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STUDY PROTOCOL

Midwifery-led care models across health systems: a scoping review protocol of organisational arrangements and core components

[version 1; peer review: 1 approved]

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Abstract

Objective

To map and characterize organisational models of midwifery-led care across healthcare systems, identifying their organisational arrangements and core and adaptable components to inform cross-country comparison and contextual adaptation.

Introduction

Midwifery-led care models are increasingly recognized as effective approaches to improving maternal and newborn outcomes and women's experiences of care while promoting continuity of care,

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Any reports and responses or comments on the article can be found at the end of the article.

person-centred maternity services, and sustainable health systems. However, substantial heterogeneity exists in how these models are organised, implemented, and integrated across different health systems. A systematic mapping of organisational arrangements and their contextual conditions is needed to support evidence-informed adaptation and implementation across diverse settings.

Inclusion criteria

This review will consider sources describing organisational models of midwifery-led care across antenatal, intrapartum, and postnatal contexts globally. Midwifery-led care is defined as models in which midwives hold primary clinical and organisational responsibility for coordinating and delivering maternity care, including referral to medical services when required. Both peer-reviewed and grey literature sources will be included.

Methods

This scoping review will follow the Joanna Briggs Institute (JBI) methodology for scoping reviews and will be reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR). Searches will be conducted in MEDLINE, CINAHL, Embase, Scopus, and Web of Science, complemented by structured grey literature searches of governmental and professional sources. Two independent reviewers will screen and extract data using a structured tool informed by the Intervention Component Analysis framework. Findings will be synthesized through descriptive mapping and comparative analysis of organisational models. Registration DOI: 10.17605/OSF.IO/DV6QB

Keywords
Midwifery-led care; Models of care; Health systems; Maternity services; Implementation science



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Introduction

Midwifery-led care is grounded in a woman-centred philosophy that emphasises physiological birth, continuity of care, and the professional autonomy of midwives. These principles underpin models of maternity care in which midwives assume primary responsibility for supporting normal reproductive processes, fostering sustained therapeutic relationships, and promoting informed and shared decision-making.[1,2]

A substantial body of evidence has demonstrated that midwifery-led care models are associated with improved maternal and neonatal outcomes, as well as enhanced person-reported outcomes, including greater satisfaction with care, stronger perceptions of safety and trust, increased involvement in decision-making, and more positive birth experiences.[3–6] However, most research has focused primarily on clinical effectiveness and experiential outcomes, while the organisational structures through which these models are implemented have received comparatively less systematic attention.[7–9]

Midwifery-led care encompasses a range of organisational arrangements, including caseload midwifery, midwifery group practice, freestanding and alongside midwifery units, birth centres, community-based maternity services, and integrated continuity pathways within hospital systems.[9] These models vary substantially in governance structures, funding mechanisms, workforce configuration, degree of professional autonomy, referral pathways, and their level of integration within broader maternity care systems. Such variability reflects differences in health system architecture, regulatory frameworks, financing arrangements, and professional cultures across countries.[7,8] At the same time, it highlights the absence of a clear and widely accepted taxonomy of organisational models of midwifery-led care, which limits comparative understanding and knowledge transfer across health systems.

Several reviews have examined different dimensions of maternity care organisation and midwifery practice across health systems. For example, Bradford et al. mapped the global implementation of midwifery continuity of care models.[7] Their findings indicate that most initiatives are concentrated in high-income countries and frequently organised around caseload or midwife-led continuity models spanning antenatal, intrapartum and postnatal care, while national-scale implementation remains rare outside New Zealand.[7] Other reviews have examined organisational aspects of maternity care policies. For instance, Gonçalves et al. analysed antenatal care policies in high-income countries with universal health systems, identifying substantial variation in consultation schedules, screening practices and the designation of primary care providers within antenatal services.[10] While this work provides important insight into the policy-level organisation of maternity care, it focuses specifically on antenatal care recommendations rather than on the organisational configuration of midwifery-led models across the full continuum of maternity care.

Recent work has also examined organisational elements of maternity care systems. Liebregts et al. analysed organisational features of integrated maternal and newborn care across 288 studies, identifying key elements such as personal continuity of care, midwife-led care provision, births outside obstetric units and alternative payment models associated with improved outcomes and experiences.[8] However, the authors note that most studies focus on individual organisational elements rather than on the overall configuration of maternity care models, and that evidence remains limited regarding how these elements are implemented and sustained within healthcare systems.

Additional studies have explored the conceptual and theoretical foundations of midwifery practice. A scoping review by Eri et al. identified several theoretical models of midwifery care developed in different countries, highlighting shared principles such as woman-centred care, reciprocal relationships between women and midwives, and a salutogenic perspective focused on supporting normal reproductive processes.[9] Similarly, Paz et al. synthesised midwifery theories underpinning professional practice, identifying a common conceptual framework centred on the woman as the focus of care, midwifery as a relational profession, holistic understandings of health, and the importance of a supportive care environment and continuity of care.[11]

Together, these studies have contributed valuable insights into the philosophical, theoretical and policy dimensions of midwifery care. However, the literature has not yet systematically mapped or classified the organisational models through which midwifery-led care is structured and delivered across health systems. As a result, important questions remain regarding how these models are organised, governed, staffed and integrated within different healthcare contexts. The theoretical and epistemological foundations of midwifery models of care have therefore been synthesised in the literature, alongside reviews examining the clinical organisation of antenatal, intrapartum and postnatal care, including screening protocols, recommended consultation schedules and clinical practices within maternity services.[9–11] The present review does not seek to replicate this work. Rather, it focuses specifically on the organisational and operational dimensions of midwifery-led care, examining how models are structured, staffed, governed and integrated within health systems, independent of the theoretical frameworks that may underpin them.

A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews, and JBI Evidