‘A longing for a sense of security’ – Women’s experiences of continuity of midwifery care in rural Sweden: A qualitative study

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\textbf{ABSTRACT}

Background: There is evidence that continuity models of midwifery care benefit women and babies in terms of less birth interventions and higher maternal satisfaction. Studies about continuity models in a Swedish context are lacking.

Objective: The aim of this study was to describe how women experience continuity of midwifery care in a Swedish rural area, and thereby provide a deeper understanding of what this care entails for women.

Methods: A qualitative interview study using thematic analysis was carried out. Telephone interviews were conducted with 33 women who participated in a continuity of midwifery care project in a rural area of Sweden.

Results: The overarching theme ‘a longing for a sense of security’, pervaded the three main themes: ‘The importance of professional midwifery care’, ‘Continuity of midwifery care – fulfilled expectations or full of disappointments’ and ‘New prerequisites – acceptable to some, but not a substitute for everyone’, which explains different aspects affecting the feeling of security. The endeavour to feel secure during pregnancy, birth and postpartum was a continually recurring subject that cannot be overstated.

Conclusion: Continuity of midwifery care strengthened women’s feelings of security during pregnancy, birth and postpartum. The deepened relationship developed over time was a central part of the positive aspects of the experience of continuity in midwifery care. Expectations and prerequisite circumstances are important to consider when developing and introducing new care models. Service providers and decision makers should pay attention to and prioritise this relational aspect when planning care for women during the childbearing period.

Introduction

The intended model of continuity of midwifery care has risen from the ‘partnership model’ where midwifery is women-centred and pregnancy and childbirth are seen as normal life events. The midwife’s primary professional role is to be with women experiencing a normal pregnancy, labour, birth and postnatal period. According to the model, throughout the childbearing experience, midwifery care provides women with continuity of caregiver [1]. Continuity models of midwifery care, as defined by the World Health Organisation (WHO), occurs when the woman meets the same midwife or a small group of midwives throughout the childbearing period [2].

Continuity models of midwifery care are growing internationally. There is strong evidence of the benefits for both women and their babies, as concluded in a Cochrane review of 15 high-quality papers including more than 17,000 women [3]. This large review reported not only improved outcomes for women and their babies, but it also indicated greater cost-effectiveness and higher maternal satisfaction among those who participated in a midwifery continuity model compared to women receiving standard care. Moreover, a meta synthesis of 13 qualitative studies based on women’s perspectives [4] focused on what women actually value in continuity models. The main message from this study is described in the overall concept: ‘The midwife–woman relationship is the vehicle through which trust is built, personalized care is provided, and the woman feels empowered’. Continuity models of midwifery care are based on a personal relationship between the woman and the midwife. The midwife has been described by women as ‘a companion’, ‘a professional friend’ [5] and as ‘empowering and endorhic’ [6], suggesting that parents value the relationship with the midwife.

In Sweden, midwives are the primary health care providers for...
pregnant women during the antenatal, intrapartum and postpartum period. The care for pregnant women is free of charge and during a normal pregnancy, most women meet one or two midwives during the eight or nine basic visits [7]. The continuity of midwifery care throughout these visits is generally beneficial; however, continuity between antenatal, intrapartum and postpartum care is rare [7]. Antenatal care is often provided in outpatient clinics organised within the primary healthcare sector, whereas intrapartum care is almost exclusively provided in a hospital setting. Midwives work with women of all ages, e.g. prescribing contraceptives and administering Pap smears. In hospital-based labour wards, midwives work in collaboration with obstetricians and assistant nurses. During a normal birth, the midwife has an autonomous responsibility for the woman and remains present in case of instrumental or surgical births. After approximately-one week after birth, the family is taken care of by a specialised paediatric nurse, who follows the family for several more years, through the outpatient clinic in the primary healthcare sector. A revisit to the midwife at the antenatal clinic is offered 6–12 weeks postpartum; however, other than that there is usually no contact with the midwife after the family has been discharged from the postpartum ward.

In recent decades, many smaller birth clinics have been closed throughout Sweden, a trend often creating long travel distances to hospitals with labour wards. Currently, there are no existing birth centres in Sweden, and home births, which normally are financed by the woman herself, are rare [8]. Continuity models of midwifery care only exist in one of 21 Swedish healthcare regions [9].

