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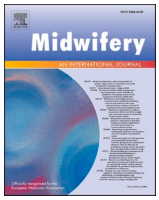

Characteristics of strong midwifery leaders and enablers of strong midwifery leadership: An international appreciative inquiry

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ABSTRACT

Objectives: This research aimed to identify the characteristics of strong midwifery leaders and explore how strong midwifery leadership may be enabled from the perspective of midwives and nurse-midwives globally.
Design: In this appreciative inquiry, we collected qualitative and demographic data using a cross-sectional online survey between February and July 2022.
Setting: Responses were received from many countries (n = 76), predominantly the United Kingdom (UK), Australia, the United States of America (USA), Canada, Uganda, Saudi Arabia, Tanzania, Rwanda, India, and Kenya.
Participants: An international population (n = 429) of English-speaking, and ethnically diverse midwives (n = 211) and nurse-midwives (n = 218).
Measurements: Reflexive thematic analysis was used to make sense of the qualitative data collected. Identified characteristics of strong midwifery leadership were subsequently deductively mapped to established leadership styles and leadership theories. Demographic data were analysed using descriptive statistics.
Findings: Participants identified strong midwifery leaders as being mediators, dedicated to the profession, evidence-based practitioners, effective decision makers, role models, advocates, visionaries, resilient, empathetic, and compassionate. These characteristics mapped to compassionate, transformational, servant, authentic, and situational leadership styles. To enable strong midwifery leadership, participants identified a need for investment in midwives' clear professional identity, increased societal value placed upon the midwifery profession, ongoing research, professional development in leadership, interprofessional collaborations, succession planning and increased self-efficacy.
Key conclusions and implications for practice: This study contributes to understandings of trait, behavioural, situational, transformational and servant leadership theory in the context of midwifery. Investing in the development of strong midwifery leadership is essential as it has the potential to elevate the profession and improve perinatal outcomes worldwide. Findings may inform the development of both existing and new leadership models, frameworks, and validated measurement tools.

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Introduction

Strong leadership in healthcare has a significant effect upon the number of lives saved during times of crisis (e.g., the COVID-19 pandemic) alongside cultures of preparedness, integrated health systems, the addressing of inequities and protecting the health of healthcare staff (Horvath, 2021). Lack of strong leadership in healthcare is known to limit innovations needed to create solutions to new and complex future problems (Huston, 2008; Marquis and Huston, 2009). Yet whilst scholars have identified the need for strong leadership in healthcare, and the results it yields on a global level (Barnard and Review, 2020; Grant-Smith and Colley, 2018), it remains unclear what 'strong leadership' means or looks like in practice. To maximise the benefits of strong leadership in healthcare, it will be important for research to explore how it is characterised and enabled, particularly in discreet areas and professions.

There are global and regional calls to strengthen midwifery leadership (Rumsey et al., 2022; UNFPA, 2021). Indeed, the scaling up of midwifery and strong midwifery leadership has been identified as a "global priority", and evidence demonstrates that the provision of high-quality care delivered and led by midwives can avert the majority of perinatal deaths worldwide (Renfrew, 2021; WHO, 2021). Despite this, the latest 'State of the World's Midwifery' report outlines how investment in midwifery leadership remains low (UNFPA, 2021). Occupational groups that primarily consist of women are often assigned lower value, and globally, women account for 93 % of midwives, 89 % of nurses, and 50 % of doctors (UNFPA, 2021). Moreover, the majority of healthcare workers are women (70 %), whilst the majority of leaders are men (75 %)(WHO, 2019). Thus, midwifery as the most highly gendered healthcare profession is arguably in most need of leadership investment. In this pursuit, it will be important to ascertain what characteristics demonstrate strength in midwifery leadership, primarily from the perspective of midwives themselves, whose voices thus far in the field of leadership have been notably lacking (Dickson et al., 2022).

Midwifery leadership has a long and complex history (Chamberlain et al., 2016). Existing literature on the topic broadly focusses upon the two most common styles of leadership in midwifery, notably situational leadership (King et al., 2012), and transformational leadership (Byrom et al., 2010). The importance of compassionate leadership in midwifery has also been highlighted more recently (Papadopoulos et al., 2021). Nevertheless, there are a myriad of other leadership approaches which may be engaged in midwifery such as transactional (Avolio et al., 1999), authentic (Thompson, 2015) and servant leadership styles (Spears, 2010). Midwives commonly adopt the position that 'leadership' is a complex term referring to a relationship in which one person influences another (Byrom et al., 2010; Thumm et al., 2018). Yet understandings in how to identify and enable 'strong' leadership in midwifery may be particularly important as it has been shown to increase staff satisfaction levels, enhance safety and decreased rates of mortality in a variety of healthcare settings (Murray et al., 2018). Contrariwise, weak leadership in the context of midwifery has been linked to a range of scandals and adverse outcomes (Bannon et al., 2017).

