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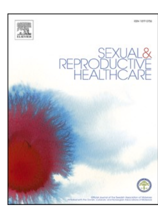

Balancing midwifery values with rural reality: Swedish midwives' views of midwifery continuity of care – A qualitative study

Johanna Sandén [a,*], Maria Lindqvist [a,b], Ingegerd Hildingsson [a,c], Margareta Johansson [d], Sophia Holmlund [a,b]

[a] Department of Nursing, Umeå University, Linnaeus väg 9, 901 87 Umeå, Sweden
[b] Department of Clinical Sciences, Division of Obstetrics and Gynecology, Umeå University, Klintvägen 10 901 87 Umeå, Sweden
[c] Department of Health Science, Mid Sweden University, Holmgatan 10, 851 70 Sundsvall, Sweden
[d] Department of Women's and Children's Health, Uppsala University, Akademiska sjukhuset, 751 85 Uppsala, Sweden

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ABSTRACT

Objective: Despite strong evidence of the benefits, Sweden has limited access to midwifery continuity of care (MCoC), particularly in rural areas. There is a knowledge gap regarding how MCoC would function in a rural Swedish context. Therefore, this study aimed to explore midwives' personal and professional views on a MCoC model and its implementation within a rural context in northern Sweden.

Methods: A qualitative interview study using reflexive thematic analysis. Semi-structured interviews were conducted with fourteen midwives working in maternity care.

Results: The findings revealed a notable duality to MCoC, consisting of two major themes. In the first theme, 'Internal conditions of midwifery', midwives reported that working in a MCoC model would offer fulfillment but also present significant challenges, which they did not feel prepared to meet. Establishing a relationship of mutual trust with pregnant women emerged as a major positive aspect. The second theme, 'The impact of external forces', highlighted significant challenges, including organisational issues, staffing shortages, and concerns regarding work-life balance. Interprofessional collaboration and rural adaptation were considered key if the implementation of the model is to go ahead.

Conclusions: For MCoC to succeed in rural Sweden, it is essential to have a supportive organisation that recognises the benefits of the model, and provides midwives with working conditions that meet their professional and personal needs. Involving midwives in the model's design, fostering interprofessional collaboration, and tailoring the model to rural settings are equally important. Addressing organisational challenges is crucial for establishing a functional and sustainable model.

Introduction

Providing and maintaining quality maternity services in rural areas is a global concern that requires attention. The issue must be addressed adequately to ensure that every pregnant woman, regardless of geographical location, has access to high-quality and safe maternity services [1]. While care during pregnancy, childbirth, and the early postpartum period can significantly impact the health and well-being of both women and newborns [1], it is equally important to ensure that care is provided by a sustainable workforce of midwives. There is strong evidence indicating that midwifery continuity of care (MCoC) models have the potential to improve perinatal outcomes, childbirth experience [2], and midwives' working conditions [3]. MCoC refers to care being provided by the same midwife or a small team of midwives during pregnancy, childbirth, and postpartum [2]. Midwives working in MCoC report lower levels of burnout and a more positive attitude to their work than midwives providing standard care [4]. However, setting professional boundaries can sometimes be challenging for midwives as they strive to build relationships while preserving a healthy work-life balance [5]. Research from Australia, where MCoC is prevalent, demonstrates that it works well in rural settings, and may help to maintain sustainable rural maternity services [6,7]. However, the long distances in rural areas

* Corresponding author.
E-mail addresses: johanna.sanden@umu.se (J. Sandén), maria.lindqvist@umu.se (M. Lindqvist), ingegerd.hildingsson@umu.se (I. Hildingsson), margareta.johansson@uu.se (M. Johansson), sofia.holmlund@umu.se (S. Holmlund).

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pose significant challenges, including lack of resources and closure of small maternity units [8].

A critical shortage of midwives has been reported in all Swedish regions [9], which may, to an extent, be due to a work environment that has become increasingly stressful over a ten-year period [10]. Swedish midwives regularly experience symptoms of depression, anxiety, and stress, with one in three considering leaving the profession [11]. A literature review of midwives' working conditions shows that high workload, lack of continuity of caregivers, low support from colleagues, challenging clinical situations, and low clinical autonomy correlate with poor emotional well-being [12], leading to high attrition rates [13]. Although midwives report high levels of meaningfulness in work, burnout and high role conflict are adversely high in relation to Swedish benchmarks [14].

