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RESEARCH ARTICLE



Women's desire to have a midwife they know during labor and birth has increased significantly over time

Ingegerd Hildingsson^{a,b,c}, Hanna Fahlbeck^{c,e}, Maria Lindqvist^{b,d}, Birgitta Larsson^f, Sophia Holmlund^{b,d,g} and Margareta Johansson^{c,e}

^aDepartment of Health Science, Mid Sweden University, Sundsvall, Sweden; ^bDepartment of Nursing, Umeå University, Umeå, Sweden; ^cDepartment of Women's and Children's Health, Uppsala University, Uppsala, Sweden; ^dDepartment of Clinical Sciences, Division of Obstetrics and Gynecology, Umeå University, Umeå, Sweden; ^eAkademiska University Hospital, Uppsala, Sweden; ^fSophiahemmet University, Stockholm, Sweden; ^gJudith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, VIC, Australia

ABSTRACT

Background: In Sweden, women often meet with different midwives during antenatal, intrapartum, and postpartum care, due to the structure of maternity care, with few alternatives which provide continuity. This study aims to explore women's interest in having a midwife they know present during labor and birth and to identify the characteristics of women who prefer this option.

Methods: A comparative study was conducted involving two Swedish nationwide cohorts of Swedish-speaking pregnant women. The first cohort included 3,061 women, and the second 1,812 women. Descriptive statistics and odds ratios were calculated.

Results: In total, 4,873 pregnant women completed the survey. Most participants were aged 25–35 years, living with a partner, and born in Sweden. Interest in having a midwife they know increased from 53% in 1999 to 76% in 2024. Key factors associated with this preference included primiparity (OR 3.80; 95% CI 3.27–4.40), being pregnant in 2024 (OR 3.21; 2.70–3.86), being born outside Sweden (OR 2.73; 2.11–3.54), and fear of birth (OR 2.03; 1.56–2.63).

Conclusions: Interest in having a known midwife during childbirth has grown significantly in Sweden, highlighting the need for policy changes that promote awareness and expand this option for women.

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Maternity care; preferences; known midwife; women; fear of birth

Background

Women in Sweden usually receive care during their pregnancy from a midwife who works solely in an antenatal clinic, but intrapartum care usually takes place in highly medicalised hospital settings, which offer limited chances to get to know the midwife who will assist during labor and birth. Alternative options for childbirth are uncommon in Sweden, due to the fragmented maternity services. According to the Swedish Pregnancy Register, women are generally satisfied with the entire chain of maternity care; however, in 2023, when women were asked if they felt that the maternity services met their needs during pregnancy, birth and the postpartum period, one in three women did not report such positive attitudes [1] and consumer organizations have advocated other options to be made available for birth alternatives [2].

A qualitative systematic review of 35 studies from 19 countries identified what women want in relation to having a positive birth experience: a healthy baby, giving birth in a safe environment, support, competent staff, and physical labor and birth [3]. One Norwegian study conducted a thematic analysis of 8,401 answers to open-ended questions about what constituted women's positive birth experience; the results showed that compassionate and respectful care, feeling safe, continuity, and family-oriented care were important aspects of care in childbirth [4].

Midwife-led care usually provides continuity and emphasizes the relationship between the woman with her partner and the midwife. This model promotes a person-centered care approach; it strives to optimize biological, physiological, psychological, social, and cultural processes, and it only uses interventions when medically indicated. Midwives also work in collaboration

CONTACT Ingegerd Hildingsson  ingegerd.hildingsson@miun.se  Department of Health Science, Mid Sweden University, Sundsvall, Sweden

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with interdisciplinary teams fostering an environment of respect, trust, and equality [5]. A recent systematic review and meta-synthesis of 13 qualitative studies identified what women value in midwife-led models: the overarching theme was the midwife–woman relationship, which was underpinned by trust, personalized care, and empowerment [6]. However, much of the literature about continuity of care lacks specificity about whether it is the specific individual midwife or a known midwife (such as in team care).

Nearly 25 years ago (in 1999–2000), a national cohort study was conducted with 3,061 pregnant women in Sweden [7]; in this study, some questions focused on women's interest in birth options, such as homebirth and birthcentre care. One question (in the first of the three questionnaires) investigated women's interest in having a midwife they knew present during labor and birth. Approximately half of the participants reported such interest, in particular women younger than 25 years, primiparous women, and women with fear of birth. These findings were confirmed in a regional longitudinal Swedish study conducted in 2007, which found that more than 50% of 1,200 pregnant women, asked mid-pregnancy, would prefer continuity with a known midwife—i.e. knowing the midwife who would later assist during labor and birth [8]; younger women, primiparous women, single women, and women with fear of birth were significantly more interested in having a known midwife assisting during labor and birth. Despite the large number of respondents, the above study is limited by its regional setting and the amount of time that has passed since the study was performed.