One of the barriers to midwives realising and enacting their leadership potential is a lack of understanding as to what strong midwifery leadership is, what may be unique about it, and what it looks like in practice (Elliott et al., 2016). This lack of understanding about leadership may jeopardise the long-term global enablement, sustainability and upscaling of midwifery leadership called for in the reduction of global perinatal mortality (Renfrew, 2021; WHO, 2021). Therefore, whilst there is a need to develop strong midwifery leaders to lead and guide the profession, and promote the expansion, professionalization, and social value of midwifery in the coming decades (Kemp et al., 2021b), it will also be necessary to define what strong midwifery leadership looks like and how it may enabled from a global perspective. This is particularly important as with strong leadership, midwives and nurse-midwives may spearhead the development of context-appropriate interventions and solutions in perinatal and newborn health worldwide (Kemp et al., 2021a).

A variety of characteristics and traits of 'effective', 'great' (Kemp et al., 2021a), and 'supportive' leadership (Thumm et al., 2018) in midwifery have been offered. However, examples of 'strong' leadership in midwifery specifically, and how such 'strong' midwifery leadership may be characterised and enabled globally has yet to be explored from the perspective of midwives and nurse-midwives themselves. This gap provides a rationale for research to elucidate both the characteristics and enablers of 'strong leadership' in midwifery. Whilst the now dated work of Byrom and Downe (2010) offered localised examples of 'good' midwifery leadership from the Northwest of England, this research extends upon this by defining strong leadership through its characterisation within midwifery more broadly and how it may be enabled from a global perspective.

Participants, ethics and methods

Aims

We aimed to identify the characteristics of strong midwifery leaders and explore how strong midwifery leadership may be enabled from the perspective of midwives and nurse-midwives around the world.

Design

We adopted an online qualitative survey design, established as an exciting and flexible method with numerous applications (Braun et al., 2021). In particular this design offered both a wide-angle global lens with reference to our aim and the potential for rich and focused data. The flexibility of this research design can also promote increased accessibility. Furthermore, this design was less demanding of time and resources, leaving the research team more time for analysis, which can oft be thwarted due to a lack of time in some cases (Braun et al., 2017). Whilst there may be many quantitative measures of 'Strong Leadership', none are tailored to midwives and do not as yet accurately and reliably reflect leadership in midwifery populations. One of the first steps in developing and validating such scales is to explore conceptual definitions, potential items and domains via qualitative research (Boateng et al., 2018), after which time subsequent phases of measurement development and validation can occur. In addition to its aim, this study provides a basis for bridging this gap, providing a contextual foundation for the development of a new scale measuring 'strong leadership' in midwifery. We used the Consolidated criteria for reporting qualitative research (COREQ) where applicable (Tong et al., 2007). We also facilitated extensive stakeholder engagement with this work throughout, the details of which are outlined in supplementary file 1.

Sample

We took a purposeful snowballing approach to sampling via social and professional networks (Naderifar et al., 2017). Those licensed to practise as either a midwife or nurse-midwife anywhere in the world were eligible for inclusion. The fact that our survey was presented in English excluded those who could not read or write in English by default. Equally, as our data collection was web-based, participants were excluded by default if they did not have access to the internet.

Recruitment commenced on the 14th of February 2022 as details of our study and the survey were launched via a global webinar hosted by the Nursing Now Challenge (NNC). Webinar attendants ($n = 64$) joined from 26 countries. Attendees were invited to participate and share recruitment information alongside the survey link with their local and regional professional networks. These were also shared via email to all members of the NNC and the Global Alliance for Nursing and Midwifery (GANM). Furthermore, recruitment information was shared via the World Health Organization's Nursing and Midwifery Community of

Practice online platform, Facebook, and Twitter (now X) to encourage global participation throughout our data collection period.

Whilst adequate sample sizes in qualitative research can be arbitrary, subjective and even paradoxical when dealing with large qualitative data sets, we aimed to recruit a minimum of 200 participants in pursuit of a relevant and representative sample to enhance the rigor, credibility, conformability, trustworthiness and acceptability of our findings (Sebele-Mpofu, 2020). We sought to include as many diverse voices as possible over and above this, and whilst we are unable to ascertain the number of eligible midwives and nurse-midwives who saw the invitation to participate, many took part ($n = 429$).

Data collection

A web-based survey was hosted via Qualtrics software and used to collect qualitative and demographic data between February and July 2022. Potential participants were invited to read a brief introduction to the study and its purpose. Participants were then invited either to confirm their eligibility, consent to participate and complete the survey, or exit by closing the web browser.