There is evidence that continuity models of midwifery care benefit women and babies in terms of less birth interventions and higher maternal satisfaction. Studies about continuity models in Sweden are lacking. It is, however, important to study women’s experiences when they have had the opportunity to be taken care of by a known midwife during pregnancy, labour, birth and postpartum. The aim of this study was to describe how women experience continuity of midwifery care in a Swedish rural area, and thereby provide a deeper understanding of what this care entails for women.

Materials and Methods

Design

A qualitative interview study including women who participated in a continuity of midwifery care project was conducted.

Study context

This interview study was part of a larger experimental cohort study implemented in a rural area of Sweden in 2017–2019, where women were offered to participate in a project involving continuity of midwifery care. Shortly before the start of the continuity project, the local labour ward was closed, and women in the area had to travel 100–120 km to the nearest hospital to give birth. In short, four midwives were recruited for the project and women were assigned a midwife who provided antenatal care. Women and their partners had the opportunity to meet all four midwives during pregnancy. Each day, one of the four midwives was scheduled for the on-call service, and when a woman in the project went into labour, the on-call midwife was contacted via telephone. After assessment of the progress of labour and the woman’s needs (at home or at the clinic), the midwife followed the woman to the labour ward and assisted her during labour and birth. Due to a shortage of midwives, working time legislation and long travel distances, on-call service was not offered around the clock. If the midwife’s shift ended during labour, the intrapartum care was handed over to the hospital staff.

Data collection in the larger cohort study consisted of two questionnaires, during mid-pregnancy and two months after birth. In the questionnaire sent to women after birth, they were asked if they wanted to participate in individual interviews. Details of the continuity project are presented elsewhere [10]. Women who did not take part in the project received standard fragmented care as described above.

Informants

A purposive sample was employed to recruit informants for this qualitative interview study. From a total of 59 women who expressed an interest to participate in a follow-up interview, 36 had had a project midwife assisting during labour and birth. Of this number, 33 women responded to the contact attempts, and they were interviewed. Only women who had continuity of midwifery care during pregnancy, labour and birth were included in this study.

Data collection

Interviews were conducted over telephone in Swedish by a research assistant or the first author following a semi-structured interview guide. Informants were asked to explain their experiences of the continuity project by answering such questions as, ‘Did you have any expectations of the project? If yes, what were they?’; ‘How was your birth? Please tell me about that event’; and ‘How do you feel when you think about the birth of your child?’ Data collection continued until no new concepts were added. The interview date varied from one to three years postpartum, but most women were interviewed one to two years postpartum. The interviews were conducted during the years 2018, 2019 and 2021 and lasted in mean time 13 min (8–20 min).

Data analysis

The interviews were digitally recorded and transcribed verbatim. A reflexive thematic analysis was employed, according to Braun and Clarke [11], with an inductive approach focusing on the semantic content. In order to fulfil the aim of this study by identifying patterns of meaning across the data set [11,12], the analysis process followed the six phases under Braun and Clarke. The first phase, becoming familiar with the data material, began while the information was being transcribed and during the repeated rereading of the interviews. The second phase included highlighting meaningful data extracts, by rereading the transcribed interviews, which was done by the first author throughout the whole data set. These extracts constituted the base from which the initial codes were manually generated by the first and the last author simultaneously using a collaborative and reflexive approach. All codes were organised into groups based on similarities.

Patterns were identified, and during the third phase, preliminary themes and subthemes were generated from patterns with shared meanings. A thematic map was created to visualise potential relationships between the themes. During the fourth phase, the preliminary themes were checked against the data set to determine whether they told a convincing story of the data, and thereafter, they were revised and renamed as needed. At this point forward, all authors were engaged. In the fifth phase, the final themes and subthemes were defined and named. The sixth phase occurred simultaneously with phases four and five, and involved writing a summary.

All four researchers are midwives with an academic degree, and three have extensive clinically experience and a wide range of knowledge in qualitative research. Throughout interviews and analysis, the authors paid careful attention to their pre-understanding, which could inevitably influence the interpretation of the women’s stories. None of the authors were providing care to the women in the project.

Ethical considerations

The study was approved by the regional ethics committee (Dnr 2017/120-31). Confidentiality was ensured as no personal data was collected in the survey or during interviews. The women provided
written consent when deciding to participate in the continuity project but were able to opt out of the project at any time. All women were informed of the purpose of the interview study, the recording and the fact that all information would be treated confidentially.

