Position Statement

Midwife-led Continuity of Care (MLCC)

Background

Evidence suggests that Midwife-led Continuity of Care (MLCC) is vital to provide the type of care that women want and to improve maternal and neonatal health outcomes while working to achieve the United Nations Sustainable Development Goals (SDG).[1]

In recent years both the WHO antenatal and intrapartum care guidance for a positive pregnancy and childbirth experience have recommended MLCC models for pregnant women in all settings provided by well-trained midwives.[2]

There is increasing consensus among health leaders at the global and national level, that there must be more targeted strategies to provide high quality, equitable and respectful healthcare to women and girls to not only achieve the SDG but also achieve Universal Health Coverage (UHC).[3]

Definition of the Midwife-led Continuity of Care (MLCC) model

A MLCC model provides women with care from the same midwife or small team of midwives during pregnancy, birth, and the postnatal period with appropriate involvement of the multidisciplinary team when needed.[4] This involves coordination and provision of care led by midwives which enables the development of a therapeutic partnership between the midwife and woman over time. MLCC is woman-centred and based on the premise that pregnancy and

[1] Renfrew, M. et al. (2014) Midwifery and quality care; findings from a new evidence-informed framework for maternal and newborn care. The Lancet. Sep 20;384 (9948):1129-45. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60789-3/references

[2] World Health Organization. (2018) Continuity and Coordination of Care. WHO, Geneva. Available at: http://apps.who.int/iris/bitstream/handle/10665/274628/9789241514033-eng.pdf?ua=1

[3] White Ribbon Alliance. (2019) What Women Want: Demands for Quality Reproductive and Maternal Healthcare from Women and Girls Report. Available at: www.whiteribbonalliance.org/whatwomenwant/

[4] Johanson, R., Newburn, M., Macfarlane, A. (2002) *Has the medicalisation of birth gone too far*? BMJ. 13;324(7342):892-5. Available at: https://pubmed.ncbi.nlm.nih.gov/11950741/

childbirth are normal life course events.[5] However, MLCC is not only restricted to healthy 'low-risk' women and there is evidence that this model positively impacts 'high-risk' women as well as those with social complexities and from marginalised.[6] [7] [8]

A MLCC model comprises, but it is not limited to, the following elements:

- The model is supported and implemented within health care systems
- The model is made available to all women, independent of individual and clinical circumstances. Every woman needs a midwife, some need a doctor too[9]
- A primary/named MLCC midwife is allocated to every woman from the start of the pregnancy
- The MLCC midwife follows a woman across settings including institutions and community through all phases of pregnancy, birth and the postnatal period. Coordinating collaboration with other health professionals when necessary[10]
- The midwife provides holistic care addressing the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations [11] [12]
- The midwife is an advocate for the woman and her choices [13] [14]
- Students are trained within a MLCC model and exposed to continuity of care during their midwifery education programme[15]

Evidence in support of Midwife-led Continuity of Care (MLCC)

MLCC models have been shown to offer multiple benefits for women and babies compared with other models of care, with no adverse effects.

The Cochrane review by Sandall et al (2016) concluded that women who received models of MLCC were: 16% less likely to lose their baby; 19% less likely to lose their baby before 24

[5] Sandall, J. et al. (2016) Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews. Apr 28;4:CD004667. Available at: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub3/full?cookiesEnabled

[6] Homer, C., Brodie, P., Sandall, J., and Leap, N. (2019) Midwifery continuity of care: a practical guide. Second Edition. Elsevier Health Sciences. Feb 27. Available at: https://www.uk.elsevierhealth.com/midwifery-continuity-of-care-9780729542951.html

[7] Allen, J., Gibbons, K., et al. (2015) Does model of maternity care make a difference to birth outcomes for young women? A retrospective cohort study. International Journal of Nursing Studies. Aug 1;52(8):1332-42. Available at: https://pubmed.ncbi.nlm.nih.gov/25952336/

[8] Corcoran, P.M, Catling, C., and Homer, C.S. (2017) Models of midwifery care for Indigenous women and babies: A meta-synthesis. Women and Birth. Feb 1;30(1):77-86. Available at: https://pubmed.ncbi.nlm.nih.gov/27612623/

[9] Sandall, J. (2012) Every woman needs a midwife, and some women need a doctor too. Birth. Dec;39(4):323-6. Available at: https://pubmed.ncbi.nlm.nih.gov/23281954/

[10] Grigg, C.P. and Tracy, S.K. (2013) New Zealand's unique maternity system. Women and Birth. Mar 26(1): e59-64. Available at: https://pubmed.ncbi.nlm.nih.gov/23107645/

[11] Kelly, J., West, R., et al. (2014) 'She knows how we feel': Australian Aboriginal and Torres Strait Islander childbearing women's experience of Continuity of Care with an Australian Aboriginal and Torres Strait Islander midwifery student. Women and Birth. Sep 1;27(3):157-62. Available at: https://pubmed.ncbi.nlm.nih.gov/24997119/

[12] McCourt, C., Page, L., Hewison, J., and Vail, A. (1998) Evaluation of one-to-one midwifery: women's responses to care. Birth. Jun;25(2):73-80. Available at: https://pubmed.ncbi.nlm.nih.gov/9668740/

[13] Finlay, S., and Sandall, J. (2009) "Someone's rooting for you": Continuity, advocacy and street-level bureaucracy in UK maternal healthcare. Social Science & Medicine. Oct 1;69(8):1228-35. Available at: https://pubmed.ncbi.nlm.nih.gov/19699570/

[14] Tilford, T. (2015) An exploration of women's perspectives of care in midwife-led continuity models of care: a qualitative synthesis. MPH Thesis. London, King's College.