The maternity care system in Sweden has been centralised over the course of the last decades, leading to the closure of small maternity units [15]. In their place, highly specialised medical care is provided to women at large hospitals. Closing rural maternity units forces women to travel long distances for labour, increasing the risk of unplanned out-of-hospital births [15]. In Sweden, rural areas are often defined as those that are more than 45 min from an urban centre that has over 3000 inhabitants, essential services, and employment opportunities [16]. Travelling long distances for labour can pose a significant source of stress for pregnant women residing in rural areas. Research indicates that many women have a strong preference for receiving care from a known midwife, as this relationship enhances their sense of safety and emotional security during pregnancy, childbirth, and the postpartum period. Such continuity of care can be effectively achieved through a MCoC model [17].

MCoC is recommended by the World Health Organization (WHO) for countries with well-functioning midwifery programs [1], such as Sweden. In March 2025, the Swedish National Board of Health and Welfare published national guidelines emphasising the need for a strengthened care chain throughout pregnancy, childbirth, and postpartum, with increased continuity of care. Another recommendation of the guidelines was that Swedish healthcare should aim to achieve more significant equity [18]. The Swedish Association of Midwives states that Swedish maternity care should provide multiple care pathways for pregnant women [19], and that MCoC can provide this. However, a MCoC model has generally not been implemented in Sweden outside large cities, with one notable exception [17]. A Swedish study found that about 50 % of women prefer continuity of care with the same midwife [20], and a national sample of 2084 midwives showed that 56 % are interested in working in a MCoC model [21]. MCoC has been described as a feasible means of halting the closure of rural maternity care units in Australia and reopening those that have already closed [7], and may be an option to attract midwives to work in rural Swedish areas.

Previous research suggests that MCoC is the gold standard of maternity care, yet this model is largely inaccessible to pregnant women in rural Sweden. There is a significant knowledge gap in how a MCoC model would function in a Swedish rural context. Therefore, this study aimed to explore midwives' personal and professional views on a MCoC model and its implementation within a rural context in northern Sweden. Additionally, the study sought to examine the perceived facilitators and barriers associated with adopting a MCoC model in such settings.

Materials and methods

Design

A qualitative exploratory study design was used, and data were collected using semi-structured interviews with midwives working in maternity care in northern Sweden. To ensure transparency, the Standards for Reporting Qualitative Research (SRQR) checklist was used [22].

Study context

In Sweden, maternity care is free of charge, with a registered midwife as the main provider, and almost all pregnant women attend the service. Today, most women in Sweden have the same midwife during pregnancy in antenatal care (ANC), but continuity of care during pregnancy, childbirth, and postpartum is uncommon [20].

In January 2023, a maternity unit in rural northern Sweden, with an annual birth rate of around 300 births, was closed due to a shortage of midwives and obstetricians. The closure led to some women driving up to 350 km in order to attend the closest labour ward. A political commitment was made to reopen the unit once staffing was sufficient, which took place in February 2024.

Participants

Purposive sampling was used to obtain a broad array of midwives' views on a MCoC model. After fourteen female midwives with no prior MCoC experience had been recruited, a sufficient variation in participant characteristics had been achieved, and data collection ceased. The midwives were employed at the recently closed rural maternity unit, a connecting primary ANC clinic, or a referral hospital, all of which were in the same region of northern Sweden (Table 1).

Data collection

From December 2022 to March 2023, semi-structured interviews were conducted online and carried out in close connection to the closure of the rural maternity unit. Midwives were informed about the study and invited to participate through their managers, and at a workshop about models of care. A semi-structured interview guide was developed as part of a national study. This included questions about the midwife's interests, the prerequisites for working in a MCoC model, and factors that may affect eventual implementation. Examples of questions included 'What are your views on a MCoC model during pregnancy, birth, and the early postpartum period?'; 'Could you describe how you think a MCoC model would fit into your workplace?'; 'Could you describe what or who you think could facilitate or hinder the implementation of a MCoC model?'. The guide was tested in one pilot interview for clarity, which was included in the analysis, as only minor adjustments were made. The interviews were performed by three midwives, of which two are experienced researchers and one a clinical midwife. The first interview was led by one of the female researchers with the clinical midwife observing, while the rest were conducted by one of the three midwives. The interviews were audio-recorded and transcribed verbatim into text by a professional transcribing company, and lasted between 21 and 70 min (median 32 min).

Table 1
Background characteristics of participants (N = 14).

Workplace	
Rural maternity unit	9
Referral hospital	3
Primary antenatal care clinic	2
Age (years)	
Mean	45
Range	30–59
Work experience as a midwife (years)	
Mean	11
Range	0.5–33

Data analysis

Inductive reflexive thematic analysis was undertaken using Braun and Clarke's six phases of analysis [23]. To begin, the first and the last author read all of the transcripts several times individually to become familiar with the data, and each coded parts of the material independently. After agreement on the coding had been reached, the first author continued with the rest of the interviews using the analysis software MAXQDA 2024. The codes were reviewed several times for broader patterns and meanings, leading to the development of an overall theme, two main themes, and six themes. The first and the last author reviewed these for consistency. Thereafter, the research team provided feedback and discussed and contributed to the defining and naming of the themes, with the final draft reviewed and approved by all members. The team of five experienced midwives – four with academic backgrounds in qualitative research experience, three with MCoC expertise, and one with prior clinical experience of MCoC – considered the themes from various perspectives.

Ethical considerations

This study was approved by the Swedish Ethics Review Authority (Dnr: 2021–01941) as part of a national study. Before involvement began, informed written consent was obtained from participants, and data were processed confidentially. The participants were informed that they could withdraw from the study at any time, without the need to provide a reason. All identifying information was removed from the quotations used in the results.

Results

The analysis resulted in an overarching theme, *Balancing midwifery values with rural reality,* which revealed a notable duality with regard to the participants' perspectives on MCoC. This acknowledged both the significant benefits MCoC could provide for women and midwives, and the challenges and concerns associated with the model in a rural context. The two main themes, *Internal conditions of midwifery* and *The impact of external forces* (Table 2), relate to the various factors within and outside the midwifery profession that could impact midwives' decisions to work in a MCoC model in a rural area.

Internal conditions of midwifery

The first main theme illustrates the personal significance that midwives assign to their roles within MCoC. Positive aspects included working to the full scope of their practice, improved job satisfaction, and building a relationship with the pregnant woman. Aspects of concern included their levels of competence and readiness.

Fulfilling professional practice

The midwives held their role and expertise in high regard, and were motivated by their ability to support and empower women, which they believed would be strengthened in a MCoC model. MCoC would enable them to work to their full scope during women's pregnancy, birth, and postpartum, which would not only be immensely rewarding for the woman but also increase the midwives' personal engagement. Greater engagement with women would promote ongoing learning and personal development, while also creating opportunities for professional advancement. The midwives felt that working across the ANC clinic and the labour and postnatal wards would provide an ideal balance, enabling them to support women in experiencing physiological births. This, in turn, would boost their motivation and enhance their overall satisfaction, ultimately leading to improved job performance.

> *"This sense of fulfillment can also be achieved for the midwife if there is an opportunity to follow the couple all the way."* (Midwife E)

Table 2
The overaching theme, main themes, and themes.

Balancing midwifery values with rural reality	
Internal conditions of midwifery	**The impact of external forces**
Fulfilling professional practice	Structural barriers to overcome
Building bonds of mutual trust	Achieving a collaborative environment
Levels of work readiness	Tailoring care for rural needs

Building bonds of mutual trust

The midwives emphasised the importance of establishing mutual trust in their relationships with women, which they believed MCoC could enable. They noted that building trust can create a supportive and calm atmosphere, benefiting the entire family and reducing anxiety for pregnant women. In a MCoC model, the midwife is committed to supporting the couple and focused on the woman's specific needs throughout childbirth, and this requires a deep understanding of her unique circumstances and preferences.