Results

Of the 33 women interviewed, the mean age was 31 years. Twenty-two women (66.7 %) were multiparas and all women except one lived with a partner. Eighteen women (54 %) had studied to some extent at a college or university.

The analysis resulted in an overarching theme ‘A longing for a sense of security’, which pervaded all the three main themes and subthemes. The three main themes: ‘The importance of professional midwifery care’, ‘Continuity of midwifery – fulfilled expectations or full of disappointments’ and ‘New prerequisites – acceptable to some, but not a substitute for everyone’. Table 1 were seen as different views of the main theme of longing and explain different aspects that affect the feeling of security. The endeavour to feel secure during pregnancy, birth and postpartum was a continually recurring subject that cannot be overstated.

The importance of professional midwifery care

This theme illustrates that women valued professional midwifery care but for different reasons and to different extents. The relational trust and the personalised care from a known midwife were highly valued by most women. To others, the attendance of a skilled midwife, regardless of whom, was more important. The theme included two subthemes: The trusting relationship – as a close friend, and The attendance of a skilled midwife.

The trusting relationship – As a close friend

In the first subtheme women described the importance of having their named midwife present during labour and birth, stating that her appearance was one of the most welcome events during labour. To be taken care of by the known midwife was, for instance, described as ‘inexorable good’ and ‘as the best thing that could have ever happened’.

A primipara emphasised the mutual woman midwife-relationship like this:

She knew me and knew what would work for me. She got to know me, which was very positive and not just the other way around! (W8)

The known midwife was highly valued since she could support the woman in experiencing the birth that she wanted. Through repeated visits and a continuing dialogue, the woman was able to share her thoughts of continuity of midwifery care in the project:

She knows exactly how I want it, because she’s the one I’ve written the birth letter with, and she’s the one I’ve been talking to all along. So it was really nice that you didn’t have to say, “I want it like this” because she already knew that. (W14)

Many women felt trust and confidence in all the midwives in the project, stressing that if their named midwife was not on call, it would be fine to have another midwife from the project take over. Comparisons were made with other hospital staff. Women felt that the absence of their named midwife affected their care negatively when she was replaced by ordinary staff. Some women expressed a feeling of abandonment when their midwives had left the hospital after finishing their shifts.

The attendance of a skilled midwife

There was a longing for a skilled and competent person, regardless of the relationship. This was mirrored by some women who stated that as long as a midwife was there for them, everything would be fine. The skills and knowledge of a midwife were viewed as more important than knowing each other. One multipara said:

For me, it didn’t matter who helped the baby out, but I liked the security that there was help along the way (to the hospital). The baby has to come out; you don’t care so much about the others around you when you are lying there. (W18)

The midwife was not taken for granted by all women. Some women expressed a humble, almost merciful attitude, stressing that they would be thankful if anyone could be there for them when the labour started. To these women, the most important thing was not to be left alone during labour and birth.

Continuity of midwifery – Fulfilled expectations or full of disappointments

The second theme reflects different views on the continuity project and what it meant to participate. The possibility of giving birth with a known midwife present was seen as beneficial and appealed to all women. However, the expectations of the project and the tolerance of the model’s perceived limitations differed, as did the women’s way of handling the unpredictability of the model. This was illustrated in two sub-themes: A known midwife - luxury or guarantee? and, Women’s concern for others.

A known midwife – Luxury or a guarantee?

Most women were fully aware that their named midwife might not be available or not on duty when they went into labour, but they still wanted to participate in the project, even though they did not expect the continuity to be fully realised. This is how a primipara described her thoughts of continuity of midwifery care in the project:

There was no guarantee that you would have the midwife with you, but if you were not involved in the project, you would definitely not get someone you knew. (W28)

Women who did not take the known midwife for granted seemed positively surprised and grateful when their midwife could care for them during labour and birth. The successful outcome of continuity from a known midwife was seen as a fortunate coincidence, pure luck or even as a luxury. Women noticed that the midwife never left the room to do something else, or never focused or someone else other than the birthing woman. This made them feel safe, confident and calm. One primipara said:

She came in and was with me all the time and that, it was like something I had never been able to dream of, that she would be there. When she showed up, then everything was just so heavenly good. (W26)

To other women, uncertainties such as the potential absence of the midwife was a stressor that threatened to ruin the whole purpose of participating in the project, and they found it hard to accept that the
named midwifewould be occupied elsewhere when she was requested. A multipara said:

It hangs over me, that even if I presumably get someone with me, it’s not certain that this will be my midwife. (W12)

For a small number of women, participation in the project meant the same thing as a promise of care from a known midwife during labour and birth. This expectation entailed a risk of disappointment.

