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Implementing midwifery continuity of care models in regional Australia: A constructivist grounded theory study

Elysse Prussing [a,*], Graeme Browne [a], Eileen Dowse [a], Donna Hartz [a,b], Allison Cummins [a]

[a] School of Nursing and Midwifery, College of Health Medicine and Wellbeing, University of Newcastle, Australia
[b] Molly Wardaguga Research Centre, Charles Darwin University, 410 Ann St Level 11, East Tower, Brisbane, QLD 4000, Australia

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ABSTRACT

Problem/background: Strong international evidence demonstrates significantly improved outcomes for women and their babies when supported by midwifery continuity of care models. Despite this, widespread implementation has not been achieved, especially in regional settings.
Aim: To develop a theoretical understanding of the factors that facilitate or inhibit the implementation of midwifery continuity models within regional settings.
Methods: A Constructivist Grounded Theory approach was used to collect and analyse data from 34 interviews with regional public hospital key informants.
Results: Three concepts of theory emerged: '*engaging the gatekeepers*', '*midwives lacking confidence*' and '*women rallying together*'. The concepts of theory and sub-categories generated a substantive theory: *A partnership between midwives and women is required to build confidence and enable the promotion of current evidence; this is essential for engaging key hospital stakeholders to invest in the implementation of midwifery continuity of care models.*
Discussion: The findings from this research suggest that midwives and women can significantly influence the implementation of midwifery continuity models within their local maternity services, particularly in regional settings. Midwives' reluctance to transition is based on a lack of confidence and knowledge of what it is really like to work in midwifery continuity models. Similarly, women require education to increase awareness of continuity of care benefits, and a partnership between women and midwives can be a strong political force to overcome many of the barriers.
Conclusion: Implementation of midwifery continuity of care needs a coordinated ground up approach in which midwives partner with women and promote widespread dissemination of evidence for this model, directed towards consumers, midwives, and hospital management to increase awareness of the benefits.

Statement of significance

Problem:

Despite strong international research widespread implementation of midwifery continuity of care has not been achieved. This is especially true in regional Australia.

What is Already Known:

Compared with current fragmented standard hospital care, midwifery continuity of care improves clinical outcomes for both the woman and her baby, promotes maternal and midwifery workforce satisfaction and is cost effective.

What this Paper Adds:

The findings from this research provide new evidence that draws attention to issues that the regional Australian midwifery workforce face when transitioning into midwifery continuity of care models, a lack of awareness surrounding the evidence and the power of partnering with women.

1. Introduction

Midwifery continuity of care (MCC) enables a known midwife to coordinate care throughout the woman's pregnancy, birth and up until the woman is six weeks postnatal. This is a globally recognized intervention [1]. Compared with current fragmented standard hospital care, this intervention optimizes clinical safety through a known midwife who ensures care is woman-centered, integrated and collaborative with all relevant medical and allied health services. It improves clinical

* Correspondence to: The University of Newcastle (UON), Department of Rural Health, 69A High St, Taree, 2430, NSW, Australia.
E-mail address: elysse.prussing@newcastle.edu.au (E. Prussing).

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outcomes for both the woman and her baby, promotes maternal and midwifery workforce satisfaction [1] and is cost effective [2]. Widespread implementation of MCC has been challenging and slow [3], particularly in rural Australia [4]. Improving maternal and infant health is an international health priority [5] and increasing access to MCC is paramount.

When compared with standard maternity care, a systematic Cochrane Review found, women who receive care in a MCC model were less likely to experience regional analgesia, instrumental vaginal birth, preterm birth less than 37 weeks and reduced fetal loss before and after 24 weeks plus reduced neonatal death rate [1]. Other studies have found that women receiving MCC are less likely to have a cesarean section [6] and have improved satisfaction with care [1]. Research suggests this model of care is cost effective [7] and enables midwives to work to their full scope of practice improving work satisfaction [8]. These are important considerations in the current global maternity climate where improving outcomes for women and their babies by reducing preventable death and morbidity is a priority [5]. Both national and international data demonstrate a concerning increase in medical interventions, like instrumental birth and cesarean sections [9]. These trends are a concern given the national and international guidelines that aim to reduce these increasing rates of medical interventions [10,11]. MCC is recognized for improving these rates when compared with medically-led hospital based care, particularly decreasing rates of interventions such as; cesarean sections and instrumental assisted births, which are associated with greater risks of morbidity for women, their babies and subsequent pregnancies [6].

For more than two decades, International and Australian government policies have recommend that MCC should be accessible for women and their families during pregnancy and birth [10,12]. Additionally, a number of MCC Tool Kits [13–15] have been developed and outline an implementation guide aimed at increasing access across maternity services. Despite these directives, only 8% of Australian women have access to MCC, primarily in metropolitan areas [12]. Evidence also suggests that MCC models could offer many benefits and improvements to maternity services within regional areas [4,12,16], however, one study found that 38% of hospitals stated they had no intention of implementing MCC and the majority of these were in regional or remote areas [12]. This is a concern as regional areas include higher priority populations, like Aboriginal families, that are at increased risk of poorer maternity health outcomes. Furthermore, research shows MCC can reduce preterm birth by 50% [17] in Aboriginal populations. This is an important finding as preterm birth is the leading cause of death and disability in children [18] and implementing MCC would help to close the gap on the high rates of infant death in these communities [17]. The Woman-Centered Care: Strategic Directions for Australian Maternity Services [19] and the First 2000 Days Framework [20] identify MCC as an important intervention to ensure that mothers and babies have the best start to life.

Research investigating factors associated with implementing midwifery continuity of care models is needed to improve translation into the diverse Australian maternity settings [3,4,12]. Research that extends beyond the well documented clinical benefits and looks towards implementation of the models through cost efficiency and benefits to the workforce is required [3,21]. The aim of this research was to develop a theoretical understanding of the factors that facilitate or inhibit the implementation of MCC models in Australian regional settings.

2. Methodology

This study uses a Constructivist Grounded Theory method, taking a relativist position that is based on a symbolic interactionist theoretical perspective [22,23]. This approach acknowledges the shared experience between the researcher and the researched world of the participants [22]. It enables the researcher to explore why a phenomenon exists and how it is experienced, whilst ensuring a co-construction of meaning, incorporating the researcher's interpretations of the data that guides the construction of theory [22]. Constructivist Grounded Theory offers an approach to research methods that complements and reflects the importance of relationships, which is a valued, and core characteristic of midwifery philosophy and midwifery continuity of care [24].