Problem area

Previous studies have shown that pregnant women seem to be interested in having a known midwife present at the birth, although until recently such options have been non-existent in Sweden. It is important to develop maternity services based on women's needs; however, up-to-date information from national samples is lacking. Therefore, the aims of this study are to investigate the current interest in having a known midwife assist during labor and birth, and to identify the characteristics of women who are interested in this option.

Methods

Design

This is a comparative study with two national cohorts of pregnant women.

Samples

The first sample included historical data from a representative sample of 3,061 Swedish-speaking women recruited in 1999–2000. The women were invited to participate in the study when they booked their first antenatal visit. The recruitment was spread across three weeks throughout the year (one each in May 1999, September 1999, and January 2000). Midwives from 593 of the 608 antenatal clinics in Sweden provided oral and written information about the study; pregnant women with an interest in participating signed a consent form, which was sent to the research team. The team then distributed the first of three questionnaires, and they sent two reminder letters to non-responders. Details of the first study, published in 2003, are found elsewhere [7].

The second sample was a national survey conducted online from September 2023 to April 2024 which included 1,812 pregnant women. Midwives at ultrasound clinics in seven regions provided both oral and written information about the study after the ultrasound examination at gestational weeks 18–20 was completed; in addition, posters and information leaflets containing a QR code to the survey were available in the waiting rooms. Information was also disseminated *via* social media (Instagram and Facebook groups) and three pregnancy apps, with all information linking directly to the survey. Participants gave their consent by opening and filling out the survey. Data collection was managed using the secure platform REDCap (Research Electronic Data Capture) [9]. In both cohorts, inclusion criteria were being pregnant and being capable of understanding and completing the Swedish-language survey.

Data collection

Both surveys included several similar questions, with some specifically for the present study. The collected background information included age, primi- or multiparity, civil status, country of birth, level of education, birth preference, and year of investigation. One question assessed participants' feelings about childbirth on a 5-point Likert scale, ranging from 'Very positive' to 'Very negative'; this served as a proxy for fear of childbirth, with responses of 'Very negative' and 'Negative' indicating fear [10].

The primary focus of this study was the importance of having a known midwife present during labor and birth. This was assessed on a 4-point Likert scale with the response options of 'Very important', 'Rather important', 'Less important', and 'Unimportant'. For the analysis, the responses were dichotomized into 'Very important' and 'Important' (1) versus 'Less important' and 'Unimportant' (0).

Analysis

Descriptive statistics were used for participants' background characteristics. Crude and adjusted odds ratios (OR) with 95% confidence intervals (CI) were calculated between the years of investigations and for participants who rated having a known midwife during labor and birth as important versus not, across the different explanatory variables. SPSS version 28 was used for the analysis. The study received ethical permission from Swedish ethical committees (Dnr 1998-356 and 2021-0194).

Results

In 1999/2000, 3,061 women completed the questionnaire, and in 2023/2024, 1,812 women completed the questionnaire, resulting in a total sample of 4,873 pregnant women. The majority of participants in both cohorts were 25–35 years old, lived with a partner, and were born in Sweden (Table 1). Some changes in population characteristics were seen over the years. For example, the number of women younger than 25 years decreased, and the number of women older than 35 years increased. Women living with a partner and the level of higher education increased over time. The proportion of foreign-born participants decreased from 9.8% in 1999/2000 to 7.8% in 2023/2024. The percentage of primiparity was similar over the years (Table 1). Compared to national statistics each sample corresponds well in terms of age, civil status, country of birth and level of education (scb.se)

Table 1. Women's background.

| | National sample 1999/2000 n = 3,061 n (%) | National sample 2023/2024 n = 1,812 n (%) | Odds ratio (95% CI) |
|---------------------------------|--|--|------------------------|
| Socio-demographic background | | | |
| Age groups (years) ^α | | | |
| 25 years | 465 (15.2) | 37 (2.9) | 0.19 (0.13–0.27)*** |
| 25–35 years | 2,137 (69.8) | 888 (69.2) | 1.0 Ref. |
| 35 years | 459 (15.0) | 358 (27.8) | 1.87 (1.60–2.20)*** |
| Civil status | | | |
| Living with a partner | 2,888 (94.8) | 1,763 (98.3) | 0.31 (0.21–0.47)*** |
| Not living with a partner | 159 (5.1) | 31 (1.7) | 1.0 Ref. |
| Country of birth | | | |
| Sweden | 2,761 (90.2) | 1,670 (92.2) | 1.0 Ref. |
| Other country | 300 (9.8) | 141 (7.8) | 0.77 (0.63–0.95)* |
| Level of education | | | |
| High school or lower | 1,182 (62.0) | 391 (21.7) | 1.0 Ref. |
| University education | 1,154 (38.0) | 1,410 (78.3) | 5.88 (5.14–6.72)*** |
| Parity | | | |
| Primiparas | 1,302 (42.5) | 810 (45.0) | 1.10 (0.99–1.43) |
| Multiparas | 1,759 (57.5) | 990 (55.0) | 1.0 Ref. |

^α Missing data of age was due to technical problems.