> *"Often when the patient calls, you don't know who you have on the other end. Like, who is the woman? It also depends on how I need to express what she should or should not do […] To someone, you need to say that you should leave right now [to go to the hospital]. To someone else, you need to say you can stay home. But when I don't know who she is, it's sometimes hard to get it right."* (Midwife A)

Concerns were also raised regarding the relationship between the woman and the midwife; the midwives expressed apprehension regarding establishing a sense of security that might become overly dependent on individual midwives, and wondered what might happen if they could not guarantee that individual's presence.

> *"If it [the feeling of security] becomes very personalised to these midwives who are part of this model of care […] And then a new person is there instead. Is everything then overturned?* […] *Or do you start from scratch? […] Will it be a disaster for those women?"* (Midwife H)

Levels of work readiness

With regard to effectively operating within a MCoC model, the midwives expressed the importance of being experienced and clinically competent across the whole spectrum of maternity care, which the current system impedes. They felt that MCoC involves working alone, which was not preferred by some. Several midwives emphasised the importance of having experience of physiological births and being prepared to handle emergencies. Almost all midwives agreed that they needed more knowledge about MCoC and initial training in all workplace areas before deciding to work in a model, although some participants said that they felt ready to work in a MCoC model immediately. In contrast, some midwives felt that they needed more work experience before they would feel prepared enough to work in another new area, e.g. ANC or labour care. They suggested that study visits to other hospitals providing MCoC would be valuable.

> *"I believe that midwives working in the labour ward need more knowledge about all aspects of pregnancy, and those in antenatal care should spend time in the labour ward to understand how it operates. And then you don't necessarily have to work there permanently, but I would like to work across all areas."* (Midwife N)

The midwives in primary care stated that they felt that they needed more experience of being primarily responsible for births and, therefore, preferred to assist as associate midwives. One midwife was worried about being reassigned to the labour ward after working in a primary ANC clinic for several years, citing anxiety and fear. Some midwives expressed concerns about potentially losing competence in a MCoC

model, especially regarding care during labour and birth, because of the small number of births at the rural unit.

> *"There may be little focus on childbirth in the end, as there are still relatively few who give birth at this unit."* (Midwife B)

The impact of external forces

The second theme addresses the external factors that the midwives contemplated in relation to MCoC. They raised concerns regarding organisational issues, staffing shortages, and work-life balance while on-call, as well as noting a need for improved working conditions to meet their needs. They highlighted the significance of interprofessional collaboration within a rural maternity unit, and emphasised the importance of involvement in the model's design in order for it to achieve optimal outcomes.

Structural barriers to overcome

This theme relates to the challenges of organisational and structural issues that a MCoC model in a rural area would eventually bring. Most of the midwives emphasised that politicians' interests and engagement are crucial in securing funding and resources for the implementation process. They believed that politicians need to learn more about MCoC and its benefits for women and midwives. Many of the midwives expressed that the structure of the maternity care system in Sweden, with ANC mostly provided in primary care and labour and postpartum care managed at hospitals, poses significant challenges that hinder midwives in providing comprehensive support to pregnant women. They believed that a single organisation overseeing all areas of maternity care would improve communication and collaboration, leading to a more seamless experience for both women and midwives.

> *"I don't know why it's so slow to get started here in Sweden. It's because we're so set in our ways of doing things since time immemorial. We go to the antenatal care clinic, and then the birth is located in a completely different place."* (Midwife M)

A primary concern of implementing MCoC at the rural maternity unit was the shortage of midwives, which would affect the ability of pregnant women to consistently access a midwife during childbirth. The midwives emphasised the importance of increasing the number of individual midwives living and working in the area, which would help to reduce the need for temporary staff at the clinic, a concern that many expressed as a structural barrier.

> *"If you're going to have a MCoC model where you work at both the antenatal care clinic and the labour ward, then you need to be based, to be resident here in [name of the location]."* (Midwife C)

Achieving a collaborative environment

Working with other disciplines to better support one another and improve care for the pregnant woman was an issue of great importance to the midwives. They described wanting interprofessional collaboration with obstetricians and paediatricians, but at the same time voiced that midwives are the primary professional group who provide care for childbearing women. They described a wish to keep birth normal, with the least possible number of interventions, and did not want physicians to take over, but instead provide backup when needed. The midwives believed that paediatricians oppose MCoC, and emphasised the need to collaborate with them to ensure a successful implementation. They were concerned that women would not want to give birth at a rural maternity unit if they believed that it did not provide safe medical care. This aspect was specifically related to maternity care in the context of the rural clinic due to limited paediatric resources, and did not directly pertain to MCoC. Complementing other professions and collectively striving towards the same goal were reported to enhance care for the birthing woman.