3. Methods

For this study 34 interviews were completed across six regional Local Health Districts in New South Wales (NSW), Australia. Constructivist Grounded Theory sampling follows two processes, firstly; initial participants were recruited using purposive sampling of maternity unit managers, midwives and women. Following this, snowball sampling saw the recruitment of additional participants allowing for theoretical sampling of data to explore emerging gaps, patterns, to verify codes and better understand the concepts and theories as they were developing. Data collection followed three phases;.

1) Phase one included: Midwifery Unit Managers (MUM), Clinical Midwife Consultants (CMC) through to state level advisors.
2) Phase two recruitment included: thirteen registered midwives, seven with experience of working in a MCC model and the remaining six had no experience of the MCC model; and,
3) Phase three included: ten women, as representatives of women within regional communities. Seven of the women had experienced care within a midwifery continuity model and the remaining three had not.

The data were collected through intensive interviews which is the recommended Constructivist Grounded Theory approach [22]. An interview guide was developed that included broad, open-ended questions [22]. Awareness and adoption of the interviewees' words and terms, called in-vivo words were also noted in field notes and used to explore ideas that had emerged during the interviews [22]. Interviews were digitally recorded and transcribed together with field notes. The documentation of field notes enhanced the process of data collection by recording the context in which it took place, and for describing any nonverbal communication. These steps provided an opportunity for reflexivity and documented a clear decision trail, adding contextual insight into the recorded data. All participants have been de-identified and given a pseudonym to maintain confidentiality.

Constructivist data analysis is an interactive and interpretive process that happens simultaneously [25]. Analysis was performed through initial coding of the raw data using line-by-line or phrase-by-phrase coding. The use of gerunds, turning verbs into nouns, was a technique applied to ensure the coding process stayed true to the words and actions of the participants, and encouraged analysis of the data from the participants' perspective [22]. These codes were raised as focused codes, using tables and concept maps to sort and summarize larger portions of the initial data. Simultaneous memo-writing helped to explore and question the developing codes and categories, and subject them to constant comparative analysis and theoretical sampling, often happening synchronously within and between interview transcripts [22,25]. Further data collection, through theoretical sampling, was resolved once no new information emerged from subsequent interviews demonstrating that data saturation had been achieved [22,25]. These processes enabled the opportunity for member checking of codes with participants, debriefing sessions with research team that ensured reflexivity, correct coding processes and ultimately led to theory development. Once concepts of theory were well established a review of these concepts within an updated review of the literature and further memo writing allowed for the construction of the substantive theory.

3.1. Ethical considerations

All aspects of the study were undertaken in accordance with the

NHMRC National Statement on Ethical Conduct in Research Involving Humans [26]. Ethical clearance was acquired through the regional Ethics Committee (**17/12/13/5.11**). Ethical clearance was also obtained through the relevant University.

3.2. Findings

This section presents the shared experiences of key stakeholders and identifies factors that influence the implementation of MCC models in regional Australia. An overarching theory was developed from these findings and recommends: *A partnership between midwives and women is required to build confidence and enable the promotion of current evidence; this is essential for engaging key hospital stakeholders to invest in the implementation of MCC models.* It is informed by three concepts of theory that emerged from within the data analysis: '*engaging the gatekeepers*', '*midwives lacking confidence*' and '*women rallying together'*. The three concepts of theory, and the related sub-categories, are presented below in order of participant groups, starting with: midwifery leaders (phase one), midwives (phase two) and women consumers (phase three).

3.2.1. Concept of theory: *"Engaging the gatekeepers"*

The first concept 'engaging the gatekeepers' emerged as a substantive category and is discussed below in relation to the three subcategories; 'acknowledging that midwives can be your biggest barrier', 'changing workplace culture' and 'funding a project officer'. Phase one participants recognized the importance of identifying certain stakeholders as particularly influential and that they may have their own agenda in relation to implementation of MCC models.

3.2.2. Sub-category *"Acknowledging midwives can be your biggest barrier"*

The sub-category 'Acknowledging midwives can be your biggest barrier' identified midwives as having a greater influence over implementing a MCC model than any other stakeholder.

You would think that, if anybody, the midwifery group would be more supportive when, in fact, they're not. They are often the ones that cause the greatest barriers with this. To me, even greater than medical. (Gail, CMC).

To a lesser extent, phase one participants identified that medical staff and hospital executive management are potential gatekeepers. Participants recognized the importance of early engagement with medical staff and communicating the evidence was essential to collaboration. As discussed by this manager, *'we didn't have a huge medical resistance.where they did have concerns, we brought them in closer. [We] met with them weekly; including them was crucial' (Tahleia, Manager)*. Participants explained that this collaboration enabled medical staff to discuss their concerns and provide education to help them understand what MCC involves. Participants explained that although there was a lot of resistance from midwifery staff, and some from other professions, issues were often related to 'misinformation' and 'not valuing MCC' due to a lack of understanding of the evidence:

'… we had monthly steering committee meetings. we had a member of the executive team there, medical staff, we had all the midwives there and we did a lot of education because no-one here knew what continuity of care was' (Sylvia, CMC).

3.2.3. Sub-category *"Changing workplace culture"*

'Changing workplace culture' emerged as a subcategory that participants repeatedly recognized as hindering implementation of MCC. Phase one participants spoke of the regional midwifery workforce being resistant to change and the difficulty in *'navigating the midwifery family'*. Participants reported that midwifery staff working in regional areas were a close-knit group of colleagues that functioned like a 'family', often because they have worked together for a long period of time: *We have an ageing workforce which means that they've probably settled into their little [midwifery] family - this is their family. …What we're about to do is break that family'* (Gail, CMC).

Participants also observed that in regional areas an ageing midwifery workforce is contributing to a culture of resistance: *'… and older, like they're all getting up to retirement age and it's like, "I don't want to do something different now. I just want to come to work.' (Taryn, CMC)*. To overcome the challenge of changing workplace culture participants suggested that regional areas would benefit from networking with midwives from existing MCC models to address the misinformation being shared amongst the midwifery workforce, as described by Willow:

I think being able to experience continuity of care helps them to work through those fears of being on-call all the time (Willow, MUM).

A similar perspective was also shared by Elsie:

If people could come out here and see what it is like and how beautiful it can be (Elsie, Manager).

The need for *'supporting new graduates and student midwives'* was repeatedly linked to a cultural shift with new graduate midwives entering the workforce. Participants described the 'passion' and 'enthusiasm' of students and new graduate midwives as motivating and encouraging for other staff:

I think they have because they're studying this sort of stuff, looking at these models at Uni so, yes, they're quite helpful in supporting some of the older staff as to how things might look. Plus, they're young and enthusiastic' (Elkie, CMC).

Phase one participants described the need to facilitate students and new graduates to work in MCC models and to recognize this cohort as future workforce ready and willing to step into these roles.

3.2.4. Sub-category: *"Funding a project officer"*

The importance of '*Funding a Project Officer'* was a frequently repeated code and proposed as another major facilitator, particularly changing workplace culture, associated with implementation of a MCC model as noted here.

It's a huge thing and if you can get a project manager dedicated to development and implementation including the change management that is an ingredient for success. You've got a much better chance at success if you invest financially into it (Judith, CMC).

Gail describes the *'project officer being available for those corridor conversations, but you can do that a lot more structured a bit more process driven*' (Gail, CMC.).

Alongside the need for a project officer, participants recognized the role of a maternity unit manager needing to show support for these models, particularly to encourage midwifery workforce support. Although managers recognized the difficulty in taking on this additional work:

Absolutely, 100% want to implement a model, in this unit …and I thought that I would have made ways around continuity by now. And I am so disappointed and annoyed at myself that I haven't done a single thing about it. Because I am so incredibly time poor and I'm someone who wants it to happen. But I'm just at a loss as to how I'm going to – even give it some energy (Lillian, MUM).

This challenge was reported by midwifery workforce as managerial resistance to implementation, and is presented below. The findings from phase one participants highlighted the midwifery workforce as the most challenging stakeholders to engage when implementing of MCC models in regional settings. This finding prompted theoretical sampling of phase two participants in order to better understand midwives perspectives and explore insights that may explain their resistance to MCC.

3.2.5. Concept of theory *"Midwives lacking confidence"*

Phase two participants represents the perspectives of regional midwifery workforce. What emerged from interviews with regional midwives was a considerable lack of confidence and this was shown to hinder their ability to see themselves transitioning into MCC models or even to support its implementation.

I think that it's just a confidence issue. And a lot of them are nervous to act without the support of higher staff (Jessica, Midwife).

Participants argued that midwives would not feel confident transitioning into MCC models because they 'feared change' – a fear that was

often attributed to a lack of confidence to work across their full scope of practice. This argument was often linked to the hospital work environment, as midwives tended to continue working in a familiar ward and lacked recent experience in certain areas of clinical practice:

You already know that there are some staff who just flat out refuse to go to birthing [unit], or they say, 'I don't work in special care [nursery]' or 'I don't do neonates'. And so, your staffing is so critical, so crucial (Jessica, Midwife).

They've practised so long in one area that they get nervous when it's time to go back in … and so they don't – and so they've lost their confidence (Violett, Midwife).

Like phase one participants, phase two participants also identified that the midwifery workforce in regional areas are nearing retirement age, which compounded the issue of resisting change:

[I] would love to take it on and do it, five years ago. But I turn 60 next year, so I'm looking at scaling down (Julie, midwife).

Participants stated that this older group of midwives was difficult to engage in change and that they often did not support the implementation of MCC models. In addition to these concerns, midwives repeatedly expressed conflicting information regarding work-life balance and MCC work:

You've got midwives who are going back on call again … midwives who need to be available 24/7, so I don't think that lifestyle with families has been considered. (Jessica, Midwife).

Which contradicted midwives with MCC experience:

I think it works well for family, which I know a lot of people are concerned about. But you can plan your day around your clients as well as your family, so it works really well. (Vanessa, Midwife).

3.2.6. Sub-category: "Wanting to be woman-centered carers"

It was evident that midwives valued a woman-centered relationship, however an insufficient understanding of current research outcomes prevents midwives from advocating for MCC. When asked to describe the benefits of MCC, only two of the midwifery participants were able to describe the evidence-based benefits for mothers and babies. All other participants described the benefits in relation to the trust and familiarity that a continuity relationship facilitates:

It's about the relationship with the woman … It's actually sharing a life experience with the woman and, potentially, more life experiences with that woman and creating that trust (Dorothy, Midwife).

The need to educate more midwives about the evidence and benefits associated with MCC models was apparent, as Doreen observed:

'hospital-trained midwives who work in a regional area and who may never have been exposed to continuity models … it's not something they've really learned or really worked with, they may not know much about it (Doreen, Midwife).

A lack of engagement with women in the local community was also reported and some midwives were uncertain whether women in their local community wanted access to MCC:

I think that the community needs to want it and that they need to fight for it – I think it's … [that some areas are] missing that community engagement (Danielle, Midwife/Academic).

3.2.7. Sub-category: "A system subordinating midwives"

Many midwives identified a medical dominance within the hospital system that they described as undermining their roles as midwives.

I think we're still very much under that subordinate medical model. We need to be seen as independent practitioners (Violett, Midwife/Academic).

Participants also expressed concern of 'Destabilizing the Midwifery Team' if a MCC model was implemented. Midwives feared they may not be supported by their midwifery colleagues, or that they would be unfairly scrutinized once they transitioned:

The other thing about the midwifery group is that you need to be good at your job because if you stuff up, it's going to ruin it for everyone else – you'll be under the looking glass. Or it goes the other way. They go, 'Oh, they're not real midwives… they're just MGPs [Midwifery Group Practice midwives]. They're just low risk.' (Penelope, Midwife) .

Similarly, Vanessa stated:

If you don't have the support of all the other midwives and other staff, if you don't have the support of the … whole team, then it just makes it a lot harder (Vanessa, Midwife).

Midwives also highlighted that 'seeking management support' —from ward management through to the executive level—was a challenge. This was due to diverse priorities and insufficient clarity regarding management roles, and difficulty communicating with managers: *There's such an obstruction to communication, and I think this keeping [of information] … I don't know … Does anybody know what goes on at this greater organizational level? (Doreen, Midwife).*

3.2.8. Sub-category: "Supporting students and new graduate midwives"

Midwives, like midwifery managers, stated students and new graduates were a valuable resource for current MCC information and experience working within these models as part of their degrees:

I think, … more midwives who are Bachelor of Midwifery [students] coming with a stronger sense of the profession of midwifery, …[and a] good understanding of research and applying evidence, and a motivation (Penelope, Midwife).

And a similar observation by Violett.

I think that it's crucial [to retain] our … midwifery workforce. And there is a little bit of a disconnect for new grad midwives coming out … where [there is limited] availability of new grad midwives being able to be involved …. health services [need] – to be able to see how they can include students and new grads into continuity of care models that are already [in] existence and/ or to develop some to support… (Violett, Midwife/Academic).

3.2.9. Concept of theory: Rallying together with women

All participants identified the existence of a gap preventing midwives forming meaningful relational-based care, a sense that woman-centered care was not a priority. This hindered women from realizing MCC as another option of care and their capacity to request service changes. These findings prompted further interviews to better understand the women's perspectives and their role in regard to implementing an MCC model in their local hospitals.

3.2.10. Sub-category: Women not knowing about midwifery continuity of care

The women participants asserted that a lack of community awareness regarding MCC models is preventing consumer demand for this option of care. As one participant explained:

I personally feel that women don't know what that model is and … so they're not driving it or asking for it because they're not aware of what the model is … (Antonia, Woman/Physiotherapist).

Similar concerns were raised by Leanne:

I work with pregnant women. Often, they don't know about continuity of care, so I'm often telling people about it (Leanne, Woman/Allied Health Worker).

Women participants frequently spoke to the value of continuity of carer for the reduced retelling of their medical history to multiple staff, a safety and quality of care concern:

It takes away a lot of that fear, that anxiety surrounding birth. If you're seeing the same person all the time, you feel like you know them better and they know you better (Leanne, Woman).

I think the right hormones would be released, and you would end up with less intervention because you've built that relationship with them …From a medical perspective, you've got someone who understands you from 'whoa to go; you don't have to repeat the story 50 million times… there's been some pretty bad communication errors that could have been easily rectified by a continuity of care model (Poppie, Woman/Allied Health Worker).

The women participants clearly valued having a known midwife and wanted access to MCC models. However, a broader community lack of awareness about MCC prevents women requesting access.

3.2.11. Sub-category: "Women underestimating their power to make change"

Phase three participants claimed that the women in their local communities generally underestimated their capacity to make changes to their local health services, stating that the women were not aware that they could or knew how to contribute to making changes:

Women feel disempowered as consumer activists, but I think that they have much more power than they realize. Particularly, if they understand the system … they have minimal resources … as midwives, you need to support them … there is such power in unity… Nobody tells them that they're partners in health care!' (Tiffany, Woman).

Women participants described their experiences of hospital maternity care as being 'processed' and as being a service that facilitates 'compliance':

So often, I just hear women say, 'Well, I was told I had to do this'…I don't think they realize that they've got the power within them to speak up… (Carly, Woman/Doula).

Josephine was concerned:

for women who don't want to do the 'yes doctor, no doctor, three bags full doctor' and who are considered this mad, bad and dangerous alternative hippie kind … they're all for informed choice, but if your informed choice is 'I want to be supported as possible to achieve a normal birth without intervention' … nope, then you're judged (Josephine, Woman).

Women also argued that not all midwives would want to support the required changes for implementing MCC, particularly in regional areas:

I think the demographic of people that you get sometimes working in regional areas can be a bit … They can be a bit stuck in their ways and really protective of their roles – and they're reluctant to change (Poppie, Woman/Allied Health Worker).

Despite women underestimating their ability to influence change in their local maternity services, a small number of women engaged with executive management:

I … made the mistake of rather than emailing the NUM at the time, I emailed [the Chief Executive]—just not knowing how many levels and not understanding … And then the phone call, and she's like, 'Just come to me.' And it was like, 'Oh, that was really quick '…I never went back up to that top, but I did realize how powerful, as a consumer, it would be to just go to the top and rustle those feathers (Poppie, Woman/Allied Health Worker).

3.2.12. Sub-category: "Rallying together"

Participants frequently spoke of 'rallying together' to feel well supported and to find the confidence to engage with the necessary stakeholders to implement an MCC model, as well as the need to be resilient:

You just have to keep going and roll with the punches … make your local health reporters your best friends. Just don't give up …it will get personal, and just keep pushing (Antonia, Woman/Allied Health Worker).

This was a similar concern for Poppie:

Thank God you do hand the baton over, because you do just get beaten down. I feel that in the seven years that I had the role [Maternity Choices Australia]; I don't think that we achieved anything. I achieved a sense of, 'Wow. It's complicated' (Poppie, Woman/Allied Health Worker).

'Rallying together' to push for the implementation of a MCC model was a crucial factor that helped women's voices be heard at an executive management level. This was identified as a substantial step that set in motion the engagement of key hospital stakeholders who facilitated implementation. As consumer representative Tiffany asserted, *'The truth of the matter is that unless consumers get involved, very little … is going to happen'*. A few participants stated that implementing a MCC model results from a 'crisis' situation, often when the maternity services will cease within a community:

The steps are: (A) often, there is some type of crisis … suddenly a unit will be closed down … and the community rallies together … consumers start to talk among themselves, and someone says, 'Let's do something about this!' (Tiffany, Woman).

Some women described how MCC models were the answer to preventing regional hospital closures:

Well, the situation was that they were going to close [Location C] maternity service because they couldn't get 24/7 obstetric cover, which was a golden opportunity. Then, we could go in and say, 'You don't need obstetric cover. We can have a completely midwifery-led unit for healthy women with healthy babies.'… it was like gold. (Antonia, Woman/Allied Health Worker).

At this point, the participants outlined specific examples of how they 'rallied together';.

They were running families and businesses and had jobs … if I could lead them by the nose, they were happy to write letters … [They were] happy to meet their local ministers if I came with them … you tell him what you need (Megan, Woman/Doula).

Phase three participants spoke about 'seeking out the champions' from both outside and within the 'system', which included midwives and obstetricians, executive-level hospital management and local media reporters, as one woman described:

My first step was finding champions within the system … I was lucky that I found [Abby], the service manager… I found [Kate] at the uni … and then I found and built a relationship with the local health reporter … I could say things that [Abby and Kate] couldn't within the system, and [I] put a lot of pressure on the CEO at the time … we kept pushing … it would have been much harder without those people within the system and the health reporter, who could see the sense in what I was saying (Antonia, Woman/Allied Health Worker).