When I went in [to the labour ward], the midwife who was on call couldn’t be there and then I was actually sad and upset. (W27)

Women’s concern for others

Reflections were expressed on the accessibility and limitations regarding not only the project setup and the midwives, but also on behalf of other women in the project. Other women were shown consideration. To some, it was calming to think that the midwife was busy with another woman in labour if she was not available. As one multipara stated,

They [the midwives] are also just people, and if they don’t answer, they are probably helping someone else. (W4)

Women expressed ideas of how the midwife could prioritize if she were forced to choose which woman to care for. They did not put themselves first but meant that the midwife could be of more importance to other women, or in another situation, such as women expecting their were forced to choose which woman to care for. They did not put

multipara stated,

I wish everyone had the opportunity to have a midwife all the way through, especially in the north with long travel distances. I hope they will continue with that [the project]. I wish it for all women who will give birth. (W21)

Sympathy was also expressed for the midwives, their work situation and their work environment. One multipara described it as follows:

I said it was strange that she would drive 120 km, leave others because of me giving birth, when I received such a good welcome [at the hospital]. I understand if someone needed her along the way, or if some complication occurred, or if there was a pregnancy at risk, but I was normal functioning, so I couldn’t understand why she would bother. (W15)

New prerequisites – Acceptable to some, but not a substitute for everyone

The third theme describes how the women handled the new conditions related to the continuity project and to what extent the previous closure of the local labour ward affected their perceptions of the continuity model. Extended accessibility through on-call telephone access made it easy to get in touch with a project midwife, which was enough for some women to feel supported at all times. Although women were positive about the new availability and the services provided by the project, the lack of a nearby labour ward was very apparent. For some women, the process of accepting the closure of the local labour ward consisted of two sub-themes: Lifeline through a phone line, and A situation no one should have to face.

Lifeline through a phone line

The phone line to the midwife on-call was used differently among the women. Some reasons to call were to get advice during the pregnancy, to have a check-up during the early stages of labour, or to get support with breast feeding postpartum after arriving home. Many women were positive about having access to a midwife on times outside usual hours of opening, over the telephone as well as by home visits. A primipara said:

After the birth, I could call and get help. There was someone who came to our house and helped me, and it was worth its weight in gold. (W2)

On some occasions, the midwife called the woman to check if everything was okay. This made the women feel that the midwives cared for them. The hotline also instilled security and safety in the women by offering answers to small or large questions. Women felt that they could call about ‘anything’ and that the answering midwife treated them in a personalised way. It was appreciated that the answering midwife was well known to, or acquainted with, the woman, and not a complete stranger. Through the hotline, the midwives were perceived to be reachable, just a phone call away.

To some women, it was calming to know that the phone line existed even though they did not need to use it. This is how one primipara explained it:

I thought it was mainly a security, but that it might not be needed, that there would be no danger. But still, it felt very nice to know that there was a number you could call. (W30)

A situation no one should have to face

The midwifery continuity project offered a new concept of care to women in the area, but the project was involuntarily forced to solve problems and face difficulties in the wake of the closure of the local labour ward. Many women inquired for the project to provide more support during night-time, on site as well as over the phone. The uncertainty about when the labour would start, and what type of support would be available at the moment, worried some women. One primipara said:

I wondered how they thought the project would be when they were not available at night. If the labour starts at night, that’s when you want someone with you … I thought it was strange that they were available during the day when it was easier to get to the hospital, rather than at night when needed. (W13)

The aspect that created the most worries and concerns was the increased travel distance after the closure of the local labour ward. Some women decided to participate in the project in order to be supported along the road. Many women expressed how the thoughts of travelling caused them stress and anxiety, because of both the distance and the risk of bad weather conditions. Women were afraid of a car drive with uterine contractions in the middle of the night, maybe during the winter or in stormy weather. There was a great fear of giving birth in the car or on the way to hospital. This is how a multipara expressed it:

This third time has been very worrying, both for me and my partner. We had filled the car with … with all sorts of equipment to cope with a possible birth on the road. And there was a snowstorm that day too, so it wasn’t the best road to travel on either. (W29)

Regardless of the midwives’ extended availability and the possibility of being taken care of by a known midwife during birth, the project was not seen as sufficient compensation. It could not fill the void caused by the closure of the local maternity ward.

