participants, including the facilitator and researcher, with each session lasting approximately one hour. Meetings covered accreditation progress, standards review, research insights, and implementation challenges. One-on-one pre- and post-accreditation interviews were conducted and recorded in April and October 2023. ALs, as key informants, were interviewed for their operational expertise and role in accreditation implementation.

Data collection and analysis

Stakeholder engagement observations and meeting activities were documented as field notes. Semi-structured interviews followed a consistent guide to ensure thematic coherence while allowing flexibility for participants to discuss personally relevant issues. Data collection continued until no new insights were observed, in line with the principles of depth and sufficiency in reflexive thematic analysis (Braun & Clarke, 2021).

Thematic analysis was conducted following Braun and Clarke's (2021) reflexive approach. Data immersion involved repeated transcript and field note readings, followed by inductive descriptive coding. Codes were visualized using a mind-mapping technique to identify relationships and thematic patterns (Burgess-Allen & Owen-Smith, 2010). Themes and sub-themes were iteratively refined in consultation with the supervisory team to ensure a robust dataset representation. NVivo software (QSR International, 2022) was used for data management and analysis. Table 2 outlines the thematic analysis workflow, from initial coding to final theme development. The study followed the principles outlined in the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist, ensuring transparency and rigour in study design, data collection, and reporting (Tong et al., 2007).

Ethical considerations

Ethical approval was granted by City St George's, University of London, School of Health and Psychological Sciences Proportionate Review Committee (ETH2223-1560). Data anonymization and participant confidentiality were ensured through assigned identifying numbers and secure storage on a password-protected laptop. Group participants provided voluntary written consent, and interviewees provided written or verbal consent, the latter being read and video recorded. Participants were given the opportunity to review and provide feedback on the transcripts and findings prior to publication.

Table 2
Thematic Analysis Process. (Adapted from Braun & Clarke, 2021; Burgess-Allen & Owen-Smith, 2010.).

Step	Description
1. Data Familiarization	Repeated reading of transcripts and field notes to ensure immersion and understanding of context and depth of stakeholder experiences. Reflexivity was applied to acknowledge assumptions and support interpretive integrity.
2. Initial Coding	Inductive, systematic line-by-line coding using NVivo to identify key concepts and patterns across interviews and observation data.
3. Code Grouping	Visual mapping of related codes using a mind-mapping technique to identify conceptual clusters, categories and emerging connections.
4. Theme Development	Identifying overarching themes that capture the essence of grouped codes.
5. Theme Refinement	Iterative reviewing and refining themes to ensure alignment with the dataset.
6. Validation	Themes reviewed in collaboration with supervisory team to enhance analytical rigour and reduce interpretative bias. Return to step 5 and then repeat step 6.

Findings

The study aimed to interview all ALs before and after the accreditation process. However, unexpected delays occurred. The final group meeting was delayed due to illness and each MC accomplished the domains at their own pace. By the time of the second interview, none of the participants had completed the process or received accreditation. Two MCs had withdrawn from the pilot, with only one AL responding to the final interview request. The remaining four MCs had completed the participatory process for each domain and were in the final phase of gathering evidence. The facilitator confirmed this "nearly finished" status, validating the appropriateness of the second interview. As such, thirteen interviews occurred; seven pre- and six longitudinal interviews. Longitudinal interviews track changes and developments with participants over time (Taylor, 2015). Four participatory group accreditation meetings were observed. The study included eleven total participants.

Participant characteristics

All six MCs are freestanding in both urban and rural areas. Five MCs are NGO-operated, and one operates for-profit. Monthly deliveries range from five to 120. These MCs are in countries with licensed midwives and professional midwifery associations but without formal licensure for MCs. However, three are licensed health facilities and such government recognition may reflect a level of health service integration. Four MCs are administered by ALs who live outside the country, while two have in-country ALs, which may influence their ability to achieve the standards. Table 3 summarizes MC characteristics.

Table 1
Inclusion and exclusion criteria.

