RESEARCH ARTICLES

Unleashing the full potential of midwifery: Victorian midwives' motivation and ability to contribute to maternity service reform

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ABSTRACT

Objective: To explore the motivation and ability of midwives in Victoria to contribute to maternity service reform recommendations, specifically expansion and promotion of midwifery continuity of care models.

Background: Since the inception of the National Maternity Services Plan in Australia in 2010, midwifery continuity of care has been a key priority area for maternity service reform. It is known that midwifery continuity of care models improves outcomes for mothers and babies, and that midwives' value and support working in these models. What is not known, is the motivating factors and ability of midwives in Victoria to contribute to Maternity Services Reform, through promotion of the initiation and expansion of midwifery continuity models.

Study design and methods: A cross-sectional, qualitative descriptive design was used. Ten midwives participated, resulting in six semi-structured individual interviews and one focus group of four midwives. Interview and focus group data was analysed using thematic analysis.

Results: Midwives in this study were generally supportive of maternity service reform, especially midwifery continuity of care models, but many felt powerless to contribute to reform agenda. Midwives described limited knowledge of maternity service reform and lack of exposure to midwifery continuity of care models. Systemic issues like medical dominance and lack of institutional support further hindered midwives' ability to enact change. Despite these challenges, many midwives expressed a desire to work to their full scope, suggesting that with adequate education, mentorship, and leadership, they could become more active agents of reform.

Conclusion: Midwives within this study are motivated to contribute to Maternity Services Reform and support greater access to midwifery continuity of care models, however, the majority felt unable to make an appreciable contribution to the expansion and promotion of these models. Strategies identified to improve midwives' contribution to reform included: education on transforming maternity care, having access to supportive midwifery leaders, successful interdisciplinary collaboration, and fostering a strong midwifery professional identity.

 https://doi.org/10.37464/2025.423.1135

Implications for research, policy, and practice: Participants in this study were motivated to contribute to maternity service reform and practice in midwifery continuity of care models. However, there were many aspects of their role as a midwife and the current maternity care system that did not enable them to contribute. Recommendations to improve midwives' ability to contribute include education programs that focus on continuity of care experiences, successful and respectful interdisciplinary collaboration, identifying midwifery leaders with a strong vision for reform agenda, and strengthening midwifery as a profession.

What is already known about the topic?

- Widespread implementation of midwifery continuity of care models remains slow in Australia.
- Midwives' ability and motivation to contribute to these models is unknown.
- Australia's maternity service reviews have recommended expansion of midwifery continuity of care models.

What this paper adds

To contribute to reform recommendations around midwifery continuity of care models, midwives require:

- education on transforming maternity care.
- supportive midwifery leaders & interdisciplinary collaboration.
- a strong midwifery professional identity.

Keywords: Caseload midwifery, maternity health services, maternity service reform, midwifery continuity of care, midwifery.

OBJECTIVE

The aim of this study is to explore the is the motivating factors and ability of midwives in Victoria to contribute to Maternity Services Reform, through promotion, initiation, and expansion of midwifery continuity models. Recommendations for midwifery practice that may lead to greater implementation of midwifery continuity of care models in Victoria, and across Australia will be outlined based on the findings of this study.

BACKGROUND

In the last three decades there have been over 15 government reviews of maternity services in Australia. Each of these reviews generate Maternity Service Reform (MSR) recommendations that aim to improve access to quality maternity services for women in Australia.[1] Midwifery Continuity of Care (MCoC), also known as caseload or Midwifery Group Practice (MGP), is a model of care that aligns with recommendations from multiple maternity service reviews over the past decade.[2] These models are defined by Australian Institute of Health and Welfare (AIHW) as where the same midwife, or small group of midwives, provides care and support to a woman during the antenatal, intrapartum and postnatal period.[10] There is high quality evidence to support the safety and efficacy of MCoC models. Women who have care from a known midwife during their childbearing journey are more likely to have a spontaneous vaginal birth, and less likely to experience interventions such as epidural analgesia, episiotomy, and instrumental birth.[3] Additionally, MCoC has been found to improve maternal mental health outcomes when compared to other models of care.[4]