Discussion

The main findings of this study show that women longed for a sense of security during pregnancy, labour, childbirth and postpartum, and the continuity of midwifery care strengthened the sense of security facilitated by the midwife-woman relationship. However, prerequisite circumstances and women’s expectations affected their experiences of continuity of midwifery care.

The essence of the overarching theme was that the feeling of being supported and taken care of during the entire childbearing period strengthened the feeling of security. These findings are similar to the results of a systematic review [4] and several other studies showing that
women receiving continuity of midwifery care are more satisfied with the care, have an overall more positive birth experience [6,13–15] and describe a sense of control with less anxiety [3,16]. Women in the present study expressed a recurring endeavour to feel secure, and this was mirrored in the overarching theme. To be supported is an important aspect in order to feel safe during birth [18,19] and a midwife’s support to a woman during childbirth in a continuity model matters for years after the baby is born [17]. Similarly, feelings of control and confidence are suggested to be related to a sense of security during birth, which could be seen as a basic need and a central issue during pregnancy, childbirth and the postnatal period [18,19], as requested by women in the present study.

The professional midwifery care was of varying significance to different women, as shown in the first theme. Most women wished for continuity, and to some, the known midwife was crucial at the time of birth. The findings of this study show that continuity of midwifery care gives the woman a unique chance to build a warm and trusting mutual relationship with the midwife, which forms the basis for a positive and strengthening experience during the whole pre-, intra- and postpartum period. These findings are in line with previous studies, describing the midwife in the continuity model as a close friend or a family member [5,20,21]. The midwife-woman relationship was described as fundamental to the building of trust, confidence and safety for the pregnant woman [18,22,23] as well as a central part of women’s experiences of continuity of midwifery care [13,15,24]. In addition, in a meta-synthesis, Perriman et al [4] identified that the midwife-woman relationship was central and generated benefits such as trust, personal care, and empowerment.

Women inquired about a wide spectrum of the midwives’ area of knowledge. The skilled midwife was coveted for providing comprehensive practical support during the childbearing period and for being a competent and skilled guide, or company, while travelling during labour. To some women, the attendance of a skilled midwife was more important than being taken care of by a known midwife. Previous positive experiences of giving birth without knowing the midwife, or previous meetings with other reliable midwives during pregnancy might have contributed to the feeling of the personal relationship as less important than the midwife herself, which is in line with other researchers’ findings of women relying on good labour care because of positive experiences of kind midwives during pregnancy [25].

Indicated by expectations to be fulfilled or risks of disappointment, women in this study had different views on the midwives and the continuity of midwifery care. For example, some women expected the midwives to provide everyone in the project with continuity during labour and birth, and a woman birthing without a midwife from the project was seen as a failure. To others, this lack of time and resources was an unfortunate sign of the midwives’ workload and work situation, regrettable but manageable. Similar findings were seen in another Swedish study, where some women accepted that the midwife in the continuity model could be unavailable, while not knowing caused anxiety and stress to others [26].

Despite the fact that the aim of this interview study was not to explore birth experience explicitly, it is obvious that expectations and how they were met influenced the overall experience among the women in the continuity project. This was implied by the finding of women expressing lower expectations on continuity and being more positive and overwhelmed when continuity was followed through intrapartum. In previous research, expectations turned out to be of great importance to women’s experiences of birth and intrapartum care [17,19,27,29] and to the overall satisfaction with care in childbirth [27,29]. Other research shows that women whose expectations for labour and birth were achieved reported higher childbirth satisfaction, compared to those whose needs were not met [28,30,31]. Expectations were not always congruent with the experience of childbirth; rather, they could be unexpectedly better or worse [17,32]. Women whose expectations were not fulfilled had a less positive overall birth experience [33]. A systematic review concluded that a mismatch between birth expectations and experiences was associated with lower birth satisfaction [34]. Midwives were even more important to women and their experiences during childbirth when expectations were not met [28].