As one participant expressed, one key factor to implementing a MCC model was understanding that women *'need the midwives yelling and screaming, but then they've only got so much of a voice. As soon as consumers jump on board and start saying, "We want this", things will shift' (Tiffany, Woman).* Throughout the interviews with the women participants, it was clear that they valued a supportive network of midwives and that they wanted midwives to help them advocate for access to an MCC model: *I think that it has to come from a collective of women in the community… and then you need that support from the midwives … (Poppie, Woman/Allied Health Worker).*

4. Discussion

This study explored the factors that influence the implementation of MCC models in Australian regional publicly funded hospital settings. Three theoretical concepts emerged from the data analysis, these concepts include 'engaging the gatekeepers', 'midwives lacking confidence' and 'rallying together with women'. In line with Constructivist Grounded Theory analysis, these three concepts of theory were evaluated and developed into the subsequent substantive theory*: A partnership between midwives and women is required to build confidence and enable the promotion of current evidence; this is essential for engaging key hospital stakeholders to invest in the implementation of MCC models.*

Engaging key stakeholders within the health organization is critical. Midwifery managers repeatedly emphasized the importance of 'Acknowledging that midwives can be your biggest barrier'. Midwifery managers encouraged being prepared for the influence that midwives have over the implementation of MCC models. These findings are evident in other studies, however, midwives are often described as less of a challenge compared with the resistance from medical staff [27,28]. Research confirms that resistance from these stakeholders exists; it also suggests that good communication and collaboration are key to engaging the support of all stakeholders [29]. Ineffective communication affected the sustainable design and future integrity of the MCC models [29]. Collaborative approaches are also highlighted in the literature, including the use of interdisciplinary training workshops, regular meetings with multidisciplinary case reviews, clear role delineation [30], model evaluation tools and auditing processes [31].

The findings revealed the strong collegial influence that midwives have with one another, especially in regional areas. These midwives have often worked together for many years and have developed long-term relationships. As evident in other studies, the midwifery workforce was reported as an ageing workforce [32] resistant to change

because they were comfortable in a familiar work environment and nearing retirement, reluctant to learn new skills. Participants were concerned about losing peers to a new MCC model, which would cause instability. This concern was also noted by Styles et al. [34], who found that the movement of more experienced staff across models was an issue that required careful consideration. Another study revealed intra-disciplinary resistance from within the midwifery workforce and suggests that a state of contentment and status quo restricts innovation [33]. The 'us and them' division is widely recognized in midwifery literature as a major concern when implementing MCC that causes instability and unsupportive work environments for midwives [33,34]. A strong predictor of successful implementation change is the time spent preparing processes for the change initiation, which includes engagement, feasibility and readiness planning [27].

A funded project officer was a repeated sub-category of 'engaging the gatekeeper', which was further explored and demonstrated this role was integral to overcoming many of the challenges presented by key gatekeepers and barriers that impeded the implementation of MCC models. Participants identified that funding for a project officer was often secured through Ministry of Health (MOH) grant opportunities. The position was often limited to a six-month time frame, but 12 months was identified as the optimal duration for ensuring local suitability, sustainability and evaluation of the model. This finding aligned with evidence showing that MCC translation periods may take six to 10 months from implementation [4,12]. Participants argued that the project officer's role was necessary because it allowed the adequate time and capacity required to engage all key stakeholders, communicate the benefits, correct misinformation, prepare the midwifery workforce and facilitate the cultural changes required for implementing an MCC model. The importance of this role is also identified in several public policy documents that were designed to assist with implementing MCC models, such as the NSW MCC Toolkit [13–15]. A project officer was identified as crucial to the successful integration of MCC models and to ensuring sustainability and organizational commitment to the project [35–38]. Employing a project officer demonstrated executive level financial commitment to implementing a MCC model. This strengthened the project officer's role and leadership capability to engage key stakeholders (especially those who are resistant) through effective communication and education to support workforce transition into MCC models.

It was clear from interviews with midwifery participants that 'midwives are lacking confidence', which often appears as resistance towards the implementation of MCC. These findings confirmed that midwives' value MCC and are 'wanting to be woman-centered carers'. However, a large portion of these phase two participants argued that midwives were not familiar with current research outcomes, or with how MCC models are operationalized. Most midwifery participants described the benefits of MCC only in terms of the trust and familiarity that developed between the woman and the midwife. Only two midwifery participants could describe the benefits as reported in the current Cochrane review [1], specifically describing the improved health outcomes for a woman and her baby. This finding supports the current literature that reveals midwives require further education to better understand the benefits of MCC models for women and their babies [35,36]. In addition to having limited awareness of the benefits of MCC, midwives lacked an understanding of how to manage new ways of working within a MCC model. This finding is supported by recently developed tools such as Implementing Better Births – A Resource Pack for Local Maternity Systems [15]; Can Continuity Work for Us? [53]; and the Ways of Working Toolkit [37]. These tools were designed in the United Kingdom (UK) to help midwives' transition into new models by improving their understanding of MCC [15,53].

In this study, both midwives and midwifery managers reported that hospital systems allowed midwives to remain in a familiar area of maternity care (e.g., birthing units, postnatal wards, antenatal clinics or special care nurseries). These findings have been reported elsewhere and highlight how midwifery is resistant to change [29,36,38]. Some midwives were reported to have preferred to stay in familiar settings rather than to practise skills across the entire childbearing continuum of care [29,36,38]. The barriers that prevented midwives from working to the full potential of their skill set in Australia has been recognized for almost two decades [39]. Issues of midwifery staff needing to 'upskill' when considering transitioning to an MCC model is consistent with other research [29,36]. For example, studies have identified perineal suturing and cannulation as common skills for which midwives should receive further education and mentorship before they can feel confident to work in MCC models [21,29]. Based on the findings of this study, it is suggested that educational opportunities and work experience in MCC models would facilitate skills acquisition, understanding of current evidence and managing new ways of working. This issue was frequently linked to the dominance of medicine in maternity care settings preventing opportunities for midwives to work across their full scope of practice [40]. Participants from all three groups described this issue repeatedly using the codes 'hierarchy' and 'patriarchy', with reference to the medical hegemony over midwifery care within the hospital maternity setting. Many authors have noted the practice trend of risk aversion and task-oriented care that medically governed hospital settings enable [36,41,42]. Routine practices of consultation and referral are based on risk assessment pathways that are designed to improve safety. However, they also articulate a clear hierarchy within hospitals settings, often documenting a flowchart of professional relationships that demonstrates unequal power in the decision-making process [38,43]. Authors of these policies and directives need to consider this effect on the midwifery workforce's ability to advocate for women and how to navigate this hierarchy of risk management in a way that maintains shared decision-making as a team. Further, interviews with all participant groups indicated that due to limited access and awareness of MCC models, most women continued to be restricted to care within obstetrics-led maternity units, which provide hospital-based fragmented midwifery care. This further embeds task-based fragmented hospital care, dubbed the 'industrial model of childbirth', as the prevailing maternity care option available to women [44]. Other evidence supports the findings of this study, which revealed that midwives' frustration with organizational attitudes affects their work and hampers their ability to provide quality woman- centered care [33,41]. These factors are shown to lead to fatigue and a lack of confidence within the midwifery workforce [45].