[15] Nursing & Midwifery Council. (2019) Standards of proficiency for midwives. NMC, London. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf

weeks; 24% less likely to experience pre-term birth; 15% less likely to have regional analgesia; 10% less likely to have instrumental birth; 16% less likely to have an episiotomy; 5% more likely to have a spontaneous vaginal birth. While no differences were found in the rates of caesarean births and no adverse outcomes were identified.

Women receiving MLCC report high level of satisfaction with information, advice, explanation, place of birth, preparation for labour and birth, choice of pain relief, care received in labour and control of their experience. They are also 8 times more likely to be attended by a midwife they know and trust at birth. Several qualitative studies have also shown that both women, experienced and newly qualified midwives value this model of care.[16] [17] [18] [19]

Other evidence from high income countries found such models to be a cost-efficient way to improve outcomes for mothers and babies, reducing medical interventions and increasing satisfaction with care.[20] [21]

The benefits also extend to midwives who provide MLCC, including high levels of occupational satisfaction, strong professional identity and autonomy and reduced burnout. [22] [23] [24]

Position

A core element of ICM's 3-year strategy 2021 - 2023[25] is to develop, strengthen and support the rollout of a new professional framework for midwifery. ICM believes the MLCC model is a core element of the ICM professional framework. The ICM:

- Recognises the importance of a positive birth experience and the psycho-social well-being of women for a healthy, promising start to a new life for mother and baby.

[16] Perriman, N., Davis, D.L., and Ferguson, S. (2018) *What women value in the midwifery continuity of care model: A systematic review with meta-synthesis*. Midwifery. 62:220-229. Available at: https://pubmed.ncbi.nlm.nih.gov/29723790/

[17] Forster, D.A., et al. (2016) Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial. BMC Pregnancy and Childbirth. 16(1): p. 28. Available at: https://pubmed.ncbi.nlm.nih.gov/26841782/

[18] Beake, S., McCourt, C., and Bick, D. (2005) Women's views of hospital and community-based postnatal care: the good, the bad and the indifferent. Evidence-Based Midwifery. Dec 1;3(2):80-7. Available at: https://repository.uwl.ac.uk/id/eprint/118/

[19] McCourt, C., Page, L., Hewison, J., Vail, A. (1998) Evaluation of one-to-one midwifery: Women's responses to care. Birth. Jun;25(2):73-80. Available at: https://pubmed.ncbi.nlm.nih.gov/9668740/

[20] Tracy, S.K., Hartz, D.L., et al. (2013) "Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial". Lancet. Nov 23;382(9906):1723–32. Available at: https://pubmed.ncbi.nlm.nih.gov/24050808/

[21] Gao, Y., Gold, L., et al. (2014) A cost-consequences analysis of a Midwifery Group Practice for Aboriginal mothers and infants in the Top End of the Northern Territory, Australia. Midwifery. Apr 30(4):447-55. Available at: https://pubmed.ncbi.nlm.nih.gov/23786990/

[22] West, M., Bailey, S., and Williams, E. (2020) The courage of compassion: supporting nurses and midwives to deliver high quality care. The King's Fund. Sep. Available at: https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives

[23] Fenwick, J., Sidebotham, M., et al. (2018) The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity. Women and Birth. 31: 38-42. Available at: https://pubmed.ncbi.nlm.nih.gov/28697882/

[24] Homer, C.S. (2016) *Models of maternity care: evidence for midwifery continuity of care*. Medical Journal of Australia. 205(8):370-374. Available at: https://pubmed.ncbi.nlm.nih.gov/27736625/

[25] ICM. 2021. Strategic Plan. The strategic direction for the triennium 2017-2020 is Quality, Equity and Leadership. Available at: https://www.internationalmidwives.org/about-us/

- Acknowledges the positive effect of MLCC on perinatal outcomes, women's experiences and cost efficiency.
- Believes continuity of care by a midwife should be available to all women during pregnancy and birth regardless of their background/ income/risk status.
- Believes a maternity care system should provide midwives the opportunity to work in a continuity of care model and encourages midwives to lobby for the development of such models of care.
- Acknowledges that the benefits of continuity of care models also extend to midwives who experience high levels of occupational satisfaction and reduced burnout.

Recommendations

Member Associations based in countries where women do not have access to MLCC models are encouraged to advocate for the development of such models in their countries, together with women and other stakeholders. Member associations in countries where MLCC models do exist are encouraged to work with women and other stakeholders to further develop, scale-up and maintain such models of care.

Related ICM Documents

- ICM. 2014. Core Document. Philosophy and Model of Midwifery Care.
- ICM. 2017. Position Statement. Midwifery Led Care, the First Choice for All Women
- ICM. 2017. Position Statement. Appropriate Maternity Services for Normal Pregnancy, Childbirth and the Postnatal Period.
- ICM. 2017. Position Statement. Home Birth.
- ICM. 2021. Strategic Plan 2017-2020.

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