As mirrored in the subtheme, Lifeline through a phone line, the continuity project offered new ways to get in touch with the midwives. The setup with the phone line appealed to women since it practically eased the contact with the project midwives. Symbolically the telephone represented the connection between women and midwives in the project, and the midwives being on call seemed to make them approachable during the entire childbearing period. The possibility of home visits was greatly appreciated by those who used it and seen as a special treatment generating feelings of support, confirmation and being watched over. Accessibility was requested and of importance to women in continuity models of midwifery care in order to make the women feel assured and connected to the midwives [5,14,24,26].

However, the changed external conditions after the closure of the local labour ward affected women in the region most noticeably, especially during labour since they had to travel hours to other labour wards. Women were upset with the project not promising company and support along the way, expressed in the subtheme, A situation no one should have to face. The issues of travelling in labour caused stress and anxiety to many women, and they feared giving birth before they reached the hospital. Increased travel distance has shown association with risk of giving birth outside of hospital [35–37].

A recently published Swedish study showed that the risk of giving birth outside hospital was two times higher for women with a travel time of 31–60 min, and more than three times higher for women with a travel time of more than 60 min, compared to women with travel time of 0–30 min to the closest labour ward [37]. Women in labour driving longer distances due to centralisation in Australia all expressed fear and anxiety about birthing outside hospital, and desired a skilled and competent midwife during labour [38]. In this study of women in a remote area, the worry of birthing outside hospital was mentioned several times, but it is difficult to say how common these thoughts are among Swedish women in general, since the subject has not been researched. During the period when the closure of the rural labour ward was frequently discussed in the media, there were some initiatives to prepare women and their partners in case of birthing in the car or before arriving to the hospital [39]. This might have contributed to the worries of giving birth outside the hospital as a real concern. No woman in this study gave birth unassisted or outside the hospital [40].

Methodological considerations

This study is the first Swedish study describing how women experience continuity of midwifery care in a Swedish rural area. In order to achieve trustworthiness, a strategy taking several aspects into account when doing qualitative research was followed [41].

One strength of the study is the relative large number of informants who provided a rich and varied picture of the experience of continuity of midwifery care among the group in question, thus strengthening the credibility of the study. Due to long travel distance and the ongoing pandemic, the interviews were conducted by telephone. It is possible that the informant’s answers were affected by this interview method. However, interviews by telephone have been described as allowing informants to speak more freely compared to face-to-face interviews [42]. Telephone interviews are also time saving, which enabled a larger number of informants. Further, credibility was also enhanced by collaborative discussions and reflections in the research group throughout the research process [41].

The description of the study context ensures transferability and the description of the methodology and the analysis process followed the checklist from Brown and Clarke [11] which allows the study to be repeated, strengthening its dependability. All researchers are midwives with clinical experience in antenatal care. Throughout the research
Declaration of Competing Interest

can deepen and develop during the entire childbearing period.

which could be seen as a limitation and an important aspect to address in future research.

In this study, only women who actually had their known midwife during birth were included. It was an active choice to focus on these women in order to explore the experience of continuity throughout pregnancy and birth. Future studies should include women in continuity models where continuity was not fulfilled during labour and birth. Furthermore, this study does not include non-Swedish speaking women, which could be seen as a limitation and an important aspect to address in future research.

The continuity project cannot be evaluated or discussed without taking the closure of the local labour ward in account. The closure was the triggering factor to initiate and secure the funding of the project, as it was the reason to start the project at the specific time and place. With the above exception, the project had nothing to do with the closure or the decision to create the shutdown. For some women, however, it was difficult to separate the closure from the project itself, as the project was perceived as a direct effect of the closure and not as an independent undertaking. This may have affected how the women experienced and valued the project, which should be viewed as a limitation.

Conclusion

Continuity of midwifery care strengthened women’s feelings of security during pregnancy, birth and postpartum. The deepened relationship developing over time was a central part of the positive aspects of the experience of continuity of midwifery care. Expectations and prerequisite circumstances are important to consider when developing and introducing new care models.

Clinical implications

Service providers and decision makers should pay attention to and prioritise the relational aspect when planning care for women during the childbearing period. Independently of current care models and external circumstances, employers and service providers should strive to plan and provide care where the relation between the woman and midwife can deepen and develop during the entire childbearing period.

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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