Women and Birth 38 (2025) 101958

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.sciencedirect.com/journal/women-and-birth

Giving a voice to early career midwives who desire to work in midwifery continuity of care: a co-designed approach

N.J. Parry [a,b,*,1,2], C. Catling [a,3,4], A.M. Cummins [b,5,6]

[a] School of Nursing and Midwifery, University of Technology, Sydney, Australia
[b] School of Nursing and Midwifery, College of Health Medicine and Wellbeing, University of Newcastle, Australia

ARTICLE INFO

Keywords:
Midwifery
Early Career
Continuity of Care
Co-design
Health Workforce

ABSTRACT

Problem: It is unknown what new graduate midwives need to transition confidently into midwifery continuity models following their new graduate year.
Background: Research has focused on exploring the opportunities and supports for midwives to work in continuity of care in their new graduate year only.
Aim: To explore what midwives need in their new graduate year that supports them towards working in midwifery continuity models.
Methods: Ten semi-structured interviews were conducted with early career midwives who aspired to work in midwifery continuity models following their new graduate year. Thematic analysis identified their needs, and informed survey items. This survey was co-designed for future use with other midwives.
Findings: Three themes were identified: The New Graduate Experience, Back Yourself, and Coming Home. Five survey sections were developed: The new graduate experience, Influence of workplace culture, Mentoring, Working in midwifery continuity of care as an early career midwife, and Preparing yourself. All items met a minimum agreement on clarity, relevance and importance.
Discussion: Midwives described reduced confidence in their ability to work in continuity models after their new graduate experience. They saw experienced midwives working in continuity models to be unsupported by other staff. Job satisfaction improved when they provided holistic care, and within a positive workplace culture. They valued the inclusion of survey items which addressed these factors.
Conclusion: Early career midwives identified aspects of their experiences which helped or hindered their goal to work in midwifery continuity models. A co-designed survey was developed to gain further insight into this topic.

Statement of Significance

Problem or issue

Early career midwives rarely have the opportunity to work in midwifery continuity of care models. It is unknown what they need from their new graduate year to enable this.

What is already known

Attrition of early career midwives is partly attributed to poor job satisfaction which may be because they do not work in their desired model.

What this paper adds

Early career midwives who aspired to work in midwifery continuity models identified what they needed in their new graduate year. Useful for designing transition programs, this could also improve job satisfaction and address attrition.

* Correspondence to: University of Technology Sydney, School of Nursing and Midwifery, Jones Street, Broadway New South Wales 2007, Australia.
E-mail addresses: Nicola.J.Parry@student.uts.edu.au (N.J. Parry), Christine.Catling@uts.edu.au (C. Catling), Allison.Cummins@newcastle.edu.au (A.M. Cummins).
[1] ORCID ID: 0009–0005-8893–4135
[2] @NicJ_Parry
[3] ORCID ID: 0000–0001-7352–2879
[4] @Allisoncummins2
[5] ORCID ID: 0000–0003-0626–3365
[6] @ChristineCatli1

https://doi.org/10.1016/j.wombi.2025.101958
Received 9 May 2025; Received in revised form 13 July 2025; Accepted 25 July 2025
Available online 5 August 2025

Introduction

There is currently a shortage of midwives worldwide [1]. Strategies are necessary to stem the attrition of midwives who often leave due to role dissatisfaction, particularly early in their career [2–4]. In Australia, one identified approach that may mitigate attrition, is to find strategies to retain midwifery graduates in their early career years [5,6]. Early Career Midwives (ECMs) are typically defined as those in the first five years of post-registration practice [3,7,8], and this paper aligns with this definition, while using new graduate midwives for those in their first year of practice only.

There are recognised approaches to increase job satisfaction for ECMs. For example, being able to practice across the full scope of midwifery practice [4], in line with their philosophy of midwifery [9], and in ways that allow them to build a relationship with women and families [3,4]. This has been reported by ECMs working in midwifery continuity of care models where they experience more opportunity to practice in these ways [4].

Midwifery continuity of care models are where a known midwife provides care across the antenatal, birthing, and postpartum period [10]. There is strong evidence for this model's safety, including a decrease in caesarean sections, epidural anaesthetics, and instrumental births, along with improved satisfaction rates for women, longer breastfeeding duration, and cost savings to the health system [11]. Some midwifery education programs in Australia focus on giving students experience in continuity of midwifery care models, and as a result, many graduates are passionate about this approach to care and aim to practice this way in their careers [12,13].

In reality, most midwives do not work in midwifery continuity of care models in their new graduate year. New graduates are often required to gain more experience before they can work in continuity models and there are fears around the safety of allowing inexperienced midwives to work in these roles [14], despite evidence that suggests new graduate and ECMs are prepared and supported to do so [15,16]. Some midwives choose not to work this way at the time of graduation due to personal reasons such as lack of confidence and wanting to consolidate skills. For example, in one study, 73 % of graduating midwives stated they wanted to work in midwifery continuity of care within five years, but the majority wanted to consolidate their skills first [17].

Most commonly in Australia, new graduate midwives complete a transition program where they rotate through different areas of maternity care [18]. Such programs are similar to nursing models which were developed to support nurses transition to hospital settings when education moved from hospitals to universities [19]. In both nursing and midwifery, these programs aimed to provide a smoother transition and consolidation of skills, closing the theory-practice gap. However, doubt remains regarding their ability to effectively help with this transition and issues such as transition shock remain [20]. For midwives, the traditional 'transition to practice' model may also be less effective than employment in a continuity of care model in relation to consolidating skills and knowledge [15]. This leads to the need for more nuance regarding the needs of new graduates and ECMs.

There is a lack of consultation with new graduate and ECMs about what they desire, and need, out of their transition program. A scoping review identified much literature exploring and describing the experiences of new graduate and ECMs, and extrapolated aspects of such programs they would find helpful [16]. However, limited research directly investigates what they want and need from a transition program, and none were found to have involved the ECMs in the development of a such a program. Therefore, the aim of this research was to explore ECMs' views and take a co-design approach about what they would find helpful to feel competent, confident and capable in their early careers, so that they are ready to work in midwifery continuity of care models. This paper reports the first stages of a larger research project that aims to develop a Professional Development Pathway for ECMs.