There are also many known benefits for midwives working in MCoC models. Midwives experience greater role satisfaction, and are less likely to experience burnout.[5,6] The perceived professional identity and autonomy for midwives working in continuity models is higher compared with midwives working in shift-work centric, fragmented models.[6] Whilst there is evidence that change is occurring in some states with more midwives working in models where they provide MCoC,[7] most midwives in Australia are currently employed within a hospital setting and provide care under a medical model of care.[8]

Despite national campaigns promoting widespread implementation of MCoC models, and the known benefits to women, babies and midwives', a significant increase in access to MCoC models for women has not been realised.[9] In 2024, the AIHW outlined in their review of maternity care models that only 11.4% of Victoria's maternity care models involved MCoC, compared to 24.1% in Queensland, 21.4% in South Australia and 16% in the Australian Capital Territory.[10] Victoria is one of the most populous childbearing states in Australia and providing maternity services in line with reform recommendations is essential.

Over the past 5 years, Victorian health services have arguably been the most impacted by the COVID-19 pandemic, and the midwifery workforce is no exception. This is due to extensive restrictions and prolonged lockdowns that led to a "transformative shock", which involved abrupt and extensive changes across Victorian healthcare services.[11] A recent Victorian study revealed that 76% of midwifery managers have inadequate staff levels, with increasing difficulty recruiting midwives since the COVID-19 pandemic.[12]

The study identified an urgent need for recruitment and retention of midwives in Victoria. Expanding and upscaling MCoC models may be a way to do this. A scoping review identifying reasons why midwives stay in the profession found themes that are synonymous to working in MCoC – such as building relationships with women, protecting normality in pregnancy and birth, and working autonomously.[13] Upscaling of MCoC models will not only improve access and outcomes for women and babies but may also provide more appealing job prospects for midwives in Victoria.

A barrier to upscaling MCoC models is midwives who are unwilling, unsupported or feel unable to work in this way.[14,15] Therefore, to support successful transition to wide scale implementation of MCoC in Victoria it is vital to explore the views of midwives working in Victoria.

STUDY DESIGN AND METHODS

DESIGN

A qualitative descriptive methodology was used. Qualitative descriptive methods stay close to the data on a surface level and provide a comprehensive description.[16] This approach is particularly useful where little is currently known about the issue under investigation.[17]

PARTICIPANTS, RECRUITMENT, AND SETTING

This cross-sectional study was conducted within the state of Victoria, Australia between December 2018 and September 2019. Midwives working in any maternity setting (public, private, or MCoC), were invited to participate. Multiple recruitment strategies were employed. A combination of purposeful, convenience, and snowballing sampling was employed as a recruitment method. These methods are frequently employed in qualitative research to gather insights from a specific population – in this case, midwives in Victoria – who possess relevant knowledge or experience regarding the phenomenon of interest.[18]. Purposeful sampling occurred through the use of social media advertising and email outreach through local midwifery networks, the Endorsed Midwives Facebook page, and an Australian University Midwifery Programs' social media page. These pages were chosen to gain interest from midwives working in private midwifery practice, as well as midwives working in the hospital setting. Six participants were recruited through the use of social media, and one was recruited via convenience sampling, through emailing of midwives who were known to the researcher to have worked in a specific area of practice for an extended period of time. This recruitment strategy was employed to add diversity to the participants, as many recruited to this point were relatively new to the profession or currently working in MCoC models. Three participants were gained through snowball sampling, which occurred through word of mouth from a colleague. Participants emailed the researcher to register their interest and receive more information to inform their decision to participate. Demographic data was collected from participants, and included age, educational pathways into midwifery, tertiary qualifications, practice setting, model of care working in, and years of experience.

DATA COLLECTION

Six one-on-one semi-structured interviews were used to collect data. In addition, one small focus group interview of four participants was conducted to elicit shared views of these midwives working in private practice. All participants were offered one-on-one interviews at the location and time of their choosing, and the participants working in private practice chose a group interview for convenience. All interviews took place face-to-face, except for one phone interview with a rural midwife. Interviews lasted on average 60 minutes. A semi structured interview guide (Appendix 1) was used, which enabled open ended discussions and flexibility depending on the participant's direction and experience. The interview questions explored participant's working context, current knowledge about MSR and perceptions around their role, motivation, and ability to contribute to MSR and MCoC in Victoria. To ensure the interviews were comprehensive and focused on the research objectives a pilot interview was conducted. The pilot interview guide was developed and reviewed by three PhD qualified, experienced researchers. Interviews were recorded and transcribed verbatim using a transcription service. All interview data was de-identified to protect the privacy of participants. In addition, handwritten field notes and memos were taken in each individual interview to add depth to the data collected.