> *"The medical team has such an authoritarian position in maternity care right now. So I think they find it a bit difficult to let go of that and be comfortable with it […] We don't want to replace them completely […] We have to be able to make them* [the obstetricians] *feel safe and understand what we mean."* (Midwife F)

Tailoring care for rural needs

The consensus among the midwives was that a MCoC model would greatly benefit their maternity unit by ensuring professional sustainability, as it could be effectively tailored for women at low risk during childbirth. They highlighted the importance of midwifery services being accessible to women in rural areas and emphasised the need for a local maternity unit. They called for suitable working conditions and influence over the model's design before participating in a MCoC model. The midwives raised concerns about work-life balance while on-call, emphasising the need for flexibility based on personal factors, such as family situations and availability, and stressed that MCoC may not fit all midwives. Voluntary participation was felt to be important, as was a fair work schedule, even on-call. However, some preferred a fixed schedule, and did not want to always be available for extended periods.

> *"I should be able to have a good schedule, so that I can have my life outside work without it being affected."* (Midwife I)

Staffing shortages were a major concern in relation to the rural context. The participants suggested that reallocating midwives could help to free up staff to provide consistent care for women. The midwives stated that a MCoC model could make the small rural maternity unit stand out, and potentially attract midwives to work within maternity care.

> *"I think we can attract a lot of people who would be interested in working this way. Because it is unique."* (Midwife J)

The midwives believed that offering home visits before, during, and after childbirth would be an important part of MCoC. However, they saw significant challenges given the long distances between the women's homes and healthcare facilities. Opinions on sustaining continuity in rural areas suggested that virtual meetings during ANC and postpartum care could be valuable.

Several midwives noted the importance of safe healthcare, emphasising that giving birth at a smaller unit in a rural area should be just as safe as at a larger unit. They stated that getting to know pregnant women well and building relationships during antenatal visits would decrease the risk of essential aspects being missed during pregnancy and childbirth. In addition, working in a MCoC model could help them to detect anomalies earlier, because they would be more present with the woman than in standard care due to providing individualised care to one birthing woman at a time.

> "*If you see the pregnant woman throughout the antenatal period and during labour, you know her much better [than in standard care]. You may not need to talk as much. You have built up so many months together with her and her partner, which you can make use of in the labour room and that you miss out on if you don't get those months before labour starts.*" (Midwife H)

Discussion

This study explored midwives' views on MCoC in the context of a maternity unit in rural northern Sweden. The results revealed a duality as regards views on MCoC, with the perspectives ranged from predominantly positive to presenting concerns that would require considerable effort to ameliorate. The main findings were that the midwives felt that working in a MCoC model would be fulfilling, but would pose challenges that they do not feel fully prepared to meet, such as being on-call. Building mutual trust with pregnant women was felt to be a

significant benefit, but obstacles included organisational issues, staffing shortages, and work-life balance concerns. Interprofessional collaboration and adapting the model to the rural setting were seen as critical components for ensuring the model's success.

Despite widespread positive attitudes toward MCoC at the rural unit, significant concerns were expressed. These findings may seem contradictory, as there is evidence that MCoC can improve midwives' working conditions and reduce rates of burnout [3,4]. A shortage of midwives willing to work in the model is a challenge, and a negative factor in introducing MCoC and ensuring that it is professionally sustainable, which may be challenged by issues such as midwives finding being on-call demanding [24]. The midwives claimed that they strongly wish to prioritise their personal lives and not always be available. This assertion does not correspond with statements indicating that MCoC offers midwives greater control over and flexibility in determining their working hours and appointments [25,26]. However, the on-call aspect poses a challenge and may limit midwives' private lives, similar to the constraints associated with shift work. It is important to address this concern, as being on-call is a prerequisite for working in a MCoC model [25]. Additionally, the midwives were concerned about working alone or travelling to conduct home visits, a sentiment that contrasts with findings from previous studies [27,28]. Working independently and being "in charge" of planning their work are reasons behind the sustained success of certain MCoC models [27]. However, it is essential to emphasise that this model can be organised in various ways and should operate within a collaborative and well-supported healthcare system [1,2]. These concerns underscore the need to improve midwives' knowledge and awareness of the model. Such initiatives should be integrated into the broader process of introducing and scaling up MCoC models [21].