Participants, ethics and methods

This research employed a mixed methods, sequential design including a co-design approach. Semi-structured interviews were held to explore the experience of 10 ECMs who had aspired to work in midwifery continuity of care, but had not done so as part of their new graduate transition year. The intent was to seek their views and experiences to inform the creation a codesigned survey around the support needs of ECMs who had desired to working in midwifery continuity of care. The epistemology of this research was constructivist. Constructionism seeks to build meaning around experience [21] and this research aimed to explore the experience of the ECMs and, together with them, build meaning around that experience. We used an inductive approach which builds meaning from the bottom up – in this case, from the individual experiences of participants to implications for the wider workforce.

The co-design approach

The survey co-design approach allowed the ECMs to describe important features of how a new graduate program should be designed to support them towards their goal of providing continuity of care. Co-design has been identified as a way to reduce inefficiency in research, and increase efficacy and relevance by involving the end user with lived experience in the research process [22,23]. This research uses a number of elements identified as suitable in co-design, including interviews, and deliberative processes such as rating systems [22]. Modified Delphi technique uses rounds of opinion from experts to reach consensus [24]. This approach was used, starting with items generated from the interviews, with repeated rounds and ratings to improve them. The experts were ECMs with lived experience of being a new graduate with a goal of working in midwifery continuity of care. The co-designed Delphi approach also targets the risk of researcher bias - the resulting survey items were generated from the experiences of the participants, with items returned to them multiple times to clarify their intent.

Ethical approval was obtained from the University Human Research Ethics Committee (approval number: HREC REF NO. ETH20-4879.) All participants freely gave consent to contribute to this research.

Recruitment

ECMs were recruited through social networks, and snowball sampling. Two social media groups, one with a focus on midwifery continuity of care and one generic group which targets women across the young adult to middle age spectrum were chosen. Given 98.9 % midwives in Australia are female, and 75–100 % of midwifery university enrolments (from one institution) are from students aged 21–39 (personal correspondence with A Cummins, PhD, Professor and Head of Midwifery University of Newcastle; in email 10th May 2025; used with permission), these social media groups were deemed appropriate to reach the target audience. Moderators permitted posting of research flyers on the sites, and the flyer was also posted on the researchers' own social media posts on Facebook, Instagram and X (known as Twitter at the time).

The reach of social media makes it an excellent place to recruit research participants, but presents some ethical concerns due to the unmoderated technique. The framework developed by Townsend and Wallace was used as a guide [25]. This framework addresses the concerns of data confidentiality, informed consent, anonymity and risk of harm, by providing a flowchart for assessing ethics for research using social media.

Demographic information, such as age, educational pathway,

context of current work and year of graduation were collected from those responding to the recruitment flyer. This enabled researchers to select a heterogeneous group with a range of experience, to ensure the developed survey would have a broad relevance, and enhance the data's robustness and credibility. This information was collected and stored using Redcap, and each potential participant was given a participant number to assure anonymity. A separate file recorded contact details connected to their participant number. The demographic data was tabled by the first author, then reviewed by all authors to agree on 10 ECMS encompassing the widest range of experiences, ages, educational pathways, and an even split of those who had, and had not, worked in midwifery continuity of care. All respondents to the recruitment flyer were then contacted and either invited to book an interview, or thanked for their interest and declined involvement. Once recruitment was finalised and interviews completed, all identifying personal data from all participants was deleted.

Participants

The aim was to involve 10 ECMs who fit the four inclusion criteria: graduated within a 2–5 year period prior to the interview, from an Australian institution; self-identify as having wanted to work in midwifery continuity of care at graduation; not commenced working in a midwifery continuity of care model as a new graduate; and currently working as a midwife in any model of care in a public hospital in Australia.

Midwives who were between two and five years post-graduation were purposively sampled as described. This timeframe captured the early career period, while ensuring that all participants had completed their new graduate year. Purposive sampling is a strategic way to get to what the researcher wants to know and [26], in this study, it was important to accurately target the participants with specific experience as ECMs.

A similar study design used a sample size of 12 to co-create a survey which was used to collect data from a greater number of participants [27]. Similarly, Keedle et al. [28] had a sample size of 11 when studying women's experience of Vaginal Birth After Caesarean in order to create a survey and Cummins et al. [15] had a sample size of 13 when exploring the experiences of new graduate midwives working in continuity of care. Additionally, although large participant numbers may enhance reliability, this can be unwieldly and reduce response rate without necessarily improving results [29].

Data collection

Semi-structured interviews were conducted with 10 ECM participants. An interview guide with open ended questions that were flexible enough to allow the participant to share their own individual experiences was used (Table 1). These guiding questions focused on whether participants achieved their goal of working in midwifery continuity of care, and what barriers/facilitators they experienced. They also explored the midwives' current interest in and passion for midwifery continuity of care models, and ongoing career aspirations.

Interviews were conducted by the first author, recorded and transcribed with participants' consent via video conferencing over Zoom. When dialling into the video conference, participants were informed that they could choose to keep cameras on or off, and names were not recorded verbally or on the screen. Pseudonyms were assigned to each participant, and recordings were saved using these on a password protected computer. This allowed participants to be anonymous, and met the conditions of ethics approval.

Data analysis

At the time of the interview, responses were auto transcribed using the software within Zoom. The first author then listened to the audio recordings and transcribed them verbatim. These two transcriptions were compared for accuracy, and final transcriptions were read three times by the first author to become familiar with the data. Using Braun and Clarke's model of reflexive thematic analysis [30], the expressed experiences of each participant were explored. Thematic analysis is a flexible and thorough tool in health research for examining perspective and looking for similarities and differences in experiences, and can be particularly useful when wanting to make research more accessible to those outside academia [31,32]. Reflexive thematic analysis allows the researcher to make thoughtful, reflective analysis of the data [30]. Through these repeated readings of interview transcripts, common ideas emerged. These were written on pieces of paper and grouped with similar ideas from multiple participants, and developed into proposed themes. These proposed themes were then discussed by all researchers, comparing and contrasting ideas until all were satisfied that they created a framework to reliably describe the data. The transcriptions were then copied into NVivo and the first author coded these using the proposed standout themes as a guide. Further readings of the transcriptions and coded material by all authors allowed themes to be refined and strengthened, or discarded, and the discovery of new themes and subthemes were identified. All data within a theme or subtheme were then pulled into a single document and shared with all researchers to consider which were valid and should be included.