ETHICAL CONSIDERATION

Ethics approval was obtained through Griffith University Human Research Ethics Committee (GU Ref No: 2018/812). Participants were invited to participate following informed written consent. Responses were de-identified throughout the transcription and data analysis process by using pseudonyms to ensure anonymity. Participants were informed of their right to withdraw at any point without penalty, however no participant employed this right.

DATA ANALYSIS

Thematic analysis was conducted according to Braun and Clarke's steps to thematic analysis. [19] These steps involved immersing in the data, generating codes, identifying and reviewing themes, defining and naming the themes, and producing the story. Following initial data analysis by the primary researcher, the three co-researchers then discussed and made recommendations until consensus was reached. The final themes and sub-themes are represented in Table 2.

TABLE 1. PARTICIPANT DEMOGRAPHICS

Pseudonym	Age	Years of experience	Midwifery qualification	Current Practice setting	Model of care working in as per MaCCs** taxonomy
Kylie	20–29	1 year	Bachelor of Nursing/ Midwifery	Urban Public Hospital	Public Hospital Maternity Care
Hayley	20–29	6 years	Bachelor of Midwifery	Urban Agency Work (public and private casual work)	Public Hospital Maternity Care & Private Hospital (Obstetrician Care)
Jessica	40–49	3 years	Bachelor of Midwifery	Urban Public Hospital	Team Midwifery Care
Karley	40–49	17 years	Bachelor of Midwifery	Rural public hospital Rural private hospital Rural midwifery private practice	Public Hospital Maternity Care, Private Hospital (Obstetrician Care) & Private MCoC
Tegan	20–29	1 year	Bachelor of Nursing/ Midwifery	Urban Public Hospital	Public Hospital Maternity Care
Caitlyn*	60+	30+ years	Graduate Certificate of Midwifery (hospital trained)	Urban midwifery private practice	Private MCoC
Ariana*	40–49	23 years	Graduate Certificate of Midwifery (hospital trained)	Rural public hospital Rural midwifery private practice	Public Hospital Maternity Care & Private MCoC
Stephanie*	40–49	6 years	Bachelor of Midwifery	Urban public hospital Urban midwifery private practice	Public Hospital Maternity Care & Private MCoC
Kelly*	60+	30+ years	Bachelor of Midwifery (UK)	Urban public hospital Urban midwifery private practice	Public Hospital Maternity Care & Private MCoC
Michelle	60+	30+ years	Graduate Certificate of Midwifery (hospital trained)	Urban Public hospital	Public Hospital Maternity Care

*Focus Group Participant **Maternity Models of Care in Australia (AIWH, 2024).

RESULTS

Participants age ranged from 20 years old -60+ years years old (Table 1). Participant years of midwifery experience ranged from one year to 30+ years. Half of the participants held an additional midwifery prescribing qualifications and worked within private MCoC models. All other participants worked within public or private maternity settings, except for one who worked in a Team Midwifery model (a midwifery-led model of care where a small team of rostered midwives provide antenatal, intrapartum, and postnatal care). Four participants who worked in private MCoC were also employed in a public hospital maternity care model. Only two participants worked in rural areas of Victoria, with others working in metropolitan Melbourne and urban surrounds.

Data analysis identified four themes related to how able and motivated participants felt they could contribute to the MSR agenda and MCoC.These themes and sub-themes are outlined in Table 2.

TABLE 2. THEMES AND SUBTHEMES

Theme	Sub-theme
I'm trying, but it's so hard	Supporting maternity service reform
	Feeling powerless
I don't know how to contribute to maternity service reform agenda	Maternity Service Reform is invisible
	University didn't prepare me
	I'm just a grad
This is bigger than me	Lack of systemic and political support
	More support is needed for midwives to contribute to MSR
	It's not my job
Unleashing the full potential of midwifery	Claiming midwifery identity
	Enable midwives to work to their full potential
	Midwives finding their political voice

I'M TRYING, BUT IT'S SO HARD

The first theme explores how despite midwives being motivated and willing to contribute to MSR, at times it was beyond their ability to do so. There are two sub-themes, *'Supporting maternity service reform'* and *'Feeling powerless'*.