The benefits of relational and individual care noted in this study support the findings of various studies that highlight the importance of relational continuity, which is fostered through mutual trust and strengthened in MCoC [2,5,17]. A strong relationship between midwives and women can significantly influence the health and well-being of both women and newborns, as well as improve birth outcomes. For instance, it may lead to a decrease in the number of caesarean sections on maternal request, and promote safer care through midwives getting to know women more thoroughly. This aligns with the results of the large Cochrane review in 2024 [2]. One important point is that building a trusting relationship can also enhance job satisfaction and well-being among midwives [14,25]. Research indicates that midwives often feel dissatisfied with their roles when they cannot build effective relationships with women [13]. This challenge tends to increase as the focus of centralisation shifts towards more institutionalised care, which consolidates services in fewer locations to assist a larger number of birthing women. Furthermore, an inability to access care is a significant source of stress for pregnant women [29], and may be seen as a failure on the part of midwives in not meeting women's need for continuity of care [28]. This study indicates that, while forming a close relationship with women has many benefits, one drawback is that the midwives can become too emotionally attached, potentially compromising their professional boundaries. However, the advantages of maintaining relational continuity have been shown to outweigh these disadvantages [28].

The second main theme shows that the current organisation of care is a barrier to providing continuity of care. Available resources, funding, and political decision-making affect midwifery work in many ways. Adcock et al. highlight the importance of midwifery leaders familiarising themselves with MCoC and its associated benefits, as well as demonstrating a solid commitment to implementing evidence-based findings [30]. The Swedish Association of Local Authorities and Regions, a politically governed organisation, advocates for the implementation and evaluation of MCoC models as a strategy to improve continuity within maternity services [31]. This recommendation presents a significant opportunity to strengthen the quality and equity of maternity care across all regions in Sweden. Achieving this requires strong organisational support and active collaboration with key stakeholders to develop a sustainable approach to MCoC [30]. In particular, there is a pressing need for regional maternity services in rural areas to collaborate in developing innovative and sustainable strategies that ensure the provision of safe and accessible care in these settings [32].

The findings indicate that staffing shortages represent a significant challenge that must be addressed before a MCoC model can be adopted at the studied rural unit. Enhancing workforce retention is a fundamental component of promoting the midwifery profession [30]. Therefore, care models that improve job satisfaction and fulfillment should be prioritised. This study highlights that meeting the needs of midwives within the current system is challenging. A common assumption is that midwives working in rural areas with lower birth rates may exhibit lower levels of competence in their professional practice, and that centralising maternity services improves their skills. However, the findings of this research show that MCoC would provide opportunities for professional advancement due to midwives working to their full scope. The implication of centralisation is a rise in patient volumes, which consequently imposes greater demands on midwives in these settings. A heightened workload can increase burnout levels among midwives [11], and potentially compromise the quality of care. It is important to consider that centralisation could limit the ability of midwives to work to their full scope of practice [7]. The findings presented in this article suggest that reorganising the midwifery service in Sweden is essential to ensuring that midwives feel that they can fully utilise their professional skillsets. A strong commitment to the profession may also protect against burnout [28]. However, the results of this study indicate that midwives want to influence the organisation of their practice, and this requires an adaptable organisational system that meets midwives' needs throughout the maternity care continuum. In rural settings, it is essential that midwives are able to adeptly fulfill their responsibilities by meeting educational requirements and advancing their professional development. This can be achieved through adequate healthcare and resource allocation [7].

The interviewed midwives felt that ensuring the sustainability of MCoC at the rural maternity unit will require interprofessional collaboration, especially with obstetricians and paediatricians. This confirms earlier work on the value of forming and working in interprofessional teams for increasing the quality of care and ensuring successful implementation of MCoC [26,30].