Our data collection tool was co-designed and piloted with steering group members who highlighted a need to be aspirational and appreciative in exploring 'Strong Midwifery Leadership'. As such, our approach to data collection was situated as an Appreciative Inquiry (AI). Being appreciative creates change (Sharp et al., 2018), and AI provides a positive way forward in achieving this in both health care and health research (Trajkovski et al., 2013). AI also focuses on what is working well and uses this knowledge to develop strategies to enhance future practice (Sharp et al., 2018). It aims to develop and strengthen what is good and any corrective actions (Cooperrider et al., 2008). Thus, AI was considered appropriate for this research, as we aimed to discover the enablers, as well as the characteristics of 'Strong Midwifery Leadership' in this context.

Demographic survey questions related to participants' age, geographical location, gender, ethnicity, and licensure (midwife/nurse-midwife). Four qualitative responses were also invited in relation to 'strong midwifery leadership'. These were guided by the four phased cycle of AI: Discovery (e.g., What shows strong midwifery leadership?), Dream (e.g., What would be ideal?) Design (e.g., How can strong midwifery leadership be improved in the future?) and Destiny (e.g., How can strong midwifery leadership be enabled and sustained?) (Cooperrider et al., 2008; Trajkovski et al., 2013), with prompts used to inspire blue sky thinking throughout. Participants were also advised to maintain anonymity in their responses. The survey could be completed in 10 min, and was available to return to throughout the entire period of data collection. At the end of the survey, participants were directed toward guidance on maintaining individual wellbeing.

Ethical considerations

This research study was granted ethical approval by the lead author's institutional Research Ethics Committee (Project reference: P132321). Study participation was voluntary. This research was conducted in accordance with the guidelines of good clinical practice. All data were stored electronically in shared secured files hosted by Coventry University. Data were analysed anonymously, whereby any inadvertent references to names and/or other identifiable features were removed prior to data analysis.

Data analysis

Demographic data were analysed descriptively. Subsequently, data analysis was undertaken in two distinct phases. In phase one we undertook a reflexive thematic analysis to make sense of the data collected (Braun et al., 2021; Braun and Clarke, 2006). Following this, phase two of our analysis involved a mapping of the characteristics of strong midwifery leaders identified to established leadership theories. Details of these analyses are presented in supplementary file 2.

Validity and reliability

Drawing on four general criteria in assessing trustworthiness; credibility, transferability, dependability, and confirmability (Lincoln et al., 1985), we reflected on the validity and reliability of this research. Whilst credibility in qualitative research may be subjective, we have been able to triangulate our themes relating to the characteristics of strong midwifery leadership, perhaps predictably to existing leadership theory and styles via phase two of our analysis. We have also pursued credibility through member checking with stakeholders. Whilst qualitative research cannot aim for replicability, we embraced our positionality throughout data analysis, and questioned and reflected on our biases rather than seeking to deny them. In pursuit of dependability, we used members of the research team to read and react to analytic notes, with their own researcher interpretations, essentially to ensure that meaning making, although nuanced, was dependable. Whilst we have not been able to engage with objective confirmability via the nature of our approach, we would invite further testing of the model of leadership presented here via future studies. Moreover, as our approach to analysis was reflexive, independent coding or inter-coder reliability was not relevant (Braun and Clarke, 2021).

Findings

Responses from participants ($n = 429$) were received from 76 countries worldwide. The following countries were identified as being the most frequent sites from which responses were received: 102 (23.8 %) from the UK, 45 (10.5 %) from Australia, 22 (5.1 %) from the USA, 16 (3.7 %) from Canada, 12 (2.8 %) from Uganda and Saudi Arabia, 10 (2.3 %) from Tanzania and Rwanda, 9 (2.1 %) from India and Kenya. Demographical data submitted by respondents are presented in Table 1 with regards to gender, ethnicity, and age. There was a relatively equal distribution of participants, 211 midwives (49.2 %) and 218 nurse midwives (50.8 %) represented. The majority of participants identified as women who were white and over the age of 35 years.

As the characteristic subthemes broadly encompassed behaviours and traits of strong midwifery leaders, they were most frequently mapped with these theories. Transformational, situational and servant leadership theories were also commonly mapped with subthemes, although these leadership theories can also often be referred to interchangeably as leadership styles within the wider literature. Collaborative, authentic, and compassionate leadership styles were also mapped with the characteristics of strong midwifery leaders, though less commonly. A summary of each theme and subtheme is provided below, with prose and quotes used to illustrate overarching and salient meanings. Not all participants provided their geographical location. Where available, participant countries are provided alongside their quotes. Further supporting quotes for each theme are presented in supplementary file 3.