**p* < 0.05,

****p* < 0.001.

Participants' birth attitudes and feelings are presented in Table 2. The majority of participants had positive feelings toward the upcoming birth and preferred a vaginal birth. There were no statistically significant differences between the years in fear of birth or cesarean section preference. The importance of having a known midwife assisting during labor and birth increased over time, from 52.6% in 1999 to 75.9% in 2024 (Table 2).

Table 3 presents crude and adjusted ORs in relation to participants' interest in having a known midwife assisting during labor and birth. The crude analysis revealed that younger age, being born in a country other than Sweden, high level of education, primiparity, fear of birth, and being pregnant in 2024 were all associated with a higher interest in knowing the assisting midwife. The majority of the identified explanatory variables remained statistically significant after adjustment, with the exception of younger age and level of education.

Table 2. Attitudes and feelings about the birth.

| | National sample 1999/2000 n = 3,061 n (%) | National sample 2023/2024 n = 1,812 n (%) | Odds ratio (95% CI) |
|---|--|--|------------------------|
| Feelings when thinking about the birth | | | |
| Positive or mixed | 2,749 (90.1) | 1,657 (91.7) | 1.0 Ref. |
| Negative | 301 (9.9) | 150 (8.3) | 0.82 (0.67–1.01) |
| Birth preference | | | |
| Vaginal | 2,767 (91.8) | 1,659 (92.8) | 1.0 Ref. |
| Cesarean section | 246 (8.2) | 128 (7.2) | 0.86 (0.69–1.08) |
| Importance of having a known midwife at birth | | | |
| Important/very important | 1,602 (52.6) | 1,283 (75.6) | 2.78 (2.43–3.17)*** |
| Less important/unimportant | 1,441 (47.4) | 415 (24.4) | 1.0 Ref. |

****p* < 0.001

Table 3. Crude and adjusted odds ratios for rating it important or very important to have a known midwife during labor and birth.

| Explanatory variables [#] | n = 4,907 | |
|---|------------------------------|--|
| | Crude Odds ratio (95% CI) | Adjusted ^α Odds ratio (95% CI) |
| Age | | |
| <25 years | 1.59 (1.33–1.89)*** | 1.21 (0.96–1.53) |
| 25–35 years | 1.0 Ref. | 1.0 Ref. |
| >35 years | 1.09 (0.95–1.26) | 1.19 (0.99–1.47) |
| Single status [#] | 1.30 (0.98–1.72) | 1.22 (0.86–1.73) |
| Born in a country outside Sweden [#] | 2.03 (1.65–3.88)** | 2.73 (2.109–3.54)*** |
| High level of education [#] | 1.27 (1.15–1.41)** | 0.96 (0.79–1.07) |
| Primiparity [#] | 2.87 (2.57–3.20)*** | 3.80 (3.27–4.40)*** |
| Fear of birth [#] | 1.81 (1.48–2.23)*** | 2.03 (1.56–2.63)*** |
| Prefer a cesarean section [#] | 1.02 (0.84–1.24) | 0.86 (0.66–1.12) |
| Pregnant in 2023/2024 [#] | 2.82 (2.48–3.22)*** | 3.21 (2.70–3.86)*** |

[#]Reference: Women not exposed to the studied variables.

**p* < 0.05,

***p* < 0.01,

****p* < 0.001.

Adjusted for all other variables.

Discussion

The main findings of this study reveal the increased interest among women in Sweden to have a known midwife assisting during labor and birth. Specifically, interest increased from 53% in 1999 to 76% in 2024, with the strongest associated factors being primiparity, being pregnant in 2024, being born in a country outside Sweden, and fear of birth.

The large increase in pregnant women's interest in having a known midwife assist during labor and birth could be attributed to the fact that in some places in Sweden, models offering a known midwife during labor and birth are currently receiving attention in regional political agendas and on social media, making women more aware that there are existing alternatives [11–13].

The present study found certain similar characteristics in the two Swedish national cohorts. The most important characteristics were primiparity, being born in a country other than Sweden, and reporting a fear of birth; these groups might be more vulnerable than others during pregnancy and birth. Midwife continuity for women with a fear of birth is known to instill a sense of security, confidence, and trust [14], and to reduce the fear experienced [14,15]. Continuity of midwifery care with a known midwife throughout pregnancy cultivates supportive relationships [16–19] which foster responsive, respectful, and safe maternity care [16,17,20].