Inclusion criteria:
Be able to speak English
Have access to Zoom or MS Teams
Provide written or verbal consent to be observed and/or interviewed
Are participating in the pilot global accreditation process from March-October 2023 as the "Accreditation Lead" or stakeholder of an MC
Exclusion criteria:
Stakeholders who have not actively participated in the accreditation process as the Accreditation Lead (for the interview)
Under 18 years old

Table 3
Characteristics of participating midwifery centres. (*World Bank, 2022).

Participant	Country	Country Income-level*	MC Type	Rural vs Urban?	NGO?	Approx. # births monthly	AL lives in-country?	Licensed facility?	Did MC complete the process?
P1	Haiti	Low	Freestanding	Rural	Yes	30	No	No	No
P2	Haiti	Low	Freestanding	Rural	Yes	50	No	Yes	Yes
P3	Haiti	Low	Freestanding	Rural	Yes	5	No	No	Yes
P4	Haiti	Low	Freestanding	Urban	Yes	15	No	No	Yes
P5	Uganda	Low	Freestanding	Rural	Yes	120	No	Yes	No
P6	South Africa	Middle	Freestanding	Urban	No	15	Yes	Yes	Yes
P7	Haiti	Low	Freestanding	Urban	Yes	15	Yes	No	Yes

Findings of interviews and participant observation

Participants described accreditation as a valuable opportunity to strengthen their organizations, enhance care quality, and promote staff development. They emphasized its perceived role in elevating the midwifery profession both locally and internationally, while developing meaningful connections within a global network. Overall, stakeholders reported that their expectations were largely met and that the process was beneficial.

Thematic analysis identified four key themes: the perceived value of accreditation, enablers and barriers to the process, and future expectations. Each theme includes multiple sub-themes, offering a comprehensive understanding of participants' experiences and insights (Table 4).

Theme 1. *Value of the process*

Self-evaluation tool for organisational development, Operational sustainability, Increased engagement

While achieving accreditation was an anticipated source of pride, participants found greater value in the process itself. Accreditation served as a reflexive tool for self-evaluation, prompting actions that supported organizational development.

> *P4: "Just the activity of going through it is beneficial, not just having the accreditation, but the process of going through it."*

Participants reported that both newly established and long-standing MCs benefited from the structured approach, describing how it reinforced accountability, procedural clarity, and long-term sustainability. A key improvement was the development of operational policy documents, which clarified values and procedural guidelines for staff and stakeholders.

> *P3: "I guess every single one of them (standards), you know, is really part of our program. It just had never really been written down. And it's just nice to have it written down… referring to this as the gold standard that we want to keep moving towards."*

The structured nature of the process contributed to sustainability by ensuring continuity, particularly in staff transitions.

> *P4: "when a new staff member comes on and we hand them our employee manual… it helps give them more understanding of our values. So it helps with sustainability… as we change our staff members. "*

The process also reinforced the core values of MCs and contributed to an enabling environment for midwives, ensuring adherence to high standards of care.

> *P4: "A great midwife put into a clinic that's not following these standards can't be a great midwife on her own, but in a facility that follows the standards it facilitates good midwifery care, yes."*

Stakeholders identified areas of MC strength and aspects requiring improvement, implementing immediate and long-term changes to meet or enhance standards.

> *P3*: "*…these dignity standards helped the clinic finally put curtains between the beds"*

> *P2: "One of the things that's come out of this is that we're working on rewriting some of the job descriptions for the midwives and the procedures that they follow."*

The accreditation process was valuable for all ALs, including non-clinical administrators, as it deepened their understanding of their MC's operations and midwifery care.

> *P2: "I was taking a closer look. Does our centre really fit the expectations for a midwifery centre? The answer is no, but I didn't realize that fully until I went with that new perspective."*

Initial concerns about meeting accreditation standards lessened as ALs engaged more fully in the process.

> *P5: "I think the reason I hung back at the beginning… is that I am pretty overwhelmed at the moment… I'm not too worried about it anymore."*

Facilitator support and peer engagement played a key role in building ALs' confidence throughout the process.

Theme 2. *Enablers of the process*

The participatory process as an inclusive, reflexive framework

Stakeholders emphasized the participatory approach as a central enabler, highlighting how it fostered teamwork, co-production, and shared ownership of quality improvement efforts. Stakeholder engagement varied across domains, but each MC identified key priorities to enhance a culture of quality, such as midwifery training, continuing education, personnel policies, and improvements to physical

Table 4
Identified themes and sub-themes.