Development of survey items

Possible survey items were derived from the themes. Other health researchers have used similar strategies for creating surveys. For example, Sheferaw et al. [33] studied satisfaction rates of perinatal women. They used interviews to generate survey items, tested them, and then used the survey to collect quantitative data. Flicker et al. [27] also used an inductive, collaborative approach to design a survey for use with teenagers around sexual health. They used a youth advisory committee to create the survey which was then pilot tested before being used to collect data from a wider selection of participants. The research reported in this paper was similar, generating possible survey items from interview data, then returning them to the participants for comment and rating.

Using the survey program Qualtrics, draft survey items were sent to the original 10 ECM participants. The participants were asked to rate

Table 1
Open ended guiding questions.

- When you graduated, what were your goals for your first five years of practice?
- Describe your current work situation.
- What changes, if any, do you plan in the next few years?
- When you graduated, you wanted to work in a midwifery continuity of care model, but weren't able to do so. Can you tell me why?
- How do you feel about that goal now?
- What are some of the things that helped/would have helped you achieve your goal of working in a midwifery continuity of care model?
- What would have helped build confidence for working in a midwifery continuity of care model?
- What barriers did you find to working in a midwifery continuity of care model?
- Tell me about developing "soft" skills – care planning, team work, etc. What did you learn about these in your new graduate year?
- What advice would you give to a graduating student who wanted to work in midwifery continuity of care early in their career?
- Is there anything else you'd like to add?

survey items as to their importance, relevance and clarity using a 4-point Likert scale (see Fig. 1). They could also give free text feedback on each item. Once all participants had submitted their responses, adjustments were made in line with their comments and ratings. The revised survey items were sent out a second time, and then adjusted again. This process continued until criteria of 70 % agreement across all scales of importance, relevance and clarity were met. However, to ensure the best possible outcome, if an item scored between 70 % and 80 % it was re-written for the next round to see if it could be further improved. Generally, the version of the item that scored the highest across all rounds, and all three measures, was used in the final survey. There were a couple of exceptions, one of which is demonstrated in the results section of this paper. In all, three rounds were competed before all items met criteria. Table 4 demonstrates three examples of how this process developed survey items.

Findings

Demographics

Twenty-five midwives responded to the recruitment flyer and 22 of these subsequently accepted the invitation to complete an eligibility survey, with 21 ultimately meeting inclusion criteria. Ten of these respondents were selected as they provided the broadest range of experience across midwifery roles, pathway to qualification, year of graduation and age range. It was important for the sample to have five midwives who had achieved their goal of working in midwifery continuity of care and five who had not, so that data could reflect both experiences. While all qualification pathways were represented, Bachelor of Midwifery graduates were overrepresented in the sample. Year of graduation (2016–2020) and age range (20−50) were relatively evenly spread. The demographics of the 10 participating midwives and their pseudonyms are listed in Table 2.

Table 2
Summary of participants with pseudonym.

	Pseudonym	Current role	Pathway to qualification	Year of graduation	Age range
1	Nellie	Midwifery continuity of care	BMid[b]	2016	20–30
2	Annette	Other[a]	Double degree[c]	2019	20–30
3	Annabelle	Midwifery continuity of care	BMid	2016	31–40
4	Evangeline	Other	BMid	2019	41–50
5	Natalia	Other	Grad Dip[d]	2019	20–30
6	Hollie	Midwifery continuity of care	BMid	2016	20–30
7	Astrid	Other	BMid	2017	31–40
8	Annalise	Midwifery continuity of care	Grad Dip	2020	31–40
9	Evonna	Other	BMid	2018	20–30
10	Heidi	Midwifery continuity of care	BMid	2020	20–30

[a] These midwives were working in any model of care other than midwifery continuity of care
[b] These midwives had completed a Bachelor of Midwifery
[c] These midwives had completed a double Bachelor of Nursing and Bachelor of Midwifery degree
[d] These midwives had completed a Graduate Diploma of Midwifery, having previously completed a Bachelor of Nursing

Themes from interviews

Three main themes were evident from the analysis of the interview data. Table 3 demonstrates examples of each theme and subtheme.

The identified themes were: *The new graduate experience, Back yourself* and *Coming home. The new graduate experience* described the ECM's experiences as new graduates, and how it affected their goal of working in midwifery continuity of care. It had two subthemes, firstly: *Loss of confidence,* where they described themselves as having less confidence in their practice after their new graduate experience. These ECMs felt they were not trusted and were being watched, which affected their confidence. The second subtheme was: *Treatment of midwifery continuity of care midwives.* Participants saw midwifery continuity of care midwives being unsupported, disrespected, and not included as part of the wider team.

The second theme, *Back yourself,* described the intentionality and confidence ECMs felt they needed to succeed in their goal. It had three further subthemes. *My goal inside* described how they kept focused on their goal, building skills and confidence, and being intentional about the decisions they made to increase their chances of being able to secure a role in midwifery continuity of care. *They're gonna trust me* focused on the relationships they built which would support them to work in midwifery continuity of care, and demonstrating competent practice so they would be trusted; and *Just jump in* reflected how those who had begun to work in midwifery continuity of care had taken that opportunity even though they did not feel completely ready.

The final theme was *Coming home.* This theme described the feeling and experience of achieving a job in midwifery continuity of care in the participants' early career period. They described how valued and supported they were by the midwifery continuity of care team, and the positive feelings they had because they were working in the model that they had chosen, delivering relational continuity to women and working to the full scope of midwifery practice.

Development of survey items

The purpose of the interviews was not only to describe the experience of the 10 ECMs, but to co-design a survey which would allow data to be collected from a larger sample size of midwives.

Items in the survey were developed from the identified themes (Table 4). Fig. 2 demonstrates this process, with the progression from themes, to sections of the survey, to examples of the survey questions that were used in the final version. Questions were grouped into five sections – The New Graduate Experience, The Influence of Workplace Culture, Mentoring, Working in midwifery continuity of care as an early career midwife, and Preparing yourself.

In the survey, **The New Graduate Experience** linked with theme one (*The new graduate experience*) and included questions about aspects

Fig. 1. Survey item rating.

Table 3
Themes and Subthemes.