Supporting maternity service reform

There was an overwhelming level of support from midwives for MSR agenda, specifically regarding MCoC models.

Support for reform from the entire midwifery profession was determined essential by all participants. As Kylie explained, to bring about change, "You'd really need support from the whole profession … because ideally caseload would be – or every woman would have caseload basically".

There was also a strong call for midwives to take initiative, as Jessica described: "…a willingness of people to take that on, a willingness of us midwives on an individual level to go yeah, we'll give it a go. We'll try it. We'll see how we go."

Those currently working in a MCoC model explained how their passion for these models fuelled their continuing desire to contribute to MSR. Karley, a midwife working in

private practice stated that "…everything else looks inferior". Midwives who had experience working in MCoC models were more familiar with the benefits and wanted to share their passion with their colleagues and encourage more midwives to work that way.

Feeling powerless

Despite all participants demonstrating support for the widescale implementation of MCoC models, a narrative of feeling powerless to contribute to the reform agenda emerged. Many midwives, like Kelly, felt unheard: "I don't think anybody is particularly listening to midwives." There was a lack of confidence that their opinion "…would be heard by anyone that needs to hear it, I suppose." (Kylie). Many participants also shared a cautionary tale involving fear of speaking out about MSR. Karley commented that: "…there's that fear of speaking up loudly and making ourselves vulnerable." Ariana, a midwife in private practice, experienced resistance within the public maternity system and commented: "We are bullied severely for standing up for women." This feeling of being persecuted and stigmatised resonated through many of the participant's stories when they advocated for MSR.

Some participants who described being willing and able to contribute to MSR also described that burnout often prevented their contribution. Maintaining mandatory training, workplace changes, and a lack of paid or personal time to participate in professional development related to the MSR agenda all contributed to their feelings of burnout. Contributing to MSR was seen as another role that the already overworked midwife had to perform, with Hayley commenting: "We're – just as a profession, we're burnt-out – totally burnt-out".

I DON'T KNOW HOW TO CONTRIBUTE TO MSR AGENDA

The second theme to emerge was around the midwife's lack of awareness and ability to contribute to the MSR agenda. There are three subthemes, *'MSR is invisible'*, *'University didn't prepare me'* and *'I'm just a grad'*.

MSR is invisible

While a small number of participants were well versed in the National Maternity Services Plan (NMSP) – being the most recent maternity service review at the time of interviews – the majority acknowledged that their first discussion around reform agenda was in these interviews. Jessica described the NMSP "…wasn't something I'd heard of, which is strange given that I work in this area, but we aren't aware." When asked if they felt MSR was visible, all participants answered "no". Hayley described MSR as:

> "Totally invisible. I think that you have to dig to find that sort of information. You have to know somebody who's informed you. It's not out there in the public, at all."

A lack of promotion around the NMSP as well as a lack of MCoC models in Victoria were seen as contributing to the invisibility of MSR recommendations. Some acknowledged the government's role in MSR but criticised the lack of dissemination of information.

> "It's too slow. Is it happening at all? Who's looking at it? There's just no information getting out to anybody. We're working on the ground here at the level that we need to know what's going to happen and how it's going to happen and which direction it's going to go in, so we can be prepared as well." (Michelle).

University didn't prepare me

Many participants could not recall learning about MSR during their university studies. Only one participant who had completed their studies in the last 10 years recalled discussing maternity reform plans. Tegan, a newly qualified midwife, recalled, that there was a focus on "numbers" and "the practical skills a midwife needed to do" rather than the preparation to work across the full scope of midwifery practice.

Many participants believed that Victorian university programs did not provide adequate exposure to MCoC models. This resulted in a lack of confidence to work in MCoC, as Tegan said,

> "…I think I need a couple of more years' experience with more support around, but having said that, if I was trained differently, I could come into that better prepared to do continuity."

Additionally, none of the participants described working in MCoC models as a student or a newly qualified midwife.

Midwives working in MCoC models, and those with more experience, also felt that graduating midwifery students were not ready to contribute to MSR. Kelly, stated "They're not training midwives to be confident to actually do a caseload."