Another major concern raised by midwifery participants was a need to 'address misinformation about [the] MCC lifestyle'. This category indicated that midwives' confidence in transitioning to a MCC model was hampered by concerns about managing on call commitments, as compared with working rostered shift work. However, other participants observed that MCC was quite flexible, as work could be negotiated around both the woman's and the midwife's needs. Perceptions of excessive workloads, long hours on call, professional isolation and difficulty achieving work–life balance have hindered the widespread translation of midwifery caseload models [36,46]. However, developing meaningful relationships, social support and occupational autonomy are all identified in caseload models as factors that help protect against work related burnout, reduction in stress and anxiety, and improved work satisfaction within the midwifery profession [46,47]. A tool kit developed by Donald et al. used action research methods to identify new ways of working that facilitated positive 'Work–Life Balance Scores' for midwives working in caseload models [37]. Dixon et al. [47] also reported that most of the midwives providing caseload midwifery had school-aged children (89.4%), stating that the participants felt they had flexible work hours; and, the autonomy to organize work patterns around childcare were beneficial to midwives with children [36]. This is important because the findings from this study claimed that midwives were concerned that having children would prevent them from working in MCC models. Australian public hospital maternity services should feel confident that a reorientation of midwifery care aligned with MCC

evidence is likely to be a sustainable way forward and improve workforce wellbeing.

Similar to phase one participants, midwives described witnessing a shift in midwifery culture, with the newer generation of midwifery students and new graduates currently emerging. Participants stated that students and new graduates had an effective understanding of recent research about MCC and were motivated to translate this evidence into practice. Students were also valued because they experienced providing continuity of care from within 'mini-midwifery practice' opportunities during their university studies. However, some participants were concerned that there was a lack of support for new graduates to find employment in MCC models, which contributes to their attrition rates from the workforce. The literature confirms that these findings demonstrate a high number of early-career midwives are leaving the profession [41,48]. New graduates and student midwives should be acknowledged as an integral part of the future midwifery workforce; one that will influence practice innovation, such as the implementation of MCC [4,49]. Currently, students' exposure to working within true MCC model models is minimal due to the limited number of models that are currently available. Furthermore, Ebert et al. [52] found that students who worked in a fragmented hospital setting with unknown supervisors were at an increased risk of stress and anxiety, which in turn reduced the students' confidence and skill competence. Research has questioned whether students can gain a realistic experience of MCC when they follow women through a fragmented system [50–52]. Evidence demonstrates that students need to be immersed in a MCC model for their practicum experience, so that they can observe the flexibility of midwives arranging workloads around family or other commitments, negotiating time off and navigating 'on call' work in a sustainable way[66]. Students stated that these experiences reaffirmed their desire to work within MCC models, and that it provided insight into how they could transition into that model upon graduation[66]. As supported in other research, participants identified the need to debunk the myth that students and new graduates require more experience before they can be included in an MCC workforce [53]. A study by Cummins et al. [49] recommended using a concept model that was designed to help organizations better understand the support required that enables new graduate midwives to work in MCC models.

Women spoke of the power in 'Rallying Together'. However, women participants frequently said women in their communities would not know what MCC was, or that it was an option of maternity care. McKellar et al. identified that a significant barrier to increasing access to MCC models was a lack of public understanding regarding the role of the midwife [54]. It was clear a lack of understanding existed about midwives' level of skill and expertize with birth, as well as a perception that midwives are assistants rather than lead care providers [54]. This lack of knowledge affects women's capacity to make an informed choice regarding care options, and it hinders the upscaling of midwifery-led models of care. Homer et al. [58] raised a concern regarding the invisibility of midwives within the Australian health system and explained that it was important that midwives be promoted, respected and have autonomy of practice. This study is consistent with the evidence indicating that women need to have a better understanding of the role of midwives [56] and that they need to know that MCC is a safer option [1]. The evidence clearly identifies that MCC models are a valued service, with some existing models being unable to manage consumer demand [12].

Despite these challenges, the women participants identified that, in some areas, women had 'rallied together' and had successfully pursued the implementation of an MCC model in their health services. The tipping point for the women in this study was the threatened closure of maternity services within their local health services, a catalyst also noted in earlier literature [55]. This 'crisis' was described as a 'golden opportunity' that resulted in a 'cascade' of actions and steps that women made to ensure that key stakeholders were engaged. These actions were consistent across health service areas, and included building community support groups, joining meetings with local politicians and local media resources (newspapers/news reporters), and writing letters to hospital executives. Several government policies recognize the difficulty for consumer enablement and engaging stakeholders that contribute to health service development or improvement [13–15]. These policies understand the importance of engaging women when working to implement MCC models [13–15]. Participants acknowledged that during the implementation of a MCC model, consumer engagement with health services became a crucial step towards changing maternity services. Current implementation research suggests that as consumers become more knowledgeable and involved in their health care, more participative models of care will be expected; this challenges current health care organizations to shift away from provider-driven systems by recognizing the importance of woman-centered care [56]. To assist with this approach, the Quality Maternal and Newborn Care framework is said to offer an evidenced-based example of value-based maternity care [57]. In the UK, the National Health Service (NHS) (2017) is currently working towards service user co-production through a Maternity Voices Partnership (MVP) initiative [15]. The formalized approach allows themes and challenges to be identified through women's experiences of maternity services, as well as maternity staff, and it is an opportunity to receive feedback, gauge changes and shape service delivery [15]. A review by Russell identified action research as a facilitator of change that allowed for the delivery of midwifery-led care, and a realist approach was highlighted as effective for evaluating midwifery practice change [38]. Community-Based Participatory Action Research is further recognized for its ground up approach to facilitating consumer and multi-stakeholder projects that effect innovative practice change.

4.1. Strengths and limitations

This study has included the perspectives of 34 participants. Although this is an adequate sample size for the qualitative design of this research, it does limit the generalizability or further application of the findings across other settings. It should also be noted that nine of the ten women were part of a consumer advocacy group for maternity choices. Nonetheless, this study has many strengths. Member checking of key categories and concepts with participants was performed to validate the interpretation of the data. The credibility of the data was ensured through triangulation, with the inclusion of a diverse range of participants who possessed a variety of experiences. Multiple sites were included, and findings are comparable with national and international studies, which strengthens the transferability of the findings to other settings. The setting of regional NSW public hospitals provided a clear boundary for interpreting and applying the findings, which ensures that the organizational characteristics of this study's context are easily identifiable.