Theme	Sub-themes
Value of the process	- Self-evaluation tool for organisational development - Operational sustainability - Increased engagement
Enablers of the process	- Participatory process as an inclusive, reflexive framework - Motivation and core midwifery values *(respect, relationships, community)* - Peer support and global sisterhood - The role of the GBN facilitator
Barriers of the process	- Structural (*infrastructure, political instability, supply chain, midwifery identity and staffing)* - Cultural *(language, hierarchy, gender inequality)* - Capacity to engage process - Complexity of process
Expectations for the future	- Stronger, sustainable organisation - Funding opportunities - Increased quality - Professional development/advancement - Increased community engagement - More midwives

infrastructure.

P4: "I love the process… how it wasn't just top down, I guess it was involved in the people that it actually affects... [The process] being participatory is so much more valuable for sure."

The Women/Dignity domain of the standards presented unique challenges for some MCs, yet also yielded valuable insights. Engaging service users provided unexpected perspectives, reinforcing the importance of incorporating women's voices in quality care initiatives.

P6: "It was quite interesting that the things that I thought were super important, they kind of felt it wasn't."

Service user engagement led to tangible changes, such as the creation of a mother's group and monthly community activities at one MC, underscoring the broader impact of stakeholder participation.

Motivation and core midwifery values (respect, relationships, community)

Respect, relationships, and community were core midwifery values emphasised across MCs. Respect for women through quality, compassionate care was a key priority, as was ensuring support for midwifery staff. Some MCs, particularly those in remote locations, expressed feelings of professional isolation, emphasising the need for community and peer support.

P3: "*We are an isolated entity….So I thought this would be a really good opportunity for them [staff] …they're excited about it."*

P2: "I think it's important that they [midwives] are respected by the community, by the people that they're serving… it's important that they feel appreciated not only by the community but by us, by their employer, that we are able to provide them with continuing education, ways to keep their skills sharp. They just want to be the best practitioners they can."

The accreditation process reinforced these values, offering MCs a structured opportunity to support midwives, strengthen community connections, and integrate more fully within global midwifery networks.

Peer support and global sisterhood

Group meetings provided a platform for connection, resource sharing, and peer support. Participants valued the sense of unity and collaboration of these sessions.

P6: "It's a nice sense of unity and connection and hearing what's happening in the other midwife practices… it's a sisterhood, really, all over the world."

The collective experience strengthened motivation and engagement, reinforcing the importance of peer networks.

The role of the GBN facilitator

The GBN facilitator was key in guiding participants, clarifying the process, and addressing challenges. In group meetings, they provided reassurance and context, boosting confidence and engagement.

Researcher field notes: "The facilitator assures P3 that we are asking women to have voices where that is not the norm and sometimes unsafe for them. She assures P3 that they have created a space and the women know that you are listening."

Participants emphasized that the facilitator's ongoing support and reassurance were essential to their sustained involvement in the accreditation process.

Theme 3. ***Barriers of the process***

Structural barriers (infrastructure, political instability, supply chain, midwifery identity and staffing)

Structural and infrastructural barriers varied by country. In Haiti, political instability, inflation, and supply chain disruptions significantly affected MC operations and resource availability, and may have influenced stakeholder engagement.

P1: "I am concerned with stock outages and supply chain, that we won't have the needed medications that we need available *all the time."*

P2: "I think the response that elicited from them [the midwives] was we're doing the best we can with what we have. And one of them said very pointedly, we're already doing everything we can."

A lack of professional midwifery in their local context and a scarcity of midwives trained in the midwifery model of care also posed barriers, raising concerns about midwife shortages, burnout, and workforce sustainability.

P5: "For us it is about the midwives working well together and having what they need and understanding the values of midwifery model of care as providers. There are days we don't have running water, so you might from the outside say well you can't provide quality midwifery care without running water, but we can. But we can't provide quality care without providers who don't understand the values."

P6: "I need more midwives."

Staff strain may also have affected the level of engagement of the domains.