I'm just a grad

Despite a lack of in-depth knowledge around MSR, the newly qualified and early career midwives (5), who had between 1-6 years' experience, described a desire to work in MCoC models and contribute to the reform agenda. However, they also described feeling apprehensive in their ability to contribute, with Kylie, a newly qualified midwife, stating:

"…it's hard, I would support anything that was sort of presented in terms of things like caseload, but I wouldn't know how I, individually right now, could do anything about it…".

 https://doi.org/10.37464/2025.423.1135

THIS IS BIGGER THAN ME

The third theme captures the perceived external factors that can influence an individual midwife's ability to contribute to MSR. There are three themes exploring these factors; *'Lack of systemic and political support'*, *'More support is needed for midwives to contribute to MSR'* and *'It's not my job'*.

Lack of systemic and political support

Most participants described a medically dominated maternity care system that did not align with MSR recommendations and MCoC models. Hayley explained that the system did not support her philosophy, having been warned during midwifery studies about the conflicting ideology in practice,

> "there's going to be a very medical model that you'll be placed into – try not to conform. Try to stick to your own philosophy. …I feel so grateful, that that was my education, because… I've never lost that. Whereas I can see there's many other midwives who completely conformed to the medical model because that's what there is and it's exhausting to attempt to do anything other."

In addition to medicalisation of the midwife's role, many participants discussed a lack of knowledge by women regarding care options and women would receive fragmented care by default,

> "…unless they're cluey and they get on and they go to somewhere like the state government's website where it does list all of your options…. and go and see that they actually do have lots of options. But most of them don't, they just go to the GP and off they go on the trolley." (Caitlyn).

It was also acknowledged that despite the government's MSR recommendations, midwives working in private practice were not supported by government policy. This included lack of insurance options, inadequate Medicare rebates for women, and the need for collaborative agreements. Ariana, who works rurally, described the public hospital in her area having an embargo on referrals to private midwives.

> "So, in the area in which I work, the hospital will have nothing to do with independent midwives. …... all their doctors have got a contract that says they will not refer to independent midwives."

Regardless of personal motivation to contribute to reform, all participants felt the government should be doing more to contribute to MSR. Many felt there was not enough government funding, and this was beyond the role of the midwife to contribute in that way.

> "Without funding you can't – I suppose that's state as well, but you can't do anything if you're not supported. In public hospitals … things like caseload and stuff can't run if you haven't got government support in the public hospital, and funding because it's obviously less cost orientated." (Kylie).

More support is needed for midwives to contribute to MSR

Midwifery leaders were seen to positively or negatively influence participant's ability to contribute to maternity reform. Many participants spoke of the need for leadership support as role modelling.

> "… I really think the management have to want it. Because if you've got management, like say you have management that didn't care about caseload…that weren't thinking about how that was going to benefit the women using the service. Then you've got no one behind you…" (Kylie).

Some participants described that the Australian College of Midwives (ACM), Australia's peak professional body for midwives, could be doing more to encourage midwives to participate in and promote MSR. Ariana explains: "Our insurance needs to be through the Australian College of Midwives, and we need to be supported by them." Midwives interviewed felt that it was more difficult to be politically active without this support from professional bodies.

All participants acknowledged that effective interprofessional collaboration was a key component to successful reform. Hayley gave a positive example of collaboration in establishing a MCoC model in a tertiary centre:

> "… it started with a really good relationship between midwives and obstetrics. The head of obstetrics and the head of the midwifery unit were on the same page and the midwife was absolutely for the idea of a continuity program. She had a couple of midwives under her who were very passionate about it. As a multi-disciplinary strategy, they made it happen."

This successful collaboration was not widely reported amongst participants, and few could provide examples of where they had seen collaborative practice resulting in successful service re-orientation.

It's not my job

There were a select few participants who were happy to leave contributions to the reform agenda to others. Although a supporter of the reform agenda, Michelle explains: "I have time issues. It's not a priority for me." Karley acknowledged her lack of skillset to lead reform changes, stating: "It would require quite a massive effort and motivation to shift things, and I'm not the one to do that, so that probably won't happen then."

There was also a small number of participants who felt that women needed to take more responsibility for changing the maternity care. Jessica described:

> "Most of the women that I've come across the majority of them are pretty naïve when it comes to their maternity care. They haven't really researched anything, be that the model of care or any of the tests or investigations or anything that you kind of offer them. They're just quite happy to be led, in which case it comes back really to the midwives to say this is the options."