Theme	Subthemes	Examples
The New Graduate Experience	Loss of confidence	*I felt quite like scrutinized by other staff members just, like, constantly because essentially, they don't really have any trust in what you're doing. And that I think filtered through to not having trust in myself.* **Annette**
		A fellow new graduate was one of those people who needed a little bit more support and probably didn't really get that……which basically kind of just shocked her confidence. Every time I spoke to her about coming to (midwifery continuity of care), because it was a reason that she studied midwifery, she always just says, like, "I don't think I'm ready. I don't think my skills are there yet." **Nellie**
	Treatment of midwifery continuity of care midwives	*(Midwifery continuity of care) at my hospital is not very well supported…. Some of the midwives are like, "we're not helping her"… they watch them, but they don't necessarily help them - they might let them make mistakes…. and then they can go in and say, "you've done that wrong".* **Evonna**
		I was quite aware of the attitudes of the core staff towards (Midwifery continuity of care), in general, and that (Midwifery continuity of care) was quite heavily scrutinised…it was very clear that we were being held to a standard that the rest of the hospital wasn't….It didn't stop me applying but I became a little bit hesitant, if that makes sense….you don't want to ostracise yourself. **Nellie**
Back Yourself	My goal inside	*I know that this is a means to an end. I have my goal inside and it's coming.* **Natalia**
		I've really honed in on what kind of midwife I am, and what kind of midwife I want to become. ***Heidi***
	They're going to trust me	*Like people see how you practice they agree with it or whatever. And then, you know, you build those relationships in that way. Yeah, they trust you. They're gonna trust me. They know that I'll come to them if something's wrong.* **Evonna**
		… being a good worker, and showing that I was really keen, and showing that I cared about the work that I was doing, and building relationships… I didn't feel like in that setting, they were kind of over my shoulder. **Nellie**
	Just jump in	*I would also tell people to back themselves as well. We kind of get stuck in the whole, like, are we ready? Do we have enough skills? Do we have enough knowledge?* **Evangeline**
		Then opportunity came up to do (Midwifery continuity of care)…so I jumped straight in which I was a little bit nervous about but ended up being good… I didn't actually know whether I was ready or not…but I thought the opportunity might not come up again later. So I'll just jump in and see how it goes. **Evonna**
Coming Home		*Going into (Midwifery continuity of care) was like coming home.* **Nellie**
		I felt I could call anyone and any experiences I had, like, I'd get emails …. checking in. "I heard you had a really like terrible birth last night are you going okay?" That sort of thing … I've never felt that I was sort of left to my own devices or left out on my own. I've always felt very supported in the role. **Hollie**

of this year which may have affected their confidence, which either supported or had been a barrier for them working in midwifery continuity of care. It also requested ideas about what supports would have helped them gain confidence, competence and skills.

The **Influence of Workplace Culture** section drew from three of the themes and subthemes. *The treatment of midwifery continuity of care midwives* subtheme demonstrated the culture they observed. The culture they experienced was demonstrated in the theme *The new graduate experience*. A more positive culture was articulated in the theme *Coming home*. This section of the survey included questions around the culture the ECM's observed and experienced as a new graduate, and the effect that had on their desire to work in a midwifery continuity of care model.

The **Mentoring** section drew from three themes. In interviews, mentors were mentioned in connection to their *New graduate experience*, in the relationships they built (*They're gonna trust me*) and once they were working in midwifery continuity of care (*Coming home*). Included in this section were questions around their experience of mentoring, and what features of a mentor were important for those aiming for employment within midwifery continuity of care models. It also asked about general advice, in addition to formal mentoring.

For those who had experienced working as a midwifery continuity of care midwife, the section on **Working in midwifery continuity of care as an early career midwife** had questions about their experience of this, and their confidence in commencing the role. It linked with the theme *Coming home*.

Preparing yourself aligned with the *Back yourself* theme. It included questions around actions the ECMs took which they believed would increase their chances of securing employment in a midwifery continuity of care model and be supported once they did.

Survey item rating

Delphi style rounds were used to rate the survey items and reach consensus. In round one, all 10 ECMs responded, however only nine responded to subsequent rounds and some participants did not answer every question. Therefore, ratings are listed as percentages. In the final draft no survey item on the final survey scored less than 75 % on any rating. Table 4 uses three examples to demonstrate the process. Each example shows the original survey item, feedback from the ECM participants, and the way the item was adjusted each round to improve its importance, clarity and relevance.

Example 1 met criteria on all three measures – 100 % on importance, 100 % on relevance and 89 % on clarity. However, the question was re-written to incorporate a free text suggestion. The participant had suggested: "Dedicated question regarding having an experienced midwife as a "partner" while a grad (sic) in Midwifery Continuity of Care, as most people are concerned about lack of support/experience". An item was added to the list of options – "Good existing support for ECMs in Midwifery Continuity of Care - eg. pairings with experienced Midwifery Continuity of Care midwives." The relevance then dropped to 88 % and the clarity improved to 100 %. Both versions of the question met the criteria, and while the original question scored higher by one point across the cumulative scores of all three measures, the lower scoring question was used as it was felt to be important to include the free text suggestion and value the input of that participant.

Example 2 demonstrates an item which was challenging to design

Table 4
Survey Question Development.