Theme one: characteristics of strong midwifery leaders

This theme broadly captures what participants perceived to be the characteristics of 'Strong Midwifery Leaders'. These are captured within 10 distinct subthemes outlined below.

Mediator

Participants reflected that strong midwifery leaders need to confront disagreements and reach resolution. As respondents outline, this broadly requires the solving of *"conflict between the colleagues and team without biases"* (P608, Saudi Arabia). In this, strong midwifery leaders are *"able to communicate effectively and be persuasive while still being respectful when*

Table 1
Participant demographics.

Demographic Category	Response options	Count (%)
Gender	Woman	402 (93.9 %)
	Man	21 (4.9 %)
	Prefer not to say	2 (0.5 %)
	Don't know	1 (0.2 %)
	Non-binary/genderqueer/agender/gender fluid	2 (0.5 %)
	Total Responses	**428**
Age	45–54	121 (28.2 %)
	35–44	121 (28.2 %)
	55–64	96 (22.4 %)
	25–34	59 (13.8 %)
	65 and over	17 (4.0 %)
	18–24	15 (3.5 %)
	Total Responses	**429**
Ethnicity	White (E.g., English, Welsh, Scottish, Northern Irish, or British, Irish Gypsy/Traveller or any other White background German, English, Italian, Polish, French)	230 (53.7 %)
	Black or African descent (E.g., African American, Jamaican, Haitian, Nigerian, Ethiopian, Somalian)	96 (22.4 %)
	Asian (E.g., Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese)	53 (12.4 %)
	Other	13 (3.0 %)
	Middle Eastern or North African (E.g., Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian)	12 (2.8 %)
	Hispanic, Latino or Spanish origin (E.g., Mexican or Puerto Rican, Cuban, Salvadoran, Dominican, Colombian)	12 (2.8 %)
	Native Hawaiian or Other Pacific Islander (E.g., Native Hawaiian, Samoan, Chamorro, Tongan, Fijian)	6 (1.4 %)
	Native/Indigenous	6 (1.4 %)
	Total Responses	**428**

The overarching themes ($n = 2$) and subthemes ($n = 17$) generated during phase one of our analysis are presented in Table 2, as are the findings from our mapping activities undertaken in phase two of our analyses.

dealing with others" (P632).

Dedicated to the profession

Overall, participants suggested that a strong midwifery leader must be dedicated to the midwifery profession and have a strong midwifery identity. For example, one participant stated that midwifery leaders *"must love to be midwives"* (P238, Kenya) and *"have passion for the profession"* (P276, Ghana). This was seemingly accompanied by a need for strong midwifery leaders to be committed and selfless in that they would be *"prepared to give of [themselves] fully"* (P196, United Kingdom) to the profession.

Evidence-based practitioner

Participants describe in this subtheme the need for strong midwifery leaders to show a furthering of understanding, practice and learning through constant inquiry and dedication to evidence-based practice. As one participant illustrates, *"strong efforts in research, in the clinical area and in teaching area makes strong midwifery leadership"* (P645, Pakistan). Such inquiry and evidence-based practice was described as needing to be multidimensional in nature, as *"Strong leadership incorporates and*

Table 2
Themes and subthemes mapped with established leadership styles and theories.

Theme	Subtheme	Situational leadership style/ theory	Transformational style/theory	Servant leadership style/ theory	Behavioural leadership theory	Trait leadership theory	Collaborative leadership style	Authentic leadership style	Compassionate leadership style
Theme One: Characteristics of Strong Midwifery Leaders	Mediator	✓	✓		✓	✓	✓		✓
	Dedication to the profession		✓	✓	✓	✓	✓	✓	
	Evidence-based practitioner		✓		✓	✓			
	Effective decision maker	✓			✓	✓	✓		✓
	Role model	✓	✓		✓	✓		✓	
	Advocate		✓	✓	✓	✓			
	Visionary	✓	✓		✓	✓			
	Resilient			✓	✓	✓			
	Empathetic	✓	✓	✓	✓	✓			✓
	Compassionate	✓		✓	✓	✓			✓
Theme	**Subtheme**	**Leadership Style/theory**							
Theme Two: Enablers of Strong Midwifery Leadership	Clear professional identity	N/A							
	Increased societal value placed upon midwifery								
	Ongoing research								
	Professional development in leadership								
	Interprofessional collaboration								
	Succession planning								
	Self-efficacy								

respects all aspects of midwifery from research to teaching, practising both in and out of hospital" (P809, Niger)". Strong midwifery leaders were also seen as *"eager to research and improve outcomes supportive to staff"* (P319, United Kingdom).