UNLEASHING THE FULL POTENTIAL OF MIDWIFERY

The fourth theme encompasses the growth and realisations that participants discussed over the course of the interviews around their role in MSR. This theme describes what midwives require to unleash the full potential of their role and their ability to contribute to MSR. There are three sub-themes: *'Claiming a midwifery identity'*, *'Enable midwives to work to their full potential'* and *'Midwives finding their political voice'*.

Claiming midwifery identity

Midwives felt they needed respect from their colleagues and medical professionals to feel confident and able to contribute to MSR. Hayley detailed:

> "I think we just need to be taken seriously. We need to have a level of respect that we're professionals who are very skilled in what we do and that we're not just hippies and witches and we're not here just to preach feminist views…"

Many participants, like Stephanie, felt that the due to the medicalisation of childbirth, those direct entry midwives without a nursing background were struggling to assimilate to hospital practice due to the vast difference in philosophies around childbirth.

> "But if you haven't done the nursing degree beforehand and you're doing the direct entry, which is much more focused on supposed midwifery care and midwifery values and midwifery philosophies, God help you, mate. Most of them don't survive." (Stephanie).

However, midwives working in private practice had a particular interest in cultivating awareness and enabling placements for midwifery students in MCoC models.

Enable midwives to work to their full potential

Although midwives were seen to have the potential to work in MCoC models as per reform recommendations, the current system did not enable midwives to work in that way. Medical dominance of maternity care, the fragmented shift-work style rosters that most hospitals employed for midwifery staff, and a lack of willingness of some midwives to rotate across all areas of maternity care prevented this way of working. "Upskilling" was a term used often and was promoted as a strategy to enhance midwives' scope of practice and ability to contribute to MSR. Jessica explained:

> "…some midwives will have worked in certain roles for many years. That might be a barrier to them to coming into caseload. They might feel I haven't done clinic in so many years or I haven't worked in labour suites for so many years. …Whereas, if they were given the correct training and cross-skilling and investment to come back into those areas, they'd be willing to do that."

When speaking of scope of practice, many participants felt that working in private practice was a way to work to their full scope of midwifery practice and directly contribute to MSR. Those working in private practice already, also expressed a desire to mentor and support more midwives to contribute in that way.

Midwives finding their political voice

Throughout the course of each interview, the narrative around MSR grew from uncertain to positive and empowered. The final question from the interviews invited participants to consider what they required to contribute to MSR in an ideal world. Most participants, like Jessica, discussed the need for midwives to be equipped with the knowledge to contribute to MSR:

> "…. ideally as well going back to the education of midwives, from the start and teaching them about maternity services and where the deficits are at the moment and what we want to achieve. Giving them that information at the beginning so they're enthusiastic and they come out with a voice. They know how to fight."

Participants also discovered midwives needed to be political when finding their role in MSR. Many participants initially struggled to identify the political role of the midwife in MSR, however throughout the interviews many identified that calling for reform action within their own profession was a political role that they could assume.

DISCUSSION

SUPPORT FOR MCOC MODELS

Like participants in this study, midwives across Australia support and wish to work in MCoC models. Midwives working in MCoC describe a way of working that is both fulfilling, and challenging.[20] Additionally, many midwives not working in MCoC in Australia describe a willingness to work in the model in the future.[5] There is, however, a feeling of powerlessness by midwives in Australia to work in and contribute to MCoC due to medically-dominated work environments.[21]

This sense of "powerlessness" has been described by others within the Australian context.[22-24] In a study exploring midwifery workplace culture, midwives described feeling fatigued and powerless to change the culture of their workplace towards MCoC and a less medically dominated

system.[22] Additionally, in an appreciative inquiry study conducted in Queensland, midwives felt powerless to contribute to MSR and demonstrated passive acceptance of the medicalised culture at their workplace.[23]

Whilst not a subtheme, the concept of burnout was also mentioned multiple times by participants in this study. Working within MCoC has been found to be a protective factor against burnout, where burnout is more likely in midwives working in standard care.[6,25] Within the literature, factors associated with feelings of work-related burnout in midwives included a sense of powerlessness to change the medicalised maternity culture and working in rotational work patterns.[6,26]

MIDWIVES IN VICTORIA FELT MORE KNOWLEDGE WAS REQUIRED TO CONTRIBUTE TO MSR

For many participants, involvement in the research interview was the first time they had considered and discussed MSR agenda. Another Australian study exploring midwives working in fragmented models of care and their knowledge around MSR discovered that there was a vast knowledge gap around reform recommendations,[26] confirming this lack of visibility. When considering gaps in midwifery knowledge around MSR, it is essential to explore how university programs are preparing midwives to transform maternity services. There has been a vast amount of literature that outlines the importance of Continuity of Care Experiences (CoCE) for both midwifery students and women.[27-30] These experiences prepare the midwife to work in and understand the value of MCoC. Although a mandated national requirement for all midwifery students, the number and structure of CoCE differs vastly among states and university programs.[31] With inconsistencies between midwifery university program requirements and content, it is unsurprising that there are varying reports from early career midwives on their ability to contribute to MCoC.