Version 1	Feedback version 1	Version 2	Feedback version 2	Final version
Example 1 How helpful would the following things be in increasing your CONFIDENCE to practice in a MIDWIFERY CONTINUITY OF CARE model at the completion of your new graduate year? (multiple choice) – Mentor who was a MIDWIFERY CONTINUITY OF CARE midwife – Shorter rotations (<3 months) through maternity areas – A rotation through a MIDWIFERY CONTINUITY OF CARE model – Extra education time to complete packages – The availability of a designated ECM position in MIDWIFERY CONTINUITY OF CARE – Good relationships with core/ward midwives – Good relationships with midwifery leadership – Midwifery leaders who were passionate about MIDWIFERY CONTINUITY OF CARE – Midwifery leaders who were supportive of ECMs in MIDWIFERY CONTINUITY OF CARE Do you have other suggestions of things that would have or did increase your CONFIDENCE to work in MIDWIFERY CONTINUITY OF CARE as an ECM?	Importance – 100 % Relevance – 100 % Clarity – 89 % Free text comment: "Dedicated question regarding having an experienced midwife as a "partner" while a grad in MIDWIFERY CONTINUITY OF CARE, as most people are concerned about lack of support/experience"	How helpful would the following things be in increasing your CONFIDENCE to practice in a MIDWIFERY CONTINUITY OF CARE model at the completion of your new graduate year? (multiple choice) – Shorter rotations (<3 months) through maternity areas – A rotation through a MIDWIFERY CONTINUITY OF CARE model – Extra education time to complete packages – The opportunity to apply for a position in MIDWIFERY CONTINUITY OF CARE as an ECM – Good relationships with core/ward midwives – Good relationships with midwifery leadership – Midwifery leaders who were passionate about MIDWIFERY CONTINUITY OF CARE – Midwifery leaders who were supportive of ECMs in MIDWIFERY CONTINUITY OF CARE – Mentor that was a MIDWIFERY CONTINUITY OF CARE midwife – Good existing support for ECMs in MIDWIFERY CONTINUITY OF CARE - eg. pairings with experienced MIDWIFERY CONTINUITY OF CARE midwives, a good orientation program, reduced caseload, etc. – Team leader/in-charge midwives who support all midwives on their shift, regardless model of care. Do you have other suggestions of things that would have, or did, increase your CONFIDENCE to work in MIDWIFERY CONTINUITY OF CARE as an ECM?	Importance – 100 % Relevance – 88 % Clarity – 100 %	No change
Example 2 Think about the choices you made in your practice as a New Graduate midwife to increase your chances of becoming an Midwifery continuity of care midwife as an ECM? How true are these statements of your experience? (Likert scale) – I applied for my New Graduate placement at a hospital where there were more options for Midwifery continuity of care practice. – I applied for my New Graduate placement at a hospital that already had an ECM Midwifery continuity of care program. – I aimed to build supportive relationships with key people who could help me get into Midwifery continuity of care – I aimed to build supportive relationships with key people who would support me on the floor once I was practicing as a Midwifery continuity of care midwife e.g. ward midwives, team leaders). – I aimed to "prove" myself as competent so people would trust my practice. – I engaged in reflective practice regularly. – I aimed to quickly complete educational packages that would enable me to practice with more autonomy. – I avoided asking for help so I would look more competent - I didn't want to show weakness. – I built relationships with Midwifery continuity of care midwives so I could learn about the practice. – I applied for Midwifery continuity of care positions even if I felt I wasn't fully ready yet, just to get my foot in the door. – I completed professional development to increase my competence and/or confidence	Importance – 89 % Relevance – 78 % Clarity – 67 %	What did you do as a New Graduate midwife to increase your chances of becoming a Midwifery continuity of care midwife as an ECM? (Likert scale) – I applied for my New Graduate placement at a hospital that offered Midwifery continuity of care to women. – I applied for my New Graduate placement at a hospital that employed ECMs in Midwifery continuity of care. – I built supportive relationships with key people who could help me get into Midwifery continuity of care – I built supportive relationships with key people who would support me once I was practicing as a Midwifery continuity of care midwife (e.g. ward midwives, team leaders). – I quickly completed educational packages or other professional development that would enable me to practice with more autonomy. – I avoided asking for help so I would look more competent - I didn't want to show weakness. – I spoke with Midwifery continuity of care midwives so I could learn about the practice. – I applied for Midwifery continuity of care positions even if I felt I wasn't fully ready yet, just to get my foot in the door. – I tried to "think like a Midwifery continuity of care midwife" in my practice. – I had a mentor who was helpful in guiding my practice towards Midwifery continuity of care. – I had a mentor, but they were not helpful in supporting my Midwifery continuity of care goals. Are there other things you did to increase your chances of becoming a Midwifery continuity of care midwife as an ECM?	Importance – 100 % Relevance – 100 % Clarity – 75 %	No change.

(*continued on next page*)

Table 4 (*continued*)

Version 1	Feedback version 1	Version 2	Feedback version 2	Final version
(e.g. lactation training, parenting education, privately practicing midwives) – I aimed to model my practice on Midwifery continuity of care. I tried to "think like a Midwifery continuity of care midwife." – I was given a mentor and I engaged intentionally with them in guiding my practice towards Midwifery continuity of care. – I was given a mentor, but they were not helpful in supporting my Midwifery continuity of care goals. – I sought out a mentor who I thought would help me guide my practice towards Midwifery continuity of care.				
Example 3 Who did you seek advice from in regards to moving into MCOC as an early career midwife? Choose all that apply, and rate how USEFUL their advice was. (multiple choice) – MUM of MCOC – MUM from another area – Clinical Educator – Clinical Midwifery Consultant – New Graduate/Early Career Midwives who were already working in MCOC – Core/Ward midwives Other (please specify)	Importance – 67 % Relevance – 67 % Clarity – 100 %	Who did you seek advice from about moving into MCOC as an early career midwife? Choose all that apply, and rate how USEFUL their advice was. (multiple choice) – MUM of MCOC – MUM from another area – Clinical Educator – Clinical Midwifery Consultant – New Graduate/Early Career Midwives who were already working in MCOC – Core/Ward midwives	Importance – 88 % Relevance – 88 % Clarity – 100 %	No change