A few initiatives to increase the likelihood of having a known midwife during labor and birth, especially for women with a fear of birth, have been introduced in Sweden. A Swedish experimental comparative study involved referring 70 pregnant women with a fear of birth to a counseling midwife who also, when possible, assisted during labor and birth. Among the 24 women who had a known midwife present during the birth, 29% reported that their fear disappeared, in contrast to the 46 women who did not have a known midwife (4.5%), but there was no statistically significant difference in the levels of fear when women graded their fear using FOBS (The Fear of Birth Scale) [21]. In addition, birth satisfaction was improved through a positive overall birth experience, with a perception of less pain intensity and better pain experience. The women rated the care better in terms of information, participation in decision-making, and perception of control [22]. By contrast, another Swedish study showed different results regarding the importance of knowing the assisting midwife before the birth. The 14 women with fear of birth in the study sample were offered standard counseling along with

continuous labor support by one of two specially assigned midwives, whom the women had met during their pregnancies. This sample was compared with 28 women without fear of birth who gave birth during the same period. In the results, women with a fear of birth were more likely to have their labor induced and reported more anxiety, and there was no difference in birth satisfaction [23]. Finally, a systematic review by Cibralic et al. [15] of eight quantitative intervention studies provides evidence for the positive impact of midwifery care continuity on maternal mental health during the perinatal period, namely in improvements in maternal anxiety, worry, and depression during the perinatal period [15].

Having a known midwife during pregnancy, birth, and the postpartum period is a cornerstone in midwife continuity models, such as caseload or midwifery group practice [24]. However, it is worth noting that many randomized controlled trials have included mainly low-risk women in continuity models [24], although the focus has started to shift toward groups of women in need of greater support due to vulnerability [25,26]; nevertheless, the focus on vulnerable populations in the literature is still limited. Notably, a scoping review concluded that 31 out of 175 initiatives on continuity of care were directed toward priority groups or vulnerable populations, which were mainly women living in rural or remote areas, indigenous women, young women, socially disadvantaged women, or women with chronic conditions or high risk of preterm birth [26,27].

A narrative systematic review of the impact of continuity of care on maternal mental health—including fear of birth, anxiety, and depression—suggests that midwifery models that include continuity may help reduce worry, anxiety, and depression during the antenatal period [15]. Midwife-led models of care are also associated with improved birth outcomes for women, such as increased likelihood of having a spontaneous vaginal birth and more positive birth experiences [24]. In addition, according to the most recent Cochrane review by Sandall et al. [24], women cared for under a continuity model are less likely to experience cesarean section birth, instrumental vaginal birth, or episiotomy.

Woman-centered maternity care is a key element in midwifery models of care [16]; it is described as intuitive and individualized care founded on knowing the woman and her significant others [16]. According to Brady et al. [28], woman-centred care is important because it helps women make better decisions when navigating complex maternity healthcare systems. Midwives are required to work with a respect for women's autonomy and in partnership with women.

The International Confederation of Midwives [29] promotes the implementation of midwifery care models incorporating the elements of human dignity, compassion, and the promotion of human rights for women. Midwifery care is characterized by a holistic approach which is grounded in social, emotional, cultural, spiritual, psychological, and physical values for women [29].

The Swedish National Board of Health and Welfare recently released a report about future intrapartum care and suggested that implementing continuity models should be part of research projects. Such models should primarily be directed toward vulnerable women such as those with a fear of birth, those with mental health conditions, or foreign-born women giving birth in Sweden [30].

These recommendations are fully in line with the findings in the present study, which identified that women who valued having a known midwife during labor and birth shared these characteristics. Consequently, it is crucial to organize continuity models of midwifery care for such women.

Strengths and limitations

This study has several limitations. One limitation is the long time span between the two survey periods, which may have influenced women's characteristics as well as those of society, as well as the organization and medicalization of maternity services over time. The participant answered the survey at slightly different gestational weeks (16 vs. 20), but we don't know if this time span had any influence on women's preferences. The exclusion of non-Swedish speaking women is another limitation. Another limitation includes the survey design, which may not provide as deep an understanding of the complexity of women's interests in different models of care as interviews. Regardless, the strength of the study lies in its large number of participants and its nationwide samples, allowing for subgroup analysis. The current study adds valuable knowledge about women's interest in knowing the assisting midwife prior to giving birth.

Conclusion

This study highlights the increased interest among women in Sweden to have a known midwife assisting during labor and birth. Specifically, interest increased from 53% to 76% over 25 years, with the strongest associated factors being primiparity, being born in a country outside Sweden, and fear of birth. The large increase in interest in already knowing the midwife should be a focus of political agendas and on social

media, acknowledging women's wishes for having a known midwife during childbirth and thereby giving women real birth choices.

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