Cultural barriers (language, hierarchy, gender inequality)

Participants described how language, gender inequality, and hierarchical structures created barriers, particularly in efforts to engage women in quality improvement initiatives in very rural regions.

Researcher field notes: "P2 explains that women are not used to being asked for feedback and do not trust it will be used against them or lead to gossip… there is a cultural difference and the women will require a lot of reassurance that there will be no repercussions to sharing."

Capacity to engage the process

The accreditation process required resources and administrative capacity, which posed challenges for some MCs. One participant withdrew due to limited capacity.

P1: "we just didn't have the capacity to do it… It's such an involved process… I respect the framework, it was just too much for me at that stage"

Administration of the MC, whether in-person or abroad, may have impacted the process. Capacity issues concerned one accreditation lead, a practicing midwife at the centre.

P6: "I am concerned. For example, the meeting on Thursday, if I'm busy with a birth, I can't attend the meeting"

Complexity of the process

The participatory process required stakeholders to prioritize domain standards and these sessions were encouraged to be led by neutral, external facilitators. Some participants found this process challenging, with variations in how standards were understood and applied. One participant completed the process as intended but didn't understand the rationale for prioritizing the standards. Other participants used the standards as a checklist to measure themselves against. These responses

suggest a lack of communication and understanding of the process, but did not seem to negatively impact the perceived benefits.

P6: "I'm not quite sure what the relevance was as to the level of importance… all of them were actually important."

While some desired more direct facilitation from GBN with their stakeholder meetings, others sought greater dialogue and interaction in group meetings. Preferences for the pacing of the process also varied, reflecting diverse operational realities.

Theme 4. *Expectations for the future*

Stronger, sustainable organisation, Funding opportunities, Increased quality, Professional development/advancement, Increased community engagement, More midwives

Accreditation was viewed as a tool to communicate the value and quality of MCs to supporters, midwives, and communities. Anticipated benefits included increased funding opportunities, enhanced professional development, improved quality of care, increased midwifery recruitment and retention, and strengthened community trust.

P3: "It inspires them [midwives] to be as professional as they can… You know the dignity that you present is so compromised [in low-resource settings] so this is a wonderful standard for our employees to really feel proud of and also to expand the trust and the respect that it (the MC) gets from the community"

P6: "a big sense of pride for our practice… this is actually a big thing and it's a good place to work. I'm hoping it's gonna inspire midwives to come and join the practice."

The expected benefits reinforce each other. The enacted change required by the participatory accreditation process created a sense of progress, and consequently, pride and hope in stakeholders. For MCs in LMICs, the value of this cannot be overstated. As Participant 2 stated, "Hope makes life."

Discussion

This study is the first to examine the potential benefits of MC accreditation in LMICs. Participants consistently highlighted the value of a participatory, self-evaluation framework in supporting MC development, quality of care, and sustainability. This reflexive approach enabled MCs of varying sizes, ages, and locations to identify areas for improvement, guiding efforts to enhance the enabling environment and health system integration. Similar generative work has been observed in European midwifery centres utilizing self-assessment frameworks (Yuill et al., 2023).

While improvement areas differed among MCs, common themes emerged. Two MCs in remote areas emphasized the need for expanded midwifery education. Structural barriers, including political instability and limited funding, prevented immediate access to training. As several stakeholders noted, continuous professional development is essential for midwives to confidently implement midwife-led care (Sangy et al., 2023; Batinelli et al., 2022). Insufficient training and education opportunities, particularly when not aligned with ICM core competencies or local context, also pose a potential barrier to accreditation sustainability in LMICs (ICM, 2021; Batinelli et al., 2022; Mansour et al., 2020).

Several MCs reported high demand for their services, driven by a reputation for compassionate, affordable care and as an alternative to under-resourced public health facilities. To maintain care quality, some MCs limited client numbers, which inadvertently resulted in turning women away. This reflects an increasing demand for well-resourced MCs in LMICs and aligns with findings that women tend to avoid under-resourced midwife-led settings (Sangy et al., 2023). Limited funding constrained expansion efforts, with all NGO-administered MCs citing financial concerns, reflecting broader sustainability challenges in LMIC health systems (Turkmani et al., 2023; Mansour et al., 2020). These challenges mirror those found in hospital accreditation programs in LMICs (Mansour et al., 2020), suggesting systemic barriers may also affect MC implementation.