4.2. Recommendations and further research

The results indicated that both midwives and women are key stakeholders who significantly influence the implementation of MCC models within their local maternity services. When women and midwives worked together, they were more successful in engaging the necessary stakeholders and in initiating changes that facilitated the implementation of an MCC model. The current hospital based care exacerbates a gap between women and midwives which is a barrier to engagement. To address this gap the findings recommend establishing stronger engagement across consumers, midwifery workforce and hospital stakeholder groups, like the Maternity Voices Partnerships in the UK [31]. Future research in this space should look towards Action Research, particularly Community-Based Participatory Action Research, as it is shown to facilitate staff ownership of change, solving local problems by establishing collaborative partnerships between diverse stakeholders. These initiatives would assist midwives to identify areas for development such as workshops to enable working to their full scope

of practice and acknowledge gaps that require further education when preparing for their transition to working in a MCC model. These activities also offer opportunities for student and new graduate midwives to build confidence and employability to step into MCC models upon graduation.

5. Conclusion

The substantive theory 'A partnership between midwives and women is required to build confidence and enable the promotion of current evidence; this is essential for engaging key hospital stakeholders to invest in the implementation of MCC models' addressed the aim of this research. Recommendations are midwives and women are key stakeholders who significantly influence the implementation of MCC models within their local maternity services, in regional settings. Midwives' reluctance to transition to work in the MCC models is based on a lack of knowledge of what it is really like to work in MCC, and an ageing workforce. Barriers include a hierarchical and medically dominated system that prevents innovation. Offering education about the ways of working and the benefits of MCC may assist with the implementation MCC in regional areas. New graduate midwives are well prepared to work in these models and would assist their implementation through providing adequate staffing. Women from regional areas require education to be fully informed of the benefits of continuity of care and together a partnership of women and midwives in regional areas can be a strong political force to influence the implementation of MCC models. This can be achieved through Community-based Participatory Research which is suggested as the next step to enable a partnership that can potentially resolve challenges and facilitate the implementation of an MCC model.

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References

[1] J. Sandall, H. Soltani, S. Gates, A. Shennan, D. Devane, Midwife-led continuity models versus other models of care for childbearing women, Cochrane Collab. 9 (2016) 1–119.
[2] S.K. Tracy, D. Hartz, M. Nicholl, Y. McCann, D. Latta, An integrated service network in maternity – the implementation of a midwifery-led unit, Aust. Health Rev. 29 (3) (2005) 332–339.
[3] C.S.E. Homer, Models of maternity care: evidence for midwifery continuity of care, Med. J. Aust. 205 (8) (2016) 370–374.
[4] M. Brown, E. Dietsch, The feasibility of caseload midwifery in rural Australia: a literature review, Women Birth 26 (1) (2013) e1–e4.
[5] World Health Organisation (WHO), United Nations Population Fund (UNFPA). Ending preventable newborn deaths and stillbirths by 2030: A renewed focus for improving maternal and newborn health and wellbeing, 2020. Available from: ending-preventable-maternal-mortality_epmm_brief-230921.pdf (who.int).
[6] H.L. McLachlan, D.A. Forster, M.A. Davey, et al., Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low risk obstetric risk: The COSMOS randomized controlled trial, BJOG 119 (12) (2012) 1483–1492.
[7] S.K. Tracy, D. Hartz, M. Nicholl, et al., An integrated service network in maternity – the implementation of a midwifery-led unit, Aust. Health Rev. 29 (3) (2005) 332–339.
[8] M. Newton, H. McLachlan, K. Willis, D. Forster, Comparing satisfaction and burnout between caseload and standard care midwives: findings from two cross-sectional surveys conducted in Victoria, Australia, BMC Pregnancy Childbirth 29 (3) (2014) 223–233.
[9] A.J. Macfarlane, B. Blondel, A.D. Mohangoo, et al., Wide differences in mode of delivery within Europe: risk-stratified analyses of aggregated routine data from the Euro-Peristat study, BJOG: Int. J. Obs. Gynaecol. 123 (4) (2016) 559–568.
[10] New South Wales Ministry of Health, Maternity: Towards normal birth PD2010_045, 2010.Available from: ⟨https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_045.pd⟩.
[11] World Health Organisation, WHO statement on caesarean section rates, 2015. Available from: ⟨WHO_RHR_15.02_eng.pdf;jsessionid=B00ECCA9027BE43D2E40DB10D42A7D5A⟩.
[12] K. Dawson, H. McLachlan, M. Newton, D. Forster, Implementing caseload midwifery: exploring the views of maternity managers in Australia – a national cross-sectional survey, Women Birth 29 (3) (2016) 214–222.
[13] New South Wales Ministry of Health, Midwifery continuity of carer model tool-kit, 2012. Available from: ⟨https://www.health.nsw.gov.au/nursing/practice/Publications/midwifery-cont-carer-tk.pdf⟩.
[14] Queensland Health, Midwifery models of care: implementation guide, 2008. Available from: ⟨http://trove.nla.gov.au/version/231493590⟩.
[15] National Health Service (NHS) England, Implementing better births: Continuity of carer, 2017. Available from: ⟨https://www.england.nhs.uk/wp-content/uploads/2017/12/implementing-better-births.pdf⟩.
[16] A. Cummins, R. Coddington, D. Fox, A. Symon, Exploring the qualities of midwifery-led continuity of care in Australia (MiLCCA) using the quality maternal and newborn care framework, Women Birth 33 (2) (2020) 125–134.
[17] S. Kildea, Y. Gao, S. Hickey, S. Kruske, C. Nelson, R. Blackman, Y. Roe, Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia, E Clin. Med. 12 (2019) 43–51.
[18] S.R. Walani, Global burden of preterm birth, Int. J. Gynecol. Obstet. 150 (1) (2020) 31–33.
[19] Council of Australian Governments. Woman-centred care: Strategic directions for Australian maternity services, 2019. Woman-centred care: Strategic Directions for Australian Maternity Services (health.gov.au).
[20] New South Wales Ministry of Health, The first 2000 days framework: conception to age 5, 2019. Available from: The First 2000 Days Framework (nsw.gov.au).
[21] M.S. Newton, H.L. McLachlan, D.A. Forster, K.F. Willis, Understanding the 'work' of caseload midwives: a mixed-methods exploration of two caseload midwifery models in Victoria, Australia, Women Birth 29 (3) (2016) 223–233.
[22] K. Charmaz, Constructing Grounded Theory, second ed., Sage, London, 2014.
[23] J. Breckenridge, D. Jones, I. Elliott, M. Nicol, Choosing a methodological path: reflections on the constructivist turn, Grounded Theor. Rev. 11 (1) (2012) 64–71.
[24] S. Pairman, J. McAra-Couper, Theoretical frameworks for midwifery practice, in: S. Pairman, J.P.C. Thorogood, S. Tracy (Eds.), Midwifery: Preparation for Practice, third ed., Elsevier, 2015, pp. 383–411.
[25] H. Hall, L. McKenna, D. Griffiths, Applying grounded theory to midwifery research problems, Int. J. Childbirth 2 (2) (2012) 136–141.
[26] National Health and Medical Reseach Council, Australian code for the responsible conduct of research, 2018. Available from: ⟨the-australian-code-for-the-responsible-conduct-of-research-2018.pdf⟩.
[27] S. Bayes, E. Juggins, L. Whitehead, A. De Leo, Australian midwives' experiences of implementing practice change, Midwifery 70 (2019) 38–45.
[28] R. Deery, D. Hughes, Supporting midwife-led care through action research: a tale of mess, muddle and birth balls, Evid.-Based Midwifery 2 (2) (2004) 52–59.
[29] C. Styles, L. Kearney, K. George, Implementation and upscaling of midwifery continuity of care: the experience of midwives and obstetricians, Women Birth 33 (4) (2020) 343–351.
[30] H. Perdok, S. Jans, C. Verhoeven, et al., Opinions of maternity care professionals and other stakeholders about integration of maternity care: a qualitative study in the Netherlands, BMC Pregnancy Childbirth 16 (2016) 1.
[31] Qureshi N., Brewster, C., The fifteen steps for maternity across Greater Manchester & Eatern Cheshire local maternity system. In: England NHSN, editor.: Greater Manchester and Estern Cheshire Strategic Clinical Networks 2019.
[32] E. Callander, M. Sidebotham, D. Lindsay, J. Gamble, The future of the Australian midwifery workforce – impacts of ageing and workforce exit on the number of registered midwives, Women Birth 34 (1) (2021) 56–60.
[33] C.J. Catling, F. Reid, B. Hunter, Australian midwives' experiences of their workplace culture, Women Birth 30 (2) (2017) 137–145.
[34] C. Styles, L. Kearney, K. George, Implementation and upscaling of midwifery continuity of care: the experience of midwives and obstetricians, Women and Birth 33 (4) (2020) 343–351.
[35] M. Lewis, C. Langley, Is to see me to know me? Are midwives prepared for continuity models? MIDIRS Midwifery Digest 28 (3) (2018) 277–284.
[36] B. Taylor, F. Cross-Sudworth, L. Goodwin, S. Kenyon, C. MacArthur, Midwives' perspectives of continuity based working in the UK: a cross-sectional survey, Midwifery 75 (2019) 127–137.
[37] H. Donald, L. Smythe, J. McAra-Couper, Creating a better work-life balance, N. Z. Coll. Midwives J. 49 (2014) 5–10.
[38] K. Russell, Factors that support change in the delivery of midwifery led care in hospital settings. A review of current literature, Women Birth 31 (2) (2018) e134–e141.
[39] P. Brodie, Addressing the barriers to midwifery—Australian midwives speaking out, Aust. J. Midwifery 15 (3) (2002) 5–14.
[40] H.G. Dahlen, M. Jackson, J. Stevens, Homebirth, freebirth and doulas: casualty and consequences of a broken maternity system, Women Birth 24 (1) (2011) 47–50.
[41] K. Harvie, M. Sidebotham, J. Fenwick, Australian midwives' intentions to leave the profession and the reasons why, Women Birth 32 (6) (2019) e584–e593.
[42] S. Miller, E. Abalos, M. Chamillard, et al., Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide, Lancet 388 (10056) (2016) 2176–2192.
[43] D. Walsh, Subverting the assembly-line: childbirth in a free-standing birth centre, Soc. Sci. Med. 62 (2006) (13330-1340).
[44] M. Kirkman, Resistance to continuity of carer: our need for the naming of parts, Midwifery Matters 149 (2016) 23–24.
[45] D. Rouleau, P. Fournier, A. Philibert, B. Mbengue, A. Dumont, The effects of midwives' job satisfaction on burnout, intention to quit and turnover: a longitudinal study in Senegal, Hum. Resour. Health 10 (1) (2012) 1–14.