Effective decision maker

Effective decision making was emphasized as being a key characteristic of the strong midwifery leader in this subtheme. This is exemplified by one participant highlighting that a strong midwifery leader was seen to *"be able to make good decisions."* (P356, United Kingdom), along with the ability to *"stay calm polite and structured in emergency situations"* (P538, United Kingdom) and demonstrate *"Critical thinking"* (P557, Bhutan) in their decision making. It was also seen as being important to involve *"the team in decision making"* (P149, Australia) and to have *"vast knowledge and skills"* (P89, Papua New Guinea) when making decisions.

Role model

Sentiments captured within this subtheme point to strong midwifery leader's role modelling within the profession. Essentially, participants observed that a strong midwifery leader is *"a role model"* (P152, Zambia). Strong midwifery leaders were seen as being *"professional, inspiring, [and] leading by example [with] good moral standards"* (P7). Broadly, strong midwifery leaders were seen to *"set examples to their team…be an example to follow"* (P470, Zambia), and exemplify *"Honesty, Integrity [and a] can do attitude"* (P379, United Kingdom). It was important that such leaders work *"alongside their team rather than barking from the top."* (P517, Australia)

Advocate

In this subtheme participants largely describe a strong midwifery leader as being an advocate. This was perceived as being advocacy both *"for the profession and for women"* (P290, Australia). Essentially, the strong midwifery leader is *"Standing up for what is right"* (P487, United States of America). In this, strong midwifery leaders were also seen to lift others up as they climbed. For example, one participant describes how a strong midwifery leader *"champions, promotes and lifts up others"* (P632).

Visionary

Strong midwifery leaders who showed initiative were seen to be inspirational visionaries for innovation. For example, one participant describes how strong midwifery leadership *"looks like the ability to dream, create, plan, implement, and promote change for the benefit of women and women's health"* (P39, Israel). Ultimately, strong midwifery leaders were seen to be taking *"initiative"* (P436), *"Innovators"* (P124, United States of America), *"Not waiting for permission" (*P850, Ethiopia), *"smashing the patriarchy"* (P180, United States of America) and *"Thinking outside the box"* (P356, United Kingdom).

Resilient

The word 'resilience' can be used to blame and gaslight healthcare staff who may simply be responding normally to a healthcare system designed to induce burnout (Traynor, 2018). Yet in this context, participants also saw the need for resilience in enabling strong midwifery leadership where problems, failures and obstructions may inevitably occur. In this, there was an expressed need for strong leaders to learn from mistakes and build a suite of resilience or survival techniques including *"Flexible working"* (P702, United Kingdom), *"Build[ing] your tribe!"* (P160) "*mentors… clinical supervision"* (P188, Australia) and *"Self-care",* which was seen as being the *"key to being resilient as challenges are many"* (P4, Ireland). Ultimately to enable strong midwifery leadership, such leaders *"must be resilient and resourceful, the job is too hard otherwise"* (P335, United Kingdom).

Empathetic

Empathy was described by many voices captured within this subtheme. It was important that strong midwifery leaders demonstrate *"Empathy with peers"* (P19, United Kingdom) and *"work with love, empathy"* (P6, United Arab Emirates). For participants, strong midwifery leaders demonstrate empathy by *"respecting and listening to both the multidisciplinary team and those in our care."* (P814, Ireland). They were also seen as being able to *"treat everyone with respect"* (P258, Iceland), and care *"about [their] staffs opinions/ work life balance/ well-being"* (P835, United Kingdom).

Compassionate

Compassion was highlighted as being a strong characteristic in strong midwifery leaders. Thus, sentiments captured in this theme outlined how strong midwifery leaders were predominantly seen as being *"compassionate, friendly, and should be intelligent in emotionally, socially and culturally"* (P709, Nepal). In this, participants reflected that compassionate leadership would enable psychologically safer working environments. For example, one participant highlights that when *"the culture of the workplace is positive, midwives feel positive and empowered and enjoy coming to work when this doesn't happen it is the opposite"* (P414, United Kingdom). It is important that strong midwifery leaders *"provide a safe environment to grow and not just the physical environment"* (P710, Australia). Ultimately, strong midwifery leaders were seen as *"approachable, kind, open … but not for the sake of it"* (P746), and *"Prioritising the well-being of staff"* (P232, United Kingdom).

Theme two: enablers of strong midwifery leadership

As well as reflecting on what strong midwifery leadership looked like, participants also shared how strong midwifery leadership may be enabled. In doing so they highlighted enablers of strong midwifery leadership in practice. These were captured under the seven subthemes outlined below.

Clear professional identity

Within this subtheme, whilst some participants advocated for the midwifery and nursing profession to be separated, others advocated simply for the midwifery profession to be valued as equal to that of the nursing profession. In this pursuit there was a call for "*empowering leadership at all levels"* (P396, Australia). Nevertheless, participants reflected that this would first require *"really having us in the positions of decision-making power"* (P671, Canada). One participant in particular envisaged *"Every state, province, locality, country has a Chief Midwife who drives the midwifery agenda at the government level"* (P283, Australia).