Contrast to the participants within this study, when exploring the experiences of midwifery students and early career midwives from across Australia, midwives and students from other states, such as Queensland, South Australia and New South Wales, described feeling prepared and motivated to work within MCoC models both as students and upon graduation.[27,32,15,33] These findings may indicate Victorian midwifery programs should increase opportunities for experience and exposure to MCoC for midwifery students, as this enables midwives to feel more motivated and prepared to work in these models upon graduation.[30]

MIDWIVES REQUIRE SUPPORT TO CONTRIBUTE TO MSR

Respectful interprofessional collaboration is widely documented as essential in providing safe and effective maternity care to women around the world.[34,35] Despite this, midwives from many countries and maternity settings have described tensions and conflict providing woman-centred care in a medically dominated setting.[36,37] These feelings of subordinacy to medical colleagues has been present for Australian midwives since the 1900s.[38] With increasing rates of medical interventions documented and described on a global scale,[39] it is unsurprising participants described a lack of support to step away from obstetric-led models of care that a majority of participants worked within.

In many recent international studies exploring the implementation of MCoC models, supportive midwifery leaders were found to be essential to lead reform.[40-44] In an exploration into the attributes required of midwifery leaders', vision, passion, courage, a realistic view of maternity services, feminist values, and a sense of social justice were identified.[45] Participants in this study who named a midwifery leader with experience and passion for MCoC models described feeling more able to contribute to MSR and described these leaders as having many of these attributes described in this exploratory study.[45]

In a recent international review of the literature exploring barriers and facilitators to MCoC, it was found that barriers were mainly systematic in nature, and included hierarchical power dynamics, inadequate healthcare infrastructure, and inadequate policy support.[44] This further bolsters the need for systemic, interprofessional, and leadership support to achieve widespread MCoC models.

STRENGTHENING THE MIDWIFERY PROFESSIONAL IDENTITY

Professional recognition is known to contribute to job satisfaction for midwives and allows midwives to work to the full potential of their role.[46,47] Despite the midwifery profession in Australia undergoing many changes in the last 25 years, midwives are still required to be political and take action to strengthen profession recognition, scope of practice, and midwifery ways of working.[48]

An exploration into the views of both women and midwives around the role of the midwife identified many barriers to midwives working to their full scope of practice.[49] Barriers included a lack of opportunity for midwives to work within MCoC models, medical dominance, and an invisibility of midwifery as a profession in the wider community.[49] In another study, midwives in Australia have described ambiguity around the scope of practice of the midwife as a barrier to working to their full potential.[50] Reasons for this ambiguity were found to be due to the competing role expectations of midwives and obstetricians and the medical setting in which they practised[50] and those reasons were mirrored by this study's participants. In a systematic review exploring experiences of midwives providing CoCE, professional autonomy was the most common benefit of working in a continuity model.[20] This sense of professional autonomy was not described by participants in this study.

A further barrier to practicing autonomously in MCoC models are restrictions incurred by Medicare funding and insurance arrangements for midwives working in private MCoC. Despite recent changes that removed the need for collaborative arrangements for midwives in private practice and increased Medicare rebates for women accessing private MCoC, this model of care still out of reach for many women in Australia. With only 2.2% of women in Australia accessing private midwifery care,[10] barriers still include the cost of private midwifery care and insurance related restrictions on midwives when providing care for women with complex pregnancies.[51] In addition, the funding model used for Australian maternity services actively restricts women's access to MCoC models despite these models costing the healthcare institution less.[45] With a health care system that is financed via public and private sources, a large proportion of public maternal health resources are expended into private funding (through medical benefits scheme to obstetricians) and pooling of finding, rather than on publicly funded MGP programs.[52] In New Zealand, where women allocate the funding for their maternity care to their chosen model of care, over 90% of women have a known midwife for their pregnancy care. [53] Increased Medicare rebates for private midwifery services have recently been implemented in Australia[54], however, cost is still a large barrier with only 41.6% of women accessing a known midwife for their maternity care.[10]