Reflections on the final theme highlighted the importance of tailoring a MCoC model to meet the unique needs of rural settings. This approach aligns with findings from prior research, reinforcing the importance of customisation in implementation [32]. The findings show that MCoC would greatly benefit the studied maternity unit, and could be easily adapted for women with low-risk pregnancies who give birth there. Establishing a comprehensive approach to MCoC that is adapted to the needs of individual women would attract expectant mothers to the unit. However, the shortage of midwives at the local labour ward, and ensuring adequate salaries and fair work schedules were some of the reported challenges and financial issues around MCoC. However, research indicates that MCoC is safer and less costly than standard care [33]. In Sweden, there is currently no national policy in place to address the management of pregnancies for women who reside far from a maternity unit [15]. Therefore, it is imperative that midwives' perspectives be incorporated before any significant organisational change is undertaken [7]. Research shows that MCoC could assist in maintaining midwifery services in rural areas by staffing the woman instead of the organisation, offering a more flexible and cost-effective approach to work [7]. For small maternity units in rural areas, the centralisation of the maternity system hinders efforts to achieve equity of care, as MCoC should not be offered only to pregnant women in major cities [24].

Strengths and limitations

When regard to assessing the transferability of the findings, it is

essential to acknowledge that this study focused on the views of a small group of midwives regarding the possible adoption of a MCoC model in a rural area. However, the interviews presented comprehensive descriptions, offering deep insights into aspects that could either facilitate or hinder the implementation of a MCoC model. In addition, the analysis process adhered to the checklist developed by Braun and Clarke [23], which ensured that coding and theme development were transparent, contributing to dependability. Furthermore, the use of anonymous quotations maintains transparency in reporting the results. Three midwives conducted all of the interviews using the same interview guide, ensuring dependability and consistency while also allowing for the emergence of individual comments and experiences. Although the research team is committed to maintaining the rural maternity unit and supports MCoC, reflexivity is crucial in recognising how our preconceptions may have influenced the interpretation of the data. Additionally, sample-selection bias may have been present, as the midwives who participated may have had more favourable views on MCoC than other midwives in rural areas of Sweden. However, the interviews revealed both positive and negative perspectives on MCoC. A notable limitation is that none of the participants could draw on actual experiences with the model. Additionally, not all of the interviewed midwives attended the workshop on models of care held before the study. A knowledge gap about MCoC could be seen as a limitation, since this work form is limited in Sweden. Another limitation is that the midwives were interviewed in close connection to the closure of the rural maternity unit and had a strong desire for its reopening, which potentially impacted their perspectives.

Conclusion

The findings of this research reveal a significant duality, highlighting contrasting perspectives and concerns regarding MCoC. While the concept has potential, in terms of fostering rewarding relationships between women and midwives, various challenges must be addressed in order for implementation to be successful, including organisational constraints, staffing shortages, and concerns about maintaining a work-life balance while on-call. Important factors to consider before implementing a MCoC model include the importance of interprofessional collaboration and adapting the model to rural needs. Crucially, the midwives felt inadequately prepared for the substantial effort required to change the existing care model. These findings highlight the critical need for a supportive organisation that understands the model's specific requirements and offers conditions for effective implementation, particularly in rural areas. Addressing these issues will be crucial for realising the benefits of MCoC in such settings. Consequently, further research should explore the perspectives of women in rural areas who face barriers in accessing healthcare due to long distances to the nearest labour ward, and investigate their perspectives on MCoC.

CRediT authorship contribution statement

Johanna Sandén: Visualization, Formal analysis, Writing – original draft, Project administration. **Maria Lindqvist:** Validation, Project administration, Investigation, Conceptualization, Writing – review & editing, Supervision, Methodology, Formal analysis. **Ingegerd Hildingsson:** Validation, Project administration, Investigation, Conceptualization, Writing – review & editing, Supervision, Methodology, Formal analysis. **Margareta Johansson:** Writing – review & editing, Project administration, Investigation, Conceptualization, Validation, Methodology, Formal analysis. **Sophia Holmlund:** Writing – review & editing, Supervision, Methodology, Funding acquisition, Conceptualization, Validation, Project administration, Investigation, Formal analysis.

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Declaration of competing interest

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

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