Infrastructure and resource limitations, particularly in Haiti, affected service quality, echoing findings from a scoping review on midwife-led birth centres in LMICs (Turkmani et al., 2023). Stakeholders shared concerns about worsening political and economic instability, which they felt directly threatened the sustainability of their centres. Beyond clinical resources, broader socioeconomic factors—including food insecurity, inflation, and transportation costs—impacted both staff and service users. Some MCs responded by establishing food programs and community gardens. Transportation costs in Haiti led some women to opt for traditional birth attendants (TBAs), and several MCs engaged TBAs through training and referral systems. In Uganda, TBAs were an integral part of the care team and worked collaboratively with nurse-midwives. Both approaches align with global recommendations on TBA engagement to improve childbirth safety (WHO, 2012; WHO, 2015; Wilson et al., 2011; Miller & Smith, 2017).

All MCs had referral networks and transfer protocols in place; however, rural centres faced greater geographic and logistical challenges, a pattern also noted by Turkmani et al. (2023). Stronger integration with the health system was observed in urban and longer-established rural MCs. In South Africa, one AL held hospital privileges, enabling timely referrals and transfers. Health system integration is vital for patient safety (Turkmani et al., 2023), yet none of the participating countries had formal licensure or national guidelines for MCs—elements considered essential for implementation and sustainability (Batinelli et al., 2022; Turkmani et al., 2023; Sangy et al., 2023). While three MCs were licensed health facilities, participants expressed doubt that GBN accreditation alone would influence their relationship with national health authorities or professional midwifery associations, both key to scale and integration (Sangy et al., 2023). Although NGOs often lead accreditation efforts in LMICs, government engagement and political will are necessary for success (Mansour et al., 2020). Embedding accreditation within broader sustainability strategies—including financing, regulation, and workforce development—could enhance its long-term contribution to health systems strengthening and universal health coverage (Mate et al., 2014; WHO, 2023a). While the GBN framework supports global standards, it does not yet engage national policymakers—a critical next step to overcome macro-level barriers.

Participants also expressed concerns about midwifery staff strain and burnout, which could impact motivation for change. Provider motivation is a crucial determinant of care quality in LMICs (Lagarde et al., 2019). Two MCs cited midwife shortages as a barrier to sustainability and professional advancement, reflecting a broader global midwifery workforce crisis (UNFPA, 2021; Sangy et al., 2023; Turkmani et al., 2023). While global MC operational standards (Stevens & Alonso, 2021) do not require student midwife training, MCs could serve as vital clinical learning environments for the midwifery model of care, contributing to midwifery workforce development (Batinelli et al., 2022).

Participants described the participatory accreditation process as instrumental in building operational capacity, with many viewing it as a tool for both organizational improvement and community engagement. Stakeholders anticipated enhanced leadership, teamwork, and efficiency—key elements of successful implementation (Batinelli et al., 2022; Sangy et al., 2023). Additionally, it functioned as a community development tool. Involving the voices of all stakeholders, including service users, was valued as a "bottom-up" process, reflecting the ethos of the midwifery model of care, which places women at the centre. Service user engagement promotes trust and satisfaction (Turkmani et al., 2023). However, sociocultural and gender-based challenges in amplifying women's voices will likely persist. A community-driven accreditation process may further improve uptake by fostering local trust (Hussein et al., 2021) and considering the local context (Mansour et al., 2020). A strong MC-community relationship was a consistent

motivator for accreditation, supporting implementation and scale-up efforts and reflecting broader evidence on the role of community engagement in maternal health program success (Hussein et al., 2021).

Participants' engagement and facilitator support enhanced confidence and momentum. Group meetings facilitated networking and resource-sharing, echoing findings from European midwifery units using self-assessment tools (Rocca-Ihenacho et al., 2023). Strengthening networking among MCs, group collaboration and participatory guidance may further optimize accreditation success. Additionally, participants consistently cited the importance of the GBN facilitator in guiding the process, resolving uncertainties, and sustaining motivation. Skilled, context-aware facilitation is critical to participatory implementation in low-resource settings and may be essential for effectively scaling and sustaining accreditation initiatives (Peters et al., 2013).