STRENGTHS AND LIMITATIONS

There have been other studies conducted in Australia examining midwives' views of MSR agenda, and perceptions of how MSR impacts the role of the midwife.[23,26] However, this is the first study that examines the motivation and ability of midwives in Victoria, Australia, to contribute to MSR, and the development of MCoC models. Midwives from Victoria were of particular interest due to the small number of MCoC models available to women[8] and growing concerns around recruitment and retention of midwives in Victoria.[12] Gaining an in-depth understanding of the barriers and enablers to the midwife's motivation and ability to contribute to MSR has produced an understanding and generated recommendations that will foster the implementation MCoC models by midwives. Although there was a diverse sample in this study who worked across a range of maternity care models with varying entry programs to practice, and years of experience, the sample size was small and only from one state in Australia. Additionally, there were many midwife participants who were already working in MCoC models, creating a potential bias. However, due to the findings, there may be an even more demonstratable difference in knowledge and interest in MSR for the wider population of midwives with most not working in MCoC.

This study was conducted prior to 2020 and the COVID pandemic which has a significant impact on maternity care. The COVID-19 pandemic has had major implications for midwives and ways of working in Australia. Arguably, midwives and women in Victoria were affected by strict lockdowns and service reforms to meet these requirements more than any other start. Changes to maternity services occurred quickly to align with lockdown requirements, and many services, including MCoC models, have not returned to pre-pandemic capacity.[52] Anecdotal reports indicate that some MCoC models have not been reestablished following COVID, further restricting midwives' ability to work and contribute to MCoC models.

CONCLUSION

Reorientation of services toward greater implementation of MCoC models in Victoria requires numerous strategies to facilitate midwives to effectively contribute to MSR. Among these is a maternity care culture that promotes effective implementation of MCoC models. This cultural change can be bolstered by supportive midwifery leadership, development of collaborative interprofessional relationships and encouragement from healthcare organisations to support MCoC models. Fostering a strong midwifery identity by enabling midwives to work across the full scope of midwifery practice and appropriate government funding of MCoC models were also identified to facilitate MSR recommendations. Other important measures include university preparation that fosters a strong midwifery identity, including opportunities to provide MCoC for future workforce capacitation.

Enabling midwives to feel able to contribute to MSR and work in MCoC models will improve satisfaction in the workforce, ensuring greater implementation of evidence-based, sustainable models of care for women and ways of working for midwives.

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

The following recommendations outline factors that will enable midwives in Victoria, and potentially midwives from around Australia, to contribute to MSR reform and MCoC models. Preparing midwives to contribute to MSR by strengthening the undergraduate education regarding reform agenda, with a focus on CoCE to build confidence in MCoC models is required. Furthermore, interdisciplinary education that focuses on maternity reform would strengthen relationships with a focused goal of improving outcomes for women at a systemic level. Providing midwifery leaders with access to postgraduate midwifery qualifications that focus on change management strategies and advocacy to promote and facilitate midwives' ability to reform maternity services will facilitate the implementation and expansion of

MCoC models. Finally, midwives who work to their full scope of practice feel empowered and have a strong midwifery identity. Professional development programs that inform and encourage midwives already practising to extend their scope of practice and highlight the benefits of MCoC models is also required. Additionally, a change in maternity care funding to allow great access to both public and private MCoC is required.

Further studies exploring the ability and motivation of midwives from different states and settings with a larger, more diverse sample size in Australia to help further identify strategies that enable midwives to feel prepared, confident and motivated to contribute to MSR is also recommended. Finally, an appreciative inquiry research project exploring how midwives develop a strong professional identity would have indirect positive influence on MSR.

Acknowledgements: The authors would like to acknowledge the participants' time and experiences they have contributed to this study

Funding Support: There were no external funding sources for this study.

Declaration of conflicting interests: The authors declare there are no actual or potential conflict of interest, including financial and personal relationships with people or organisations within three years of beginning the submitted work that could inappropriately influence (bias) their work. There were no external funding sources for this study. All authors have no financial and personal relationships with other people or organisations that could inappropriately influence (bias) their work.

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