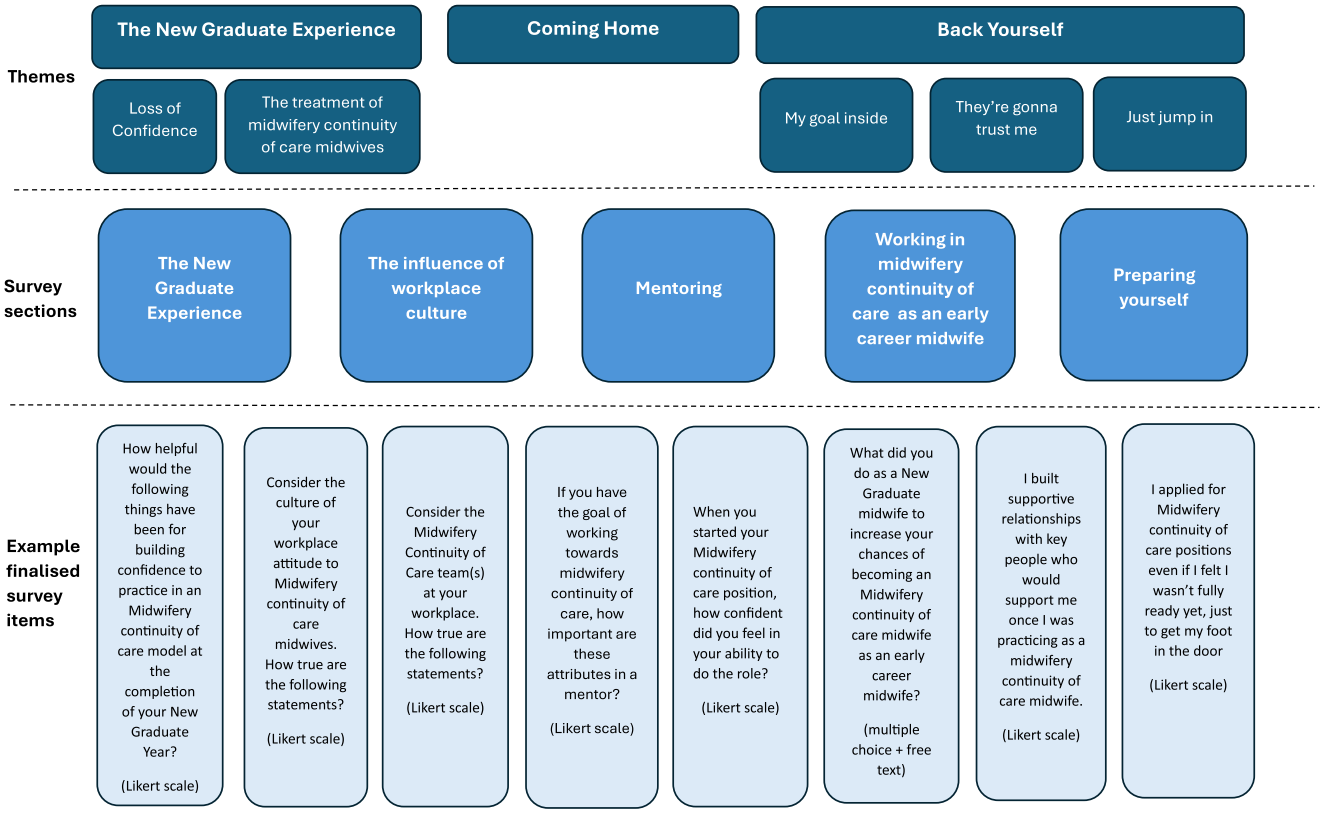

Fig. 2. Development of survey items from themes.

with clarity because of the sheer number of possible responses. In the initial draft survey, it did not meet criteria of 70 % agreement. The number of items were then reduced by consolidating some of the ideas. This improved the importance and relevance to 100 %, and the clarity rating increased to 75 %, thus meeting the criteria.

Example 3 demonstrates an example which scored below criteria on importance and relevance, and a simple rewrite of the wording improved these to 88 % agreement.

After the second round of changes, the survey was sent to the participants again for comment. There were no further significant changes

to any sections of the survey items. The final survey contained 31 survey items, that reached consensus of 75 % agreement as being important, relevant and clear for collecting data on the experiences of ECMs who desired to work in midwifery continuity of care.

Discussion

The purpose of this research was to listen to the voices of ECMs who desire to work in midwifery continuity of care, and co-design a survey that could be used with a larger group of midwives to gather their experiences.

We know that there is a shortage of midwives in Australia [2,5], and indeed worldwide [1]. One driver behind this is the attrition of midwives, and this is most common in the early career period [2]. The primary reason cited by midwives for leaving the profession is lack of job satisfaction [3,4]. A scoping review found this lack of job satisfaction, along with poor support and stress, are common features in the literature [34] and these are also prevalent in data reported in this paper. Interviewed midwives described a loss of confidence due to a lack of support, both for themselves, but also for the midwifery continuity of care midwives they aspired to be. They described feeling stressed and feared making mistakes because of this. When co-designing survey items, the ECMs valued the inclusion of questions which asked for ideas about what would have helped address such issues.

Many midwives get job satisfaction from their pride and a sense of calling in being a midwife [4], the building of relationships and promoting positive outcomes for women [3,4,8]. The EXPert study, which researched burnout among 257 midwives in Melbourne, in Victoria, Australia, found that midwives valued being able to practice in line with their philosophy of midwifery and wanted to make a difference to the families they cared for [9]. The personal experiences of the midwives interviewed in this research, suggests similar desires. In interviews, they described the job satisfaction they received from providing good holistic care for women. Those who had worked in midwifery continuity of care described feeling celebrated and valued by the team, and having satisfaction in being able to work in a way that supported their midwifery philosophy. Many of them described a sense of pride in the belief in themselves they had shown in achieving their goals. Respectful and supportive relationships with other midwives were also important to them. Similar findings were reported by Sheehy et al. [4] where collegial relationships, and social support by other midwives, along with formal and non-formal mentoring relationships were reported positively by ECMs in strengthening their job satisfaction. Similarly, in a scoping review on new graduate midwives, support in the form of mentoring, collective relationships of midwives, and working in models of care that supported their midwifery philosophy were common themes in much of the literature [16]. Similar ideas were expressed by the interview participants in this study. They described the confidence they found in being about to turn to midwifery continuity of care midwives for support, building trusting relationships, and becoming the kind of midwives they wanted to be. The co-designed survey in this study included entire sections on midwifery culture, mentoring relationships and leadership, and the experience of working in midwifery continuity of care models. Questions regarding these topics numbered over a third of total survey items, demonstrated the importance participants placed on these issues.

In an effort to address midwifery shortages and high attrition, midwifery culture has been the focus of much research. A positive workplace culture, and being surrounded by midwives who were friendly and supportive, correlated positively with confidence in early career midwives [35]. Catling et al. [36], studied midwifery culture in Sydney, Australia, and found over a third of participants had considered leaving the profession, citing lack of support, understaffing, and managers who micromanaged their work. Lack of support was linked also linked to poor culture in the FUCHSIA study which surveyed over a 1000 midwives in Victoria, Australia [2]. There has also been a recognition of the enculturation process that occurs when midwives work within a system which does not support their passion, or the way they want to practice midwifery. This enculturation begins early with Arundell et al. [37], in a synthesis of research on midwifery culture, finding evidence that student midwives found there were rewards such as being given interesting experiences and extra education opportunities when they conformed to the culture. These concepts were described in interviews by some of the midwives in the first part of this study. They noted that across the new graduate experience, either themselves, or other midwives they worked with, went from being keen to work in midwifery continuity of care, to not wanting to work in that way. The participants described it as too challenging; they were not ready yet and they noted a lack of support for the midwives already working in midwifery continuity of care. They observed defensive practice, and recognised those fears developing within their own practice. However, they also described an antidote to these feelings; the participants urged midwives to "back themselves", to hold onto their goal, to practice like midwifery continuity of care midwives in their everyday practice, and to be proactive in addressing their weaker skills, building relationships and seeking opportunities. These ideas were developed into a section in the survey about how the ECMs could intentionally prepare themselves for working in midwifery continuity of care to counter the pull of enculturation. Table 4 demonstrates one of the questions from this section, highlighting the ideas of nurturing supportive relationships and mentors, building skills that would enable them to practice with autonomy, and "think(ing) like a midwifery continuity care midwife".