[46] J. Fenwick, M. Sidebotham, J. Gamble, D.K. Creedy, The emotional and professional wellbeing of Australian midwives: a comparison between those providing continuity of midwifery care and those not providing continuity, Women Birth 31 (1) (2018) 38–43.
[47] L. Dixon, K. Guilliland, J. Pallant, et al., The emotional wellbeing of New Zealand midwives: comparing responses for midwives in caseloading and shift work settings, N. Z. Coll. Midwives J. 53 (2017) 5–14.
[48] J. Cull, Making women matter: the Australian midwifery group practice model, MIDIRS Midwifery Digest 28 (2) (2018) 141–146.
[49] A.M. Cummins, C. Catling, C.S. Homer, Enabling new graduate midwives to work in midwifery continuity of care models: a conceptual model for implementation, Women and Birth 31 (5) (2018) 343–349.
[50] J. Gamble, M. Sidebotham, A. Gilkison, D. Davis, L. Sweet, Acknowledging the primacy of continuity of care experiences in midwifery education, Women Birth 33 (2) (2020) 111–118.
[51] M. Sidebotham, J. Fenwick, Midwifery students' experiences of working within a midwifery caseload model, Midwifery 74 (2019) 21–28.
[52] L. Ebert, O. Tierney, D. Jones, Learning to be a midwife in the clinical environment; tasks, clinical practicum hours or midwifery relationships, Nurse Educ. Pract. 16 (1) (2016) 294–297.
[53] A.M. Cummins, E. Denney-Wilson, C.S.E. Homer, The challenge of employing and managing new graduate midwives in midwifery group practices in hospitals, J. Nurs. Manag. 24 (5) (2016) 614–623.
[54] L. McKellar, A. Brown, P. Adelson, P. Medway, Public survey to explore community understanding of the role of the midwife in Australia and inform a public awareness media campaign, Women Birth 31 (2018) (S12-S).
[55] R. De Vries, C. Benoit, E. van Teijlingen, S. Wrede, Birth By Design: Pregnancy, Maternity Care and Midwifery in North America and Europe, Routledge, London, 2001.
[56] A. De Jonge, S. Downe, L. Page, et al., Value based maternal and newborn care requires alignment of adequate resources with high value activities, BMC Pregnancy Childbirth 19 (1) (2019) 428.
[57] M.J. Renfrew, A. McFadden, M.H. Bastos, et al., Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care, Lancet 384 (9948) (2014) 1129–1145.
[58] C.S. Homer, L. Passant, P.M. Brodie, S. Kildea, N. Leap, J. Pincombe, C. Thorogood, The role of the midwife in Australia: views of women and midwives, Midwifery 25 (6) (2009) 673–681.