Increased societal value placed upon midwifery

Participants imagined the possibilities where increased societal value might be placed upon midwifery in future within this subtheme. In this, they lamented and wished that *"midwifery was truly valued in society, governments, and healthcare systems"* (P487, United States of America). Participants described how in turning this vision into practice, the enablement, sustainability, and upscaling of strong midwifery leadership across the world could be activated.

Ongoing research

Research in the area of midwifery workforce was expressed by participant sentiments captured within this subtheme as being central to

the enablement of strong midwifery leadership. For example, participants highlighted that it is *"through research"* (P705, Pakistan) and more dedicated *"research centres"* (P660, Liberia) focused on the midwifery workforce that this would be achieved. Participants also expressed how midwives should *"conduct research and disseminate the impact"* (P474, Rwanda) themselves, and share *"research findings with colleagues globally"* (P183, Montserrat). This was linked to increasing the societal value placed upon midwives, as it one participant expressed how *"Fostering innovation and improving on evidence-based practice will help raise the profile of midwifery*" (P540, Uganda).

Professional development in leadership

Within this subtheme, participants outlined how strong midwifery leadership may be better enabled via continued professional development in leadership, and the increased development of leadership skills in midwifery populations. It was broadly suggested that this be achieved via bespoke *"leadership training"* (P404, The Gambia). In this there was an expressed *"need for scholarships"* (P113, Ghana). One participant also advocated to *"Include leadership and management as part of university curriculum for midwife training"* (P16, Qatar).

Interprofessional collaboration

Participants contributing to this subtheme expressed how strategic interprofessional collaborations both in and outside of the midwifery profession may enable strong midwifery leadership. As an example of this, one participant outlines how *"collaborative working is more likely to bring about meaningful change that can be sustained"* (P445, United Kingdom). In this, there were calls for all of the healthcare professions to *"work together for our common scope: the health and well-being of women and newborns."* (P35).

Succession planning

Within this subtheme, participants identified the importance of succession planning in sustaining strong midwifery leadership. One participant quote underscores further the need for *"succession planning and pathways to reach leadership roles"* (P735, United Kingdom). Indeed, participants expressed that such leadership *"ought to be focussed on succession planning as much as possible"* (P254, United Kingdom). The rationale for this was posited as *"a lot of midwifery leaders move onto other things quickly and don't stay to see things through. The next person then comes with different ideas for a while and then we are back to square one."* (P335, United Kingdom).

Self-efficacy

Self-efficacy broadly refers to beliefs in one's capabilities to organize and execute the actions required to produce given accomplishments (Bandura et al., 1999). Within this subtheme, participants reflected that midwives already had the ability to become leaders, but that they must first appreciate and realise their own potential. In this, one participant expressed how *"every midwife has a leadership role to play"* (P682, Somalia), and yet another suggested that midwives presently *"just blindly accept the status quo"* (P292, New Zealand). To enable their own strength in midwifery leadership, participants suggested that midwives should actualise themselves as leaders by speaking *"as a professional rather than a clinician all the time"* (P45) and simply *"be a leader"* (P650, The Bahamas). Building on this concept, one participant had the following message for midwives; *"Act like you should be respected and you will be"* (P838, United States of America). There was also a need expressed for midwives to value themselves as *"If nurses and midwives do not value themselves, others will not"* (P610, Republic of Somaliland).

Discussion

This study has identified characteristics of strong midwifery leaders and explored how strong midwifery leadership may be enabled from the perspective of midwives and nurse-midwives around the world. Overall, subthemes related to both characteristics of strong midwifery leaders ($n = 10$) and enablers of strong midwifery leadership ($n = 7$), which may be useful in strengthening the midwifery profession's ability to lead in healthcare worldwide (Renfrew, 2021; WHO, 2021). Ultimately, the findings presented here add to the body of knowledge emerging in the area of strengthening midwifery leadership (Jackson et al., 2021). Findings may also contribute to enhancing existing multi-professional leadership frameworks and models in healthcare (Kaehne et al., 2022). Yet because our mapping analyses demonstrate that the characteristics of strong midwifery leadership do not wholly align with any one single established leadership style, some more hybrid models focussed on adaptability such as complexity leadership may apply in this field (Uhl-Bien et al., 2020). The development and testing of a complementary leadership framework and/or measurement tool, drawing from the findings presented here for the advancement of strong midwifery leaders in future may also be justified.