Traditional Transition to Practice models promote consolidation of skills and confidence [19]. This focus on skills consolidation was a concern for the participants in the current research. Participants generally felt that the type of transition program they experienced did not promote good consolidation of skills and described feeling less confident as a result of their experiences. When asked what would have helped them build skills and confidence, an extensive list was developed, and this caused challenges designing survey items that met clarity criteria. Along with more traditional inclusions such as education packages and rotations through all areas, they suggested building good relationships, mentoring by a midwifery continuity of care midwife, staff mental health and wellbeing supports, and midwifery leadership passionate about midwifery continuity of care.

Asking ECMs what they needed out of a transition to practice package is a novel approach. No other studies have reported how new graduate and early career midwives have been included in the design of these programs. The importance of including those with lived experience is integral to co-design [23], and it can be reasonably concluded that involving new graduate and ECMs in the design of a program is more likely to produce a pathway that meets their needs. Through interviews and the co-design of a survey, this research gave ECMs the opportunity to have input into addressing the needs specific to ECMs who want to work in midwifery continuity of care. Further research, still to be reported, provides results of the survey responses from a larger group of midwives. The results will be used to inform the co-development of a Professional Development Pathway for ECMs working in fragmented models of care who want to develop the skills, competence and confidence to move into midwifery continuity of care.

Limitations

A strength of this research is the depth of insight and experiences reported by ECMs who wanted to work in midwifery continuity of care. The outcomes are limited by the fact that only 10 ECMs provided input. The second phase of the wider study surveyed a larger group of midwives, allowing the data reported here to be triangulated and strengthened (not reported in this paper).

All midwives in this study were practicing in Australia. It is not known whether results can be generalised to other populations.

Midwives who graduated from a Bachelor of Midwifery program are overrepresented in this sample. It is possible that data would be different

if more midwives from other educational pathways were represented.

Demographic data on cultural identity was not collected. It would be valuable to know whether the opinions expressed in interviews were primarily or exclusively from a western-based view. Aboriginal and Torres Strait Islander midwives, and midwives from other non-western cultures may have alternative or differently nuanced experiences, and further research into this would be beneficial.

Conclusion

Early Career Midwives were given a voice in how traditional transition to practice programs affected their goal of working in midwifery continuity of care. The participants described their experience, including the facilitators and barriers they faced. Using their insights a survey was co-designed for collecting data from a larger group of participants. The data will be used to build a Professional Development Pathway for other midwives who share their goal of working in midwifery continuity of care but cannot do so when they first graduate. They have been given a genuine opportunity to drive change, and contribute to the planned design of a pathway fit for purpose for early career midwives who desire to work in midwifery continuity of care. This may improve job satisfaction among early career midwives, and reduce attrition rates.

Author agreement

This article is the original work of the authors listed. It has not been previously published and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted. The authors abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

Funding

No funding was used in preparing this paper.

Ethical statement

Ethics for the project that this review forms part of has been granted by University of Technology Sydney, University Human Research Committee. Approval number: ETH20-4879. Approval date: 30/7/2021

CRediT authorship contribution statement

Nicola Parry – conceptualisation, investigation, methodology, project administration, writing – original draft, writing – reviewing and editing. Christine Catling – conceptualisation, methodology, writing – reviewing and editing. Allison Cummins – conceptualisation, methodology, writing – reviewing and editing, oversight of project.

Declaration of generative AI and AI-assisted technologies in the writing process

AI was not used in the preparation of this work.

Declaration of competing interest

None declared.

Acknowledgements and disclosures

No financial funding, technical support or other assistance has been provided for this research. No conflicts of interest are declared.

Acknowledgements

No financial funding, technical support or other assistance has been provided for this research.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2025.101958.