Strengths and limitations

This is the only known study exploring the expectations and experiences of stakeholders in an accreditation project for MCs in LMICs. A notable strength lies in its embedded partnership with GBN, which facilitated access to a diverse range of pilot sites and enhanced the contextual relevance of the accreditation process. However, the small sample size may impact the generalizability of the findings. Including more MCs in more countries, and across sectors, may offer more diverse data. Also, two MCs withdrew from the accreditation process, leaving four MCs in two countries, Haiti and South Africa, a low- and middle-income country, respectively. Despite facing unique challenges, all reported benefits to participating in the process.

Although many MCs were staffed locally, most were administered or affiliated with "Western hands," raising questions about power dynamics in post-colonial contexts. These dynamics may have influenced stakeholder engagement and data interpretation. The potential perception of accreditation as exclusive to "outsiders" could also impact future participation. However, the participatory, Human Rights-Based approach emphasized community engagement, gender equality, and accountability, offering valuable insights into its effectiveness in post-colonial settings. Findings may reflect some social or professional acceptability bias, shaped by the primary researcher's position as a UK-based female midwife, postgraduate student, external evaluator, and perceived GBN affiliate. Reflexivity was applied throughout, and the study's design and reporting were guided by COREQ principles to enhance transparency and interpretive rigour (Tong et al., 2007).

No MC had completed the process when final interviews were conducted and a longer timeframe would have allowed for interviews post-accreditation. However, the findings indicate that the value to participants was found in the *process*. A follow-up study would be beneficial to determine if, following accreditation, the MCs achieved their expected benefits and if it impacted care in any way.

Implications for research

While evidence supports the midwifery model of care in LMICs, more research on culturally safe implementation in post-colonial settings is needed. Additionally, exploring MCs in LMICs as training sites for midwifery education and workforce development is crucial. Some participants were struck by service users' prioritization of quality care standards, highlighting the importance of the participatory approach and further research on service user values, expectations, and experiences at MCs in LMICs.

The literature on accreditation in LMICs is limited to hospital settings with mixed evidence (Mansour et al., 2020; El-Shal et al., 2021; Mate et al., 2014). In Egypt, hospital accreditation was associated with short-term improved maternity outcomes that weakened over time (El-Shal et al., 2020). In Tanzania, accreditation had limited quality of care (QoC) impact in the private health sector (King et al., 2021) and highlighted the difficulty in measuring QoC (Roder-DeWan and Yahya, 2021). It is unknown if the effects of the MC accreditation process, and pending award, will have short and/or long-term benefits. Further research is needed to evaluate MC accreditation as a quality improvement intervention and to identify policy integration strategies that enhance its impact within health systems.

Conclusion

This study provides the first empirical insights into the accreditation process for MCs in LMICs, establishing a framework for operational improvement and stakeholder engagement. By examining stakeholders' expectations and experiences, the findings highlight accreditation's role in addressing quality gaps within maternal health systems.

The accreditation process emerged as a valuable, reflexive tool for maintaining global operational standards of safe care while strengthening the enabling environment. A key enabler was the participatory approach, which engaged service users, midwives, and staff in co-producing a culture of continuous quality improvement. Participants highlighted the benefits of structured, peer-supported, and well-facilitated processes in enhancing quality assurance, operational development, and community engagement. These findings emphasize the importance of collaboration and sustained support for local stakeholders in MC implementation.

Further research is needed to evaluate the long-term impact of accreditation on MC integration and sustainability in LMICs. Future studies should explore accreditation's role in advancing health system integration, policy adoption, and scalability of MCs as a sustainable model for maternal health improvement.

Ethics approval

This study was granted ethical approval by City St George's, University of London, School of Health and Psychological Sciences Proportionate Review Committee (ETH2223-1560).

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Summer M. Aronson: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Laura Batinelli:** Writing – review & editing, Supervision, Data curation. **Lucia Rocca-Ihenacho:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Jennifer R. Stevens:** Writing – review & editing, Project administration.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Jennifer Stevens is the co-founder of Goodbirth Network, the organization providing the accreditation. In addition she was the facilitator during the entire process.

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