Our international findings somewhat echo those presented on national, regional, and local levels. For example, in relation to what midwifery leaders need to be effective in contributing to the reform of services, the cultivation of strategic relationships, being a visionary, having a strong midwifery identity and dedication to evidence-based practice has similarly been identified (Adcock et al., 2022). A review of the literature on leadership during the COVID-19 pandemic also revealed that leaders who similarly embodied values of compassion, empathy and authenticity created conditions for positive workplace cultures and staff wellbeing (Dickson et al., 2022). Midwifery leaders being innovative, visionary, and motivated to make a difference have also been identified as necessary characteristics elsewhere (Casey et al., 2011; Divall, 2015; Kay, 2010). Further in line with the findings presented here, establishing collaborations, showing empathy, cultivating a strong professional identity, and resolving conflict via effective communication have also been found to enable midwifery leadership elsewhere (Casey et al., 2011; Clarke et al., 2012; Divall, 2015; Kay, 2010; Miskelly and Duncan, 2014; Patton et al., 2013). Considering the above, our international findings may be somewhat confirmatory, and may be suggestive of shared understandings across the profession.

Our findings also build upon the regional work of Byrom and Downe (Byrom and Downe, 2010), whose data were linked strongly to transformational leadership (Avolio et al., 1999), via the 'good' leadership traits described by participants. Indeed, our findings also link to transformational leadership styles in healthcare where 'strong' midwifery leaders were similarly seen to be inspirational, motivational, influential or 'persuasive' visionary recommend opportunities for development, intellectual stimulation whilst staying connected to their followers (Gabel, 2013). This is encouraging as transformational leadership styles in healthcare have been most aligned and associated with higher rates of employee retention and job satisfaction (Perez, 2021), and safety behaviour (Hassan et al., 2023). Transformational leaders are also less biased and more emotionally intelligent, which is observed as a notable success factor in strong leadership risk attitude and risk-intelligent decisions (Moon and Management, 2021). Thus, the cultivation of transformational leadership skills in midwifery may similarly serve to increase effective decision-making skills, which were also perceived by participants here as being an essential characteristic. This may be particularly important in areas where autocratic leadership styles in midwifery prevail (Fenta Kebede et al., 2023).

Data mapped to leadership styles were also mapped to contribute toward understandings of trait, behavioural, situational, transformational and servant leadership theory and practice (Benmira and Agboola, 2021). On a more granular level the compassion seen as an essential characteristic of the strong midwifery leader here adds to

understandings of the importance of compassionate leadership, defined as the combination of supportive leadership approaches with combined with four pillars of compassion: attending, understanding, empathising, and helping (West et al., 2017), in midwifery (Papadopoulos et al., 2021). Equally, the perceived need for strong midwifery leaders to embody dedication to the midwifery profession, and uphold moral values echoed by actions and self-discipline in role modelling is analogous to alternative authentic leadership styles (Thompson, 2015), and could be advantageous for leaders in gaining competitive advantage (Hassan et al., 2023). Yet an over dedication in this context could problematically lead to burnout and higher attrition rates. Such understandings may usefully inform the development of future strong midwifery leaders and leadership training and professional development programmes, as these leadership styles are also evidenced to strengthen the healthcare professions (Perez, 2021). Notably, none of the characteristic subthemes related to transactional leadership theories (Avolio et al., 1999). This observation along with the apparent crossovers between strong midwifery leaders' characteristics and other theoretical approaches to leadership invite further exploration in this area.

To enable strong midwifery leadership, participants identified investment in midwives' clear professional identity, increased societal value placed upon the midwifery profession, ongoing research, professional development in leadership, interprofessional collaborations, succession planning and increased self-efficacy. Some of these perceived enablers of strong midwifery leadership have been highlighted elsewhere (Pezaro et al., 2022), and offer opportunities for further programmes of research and education in sustaining strong midwifery leadership both individually and collectively. Any new leadership training programs developed in this regard may usefully offer a structured multi, and interprofessional approach along with joint learning components given the findings presented here and elsewhere (Onyura et al., 2019). Governance structures and instruments for leadership training offers will also be required to enable capacity development (Nawagi et al., 2023). Any uni-professional cultures with profession-centric and siloed tendencies may create obstacles to the successful collaborations required of strong midwifery leaders as outlined here. The development of a postgraduate career framework may also be useful, particularly in succession planning. A failure to invest in these enablers may perpetuate a weakening of the strong midwifery leadership required to meet global challenges in perinatal health and mitigate risk. As a starting point, midwives may usefully exemplify the characteristics of strong midwifery leaders identified here and activate themselves as strong midwifery leaders in their own context.