References

[1] A. Nove, P. ten Hoope-Bender, M. Boyce, S. Bar-Zeev, L. de Bernis, G. Lal, Z. Matthews, M. Mekuria, The state of the world's midwifery 2021 report: findings to drive global policy and practice, Homer CSE 19 (2021) 1–7.
[2] R. Matthews, D. Forster, R. Hyde, H. McLachlan, M. Newton, S. Mumford, T. Shafiei, F. Llewelyn, M. Cullinane, A. Cooklin, 2022, FUCHSIA Future proofing midwifery workforce Vic. A statewide CrossSect. study explor. health wellbeing sustain..
[3] K. Harvie, M. Sidebotham, J. Fenwick, Australian midwives' intentions to leave the profession and the reasons why, Women Birth 32 (6) (2019) e584–e593.
[4] A. Sheehy, M.R. Smith, J. Gray, C.H. Ao, Understanding workforce experiences in the early career period of Australian midwives: insights into factors which strengthen job satisfaction, Midwifery 93 (2021) 102880.
[5] C. Homer, K. Small, C. Warton, Z. Bradfield, J. Fenwick, J. Gray, M. Robinson, Midwifery futures–building the future Australian midwifery workforce, A research project commissioned by the Nursing and Midwifery Board of Australia, Burnett Institute, Curtin University and the University of Technology Sydney, 2024.
[6] Department of Health, 2019, Aust. 's. future health workforce rep. Midwives.
[7] B. Hunter, J. Fenwick, M. Sidebotham, J. Henley, Midwives in the United Kingdom: levels of burnout, depression, anxiety and stress and associated predictors, Midwifery 79 (2019) 102526.
[8] J. Cull, B. Hunter, J. Henley, J. Fenwick, M. Sidebotham, Overwhelmed and out of my depth": responses from early career midwives in the United Kingdom to the work, health and emotional lives of midwives study, Women Birth 33 (6) (2020) e549–e557.
[9] R. Hyde, R. Matthews, F. Llewelyn, T. Shafiei, M. Newton, D. Forster, What factors contribute to midwives' work satisfaction–and do years post-registration make a difference? findings from the 'EXPert'study, Women Birth 31 (2018) S15.
[10] N.R. Donnolley, G.M. Chambers, K.A. Butler-Henderson, M.G. Chapman, E. A. Sullivan, More than a name: heterogeneity in characteristics of models of maternity care reported from the Australian maternity care classification system validation study, Women Birth 30 (4) (2017) 332–341.
[11] J. Sandall, C. Fernadez Turienzo, D. Devane, H. Soltani, P. Gillespe, S. Gates, L. V. Jones, A.H. Shennan, H. Rayment-Jones, Midwife continuity of care models versus other models of care for childbearing women, Cochrane Database Syst. Rev. (4) (2024).
[12] J. Carter, E. Dietsch, M. Sidebotham, The impact of pre-registration education on the motivation and preparation of midwifery students to work in continuity of midwifery care: an integrative review, Nurse Educ. Pract. 48 (2020) 102859.
[13] J. Evans, J. Taylor, J. Browne, S. Ferguson, M. Atchan, P. Maher, C. Homer, D. Davis, The future in their hands: graduating student midwives' plans, job satisfaction and the desire to work in midwifery continuity of care, Women Birth 33 (1) (2020) e59–e66.
[14] A.M. Cummins, E. Denney-Wilson, C. Homer, The challenge of employing and managing new graduate midwives in midwifery group practices in hospitals, J. Nurse Manag. 24 (5) (2016) 614–623.
[15] A.M. Cummins, E. Denney-Wilson, C. Homer, The experiences of new graduate midwives working in midwifery continuity of care models in Australia, Midwifery 31 (4) (2015) 438–444.
[16] M.D. Hopkinson, L. Kearney, M. Gray, K. George, New graduate midwives' transition to practice: a scoping review, Midwifery 111 (2022) 103337.
[17] K. Dawson, M. Newton, D. Forster, H. McLachlan, Exploring midwifery students' views and experiences of caseload midwifery: a cross-sectional survey conducted in Victoria, Australia, Midwifery 31 (2) (2015) e7–e15.
[18] M. Gray, E. Kitson-Reynolds, A. Cummins (Eds.), Starting Life as a Midwife, Springer, Cham, Switzerland, 2019.
[19] M. El Haddad, L. Moxham, M. Broadbent, Graduate nurse practice readiness: a conceptual understanding of an age old debate, Collegian 24 (4) (2017) 391–396.
[20] A.C. Graf, E. Jacob, D. Twigg, B. Nattabi, Contemporary nursing graduates' transition to practice: a critical review of transition models, J. Clin. Nurs. 29 (15-16) (2020) 3097–3107.
[21] M. CrottyConstructionism:1998: 42-65.the making of meaning. in crotty m. the foundations of social research: meaning and perspective in the research process.
[22] P. Slattery, A.K. Saeri, P. Bragge, Research co-design in health: a rapid overview of reviews, Health Res. Policies Syst. 18 (2020) 1–13.
[23] J. River, K. Gill, M. Goodhew, C. Sinclair, F. Orr, Co-design research: what does it mean, and why should we do it? Aust. Nurs. Midwifery J. 28 (7) (2025) 30–31.
[24] F. Hasson, S. Keeney, H. McKenna, Revisiting the delphi technique-research thinking and practice: a discussion paper, Int. J. Nurs. Stud. 168 (2025) 105119.
[25] L. Townsend, C. Wallace, 2016, Soc. Media Res. A Guide Ethics.
[26] N. Emmel, Sampling and choosing cases in qualitative research: a realist approach, SAGE Publications Ltd, London, 2013.
[27] S. Flicker, A. Guta, J. Larkin, S. Flynn, S. Fridkin, R. Travers, J.D. Pole, C. Layne, Survey design from the ground up: collaboratively creating the toronto teen survey, Health Promot. Pract. 11 (1) (2010) 112–122.
[28] H. Keedle, V. Schmied, E. Burns, H. Dahlen, A narrative analysis of women's experiences of planning a vaginal birth after caesarean (VBAC) in Australia using critical feminist theory, BMC Pregnancy Childbirth 19 (2019) 1–15.

[29] S. Keeney, F. Hasson, H. McKenna, The delphi technique, Delphi Tech. Nurs. Health Res. (2011) 1–17.
[30] V. Braun, V. Clarke, N. Hayfield, L. Davey, E. Jenkinson, Doing reflexive thematic analysis, in: Supporting research in counselling and psychotherapy: Qualitative, quantitative, and mixed methods research, Springer, 2023, pp. 19–38.
[31] V. Braun, V. Clarke, What can "thematic analysis" offer health and wellbeing researchers? Int. J. Qual. Stud. Health Wellbeing (2014) 26152.
[32] L.S. Nowell, J.M. Norris, D.E. White, N.J. Moules, Thematic analysis: striving to meet the trustworthiness criteria, Int. J. Qual. Methods 16 (1) (2017) 1609406917733847.
[33] E.D. Sheferaw, T.Z. Mengesha, S.B. Wase, Development of a tool to measure women's perception of respectful maternity care in public health facilities, BMC Pregnancy Childbirth 16 (2016) 1–8.
[34] N. Parry, C. Catling, A. Cummins, Early career midwives' job satisfaction, career goals and intention to leave midwifery: a scoping review, Women Birth 37 (1) (2024) 98–105.
[35] J. Fenwick, A. Hammond, J. Raymond, R. Smith, J. Gray, M. Foureur, C. Homer, A. Symon, Surviving, not thriving: a qualitative study of newly qualified midwives' experience of their transition to practice, J. Clin. Nurs. 21 (13-14) (2012) 2054–2063.
[36] C. Catling, C. Rossiter, A. Cummins, E. McIntyre, Midwifery workplace culture in Sydney, Australia, Women Birth 35 (4) (2022) e379–e388.
[37] F. Arundell, J. Mannix, A. Sheehan, K. Peters, Workplace culture and the practice experience of midwifery students: a meta-synthesis, J. Nurs. Manag. 26 (3) (2018) 302–313.