Whilst our findings illuminate perceptions of what may appeal to midwives with respect to their 'strong' midwifery leaders, prestige-oriented leaders may make poor decisions where they are motivated simply by what is popular within their followership, rather than what may actually be performance-enhancing (Case et al., 2018). Equally, followers' desires for certain characteristics in their leaders may be overridden by actions which contradict their stated beliefs (e.g., following a leader lacking integrity to advance personal views or career ambitions) (Holder, 2018). Hence, it has been argued that we have the leaders we deserve, because essentially, we collectively select and construct our leaders to satisfy our own needs and desires (Mayo, 2017). Indeed, as a profession, midwives can choose humility or socialized charisma over narcissism in their midwifery leaders. Ultimately, the challenge now will be to select, embolden, upskill, enable, and sustain the 'strong' midwifery leaders called for to fulfil the professions' potential in healthcare leadership globally.

A key strength of this study is the inclusion of international participants beyond anglophone countries. However, our survey tool was limited in that it was only available in English. Consequently, we have only been able to include contributions written in English. Participants without internet access were also not able to complete the survey. Nevertheless, we engaged stakeholders heavily throughout in an effort to maximise global recruitment. Despite our efforts to solicit a diversity of voices, the majority of participant statements offered were from westernised countries. Whilst there remains an anglophone bias in the responses, this research has nevertheless taken a step in the right direction of broader inclusivity, which is appropriate given the global nature of this topic. Future research of this type could usefully broaden inclusivity further by offering participation via different languages.

Our sample is skewed in that it consisted predominantly of white and older women, though women account for up to 93 % of midwives globally (UNFPA, 2021). Most respondents (23.8 %) were from the UK, and we recognise that strong midwifery leadership may be perceived, enabled, and enacted differently in different countries and contexts. Nevertheless, what our sample lacked may be somewhat meditated through the richness of the data obtained (Sim et al., 2018).

The leadership styles and theories mapped to the findings presented here may not be exhaustive, as a myriad of evolving and earlier leadership styles and theories may also map to the findings presented (Benmira and Agboola, 2021). For example, a democratic leadership style may well be employed by the effective decision maker or mediator (Avolio et al., 2009), a coaching leadership style may well be embraced by the advocate (Boyatzis et al., 2019), or the role model may well take on an ethical leadership style (Den Hartog, 2015). Leadership theories and styles may also be referred to interchangeably. Nevertheless, the purpose of qualitative research such as this is to gain a deeper understanding of a phenomenon, rather than generate wholly generalizable findings (Naderifar et al., 2017). Furthermore, our AI approach discouraged negative responses in this context. Future research could usefully explore the barriers and detractors to enabling 'strong' midwifery leadership, and what it looks like in discrete contexts and from the perspective of the teams, and families' midwives work with. The characteristics and enablers of strong midwifery leadership presented here will make contributions toward the development of future validated measurement tools for use in this context (Boateng et al., 2018), and future competency frameworks for midwifery.

Conclusion

This study offers important insights in relation to both leadership styles and leadership theory in the context of midwifery. As the scaling up of midwifery and strong midwifery leadership has been identified as a global priority in averting the majority of perinatal deaths worldwide, investment in midwifery leadership is vital. Whilst the findings presented here may not be surprising, and are somewhat confirmatory, they offer insights as to how 'Strong Midwifery Leadership' may be characterised and enabled from the perspective of midwives globally. Educators along with policy and decision makers could usefully prioritise and invest in the development of clear professional identity and distinct midwifery leadership roles, ongoing midwifery workforce research, professional development, education in leadership for early career midwives and midwifery students, interprofessional collaboration, and succession planning. Midwives themselves may usefully evaluate and actualise their own potential in leadership against the characteristics of strong midwifery leaders presented here. Projects aimed at increasing the societal value placed upon midwives and midwifery are also called for. We would welcome interprofessional, international collaborations in this pursuit.

CRediT authorship contribution statement

Dr Sally Pezaro: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. **Gila Zarbiv:** Investigation, Writing – review & editing. **Jude JONES:** Investigation, Writing – review & editing. **Mariama Lilei Feika:** Investigation, Writing – review & editing. **Laura Fitzgerald:** Formal analysis, Investigation, Writing – review & editing. **Sanele Lukhele:** Investigation, Writing – review & editing. **Jacquelyn Mcmillan-bohler:** Investigation, Writing

– review & editing. **Olivia B. Baloyi:** Investigation, Writing – review & editing. **Ksenija Maravic da Silva:** Formal analysis, Investigation, Writing – review & editing. **Christine Grant:** Formal analysis, Investigation, Writing – review & editing. **Lisa Bayliss-Pratt:** Formal analysis, Funding acquisition, Resources, Supervision, Writing – review & editing. **Pandora Hardtman:** Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Supervision, Writing – original draft, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethical Approval

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Supplementary materials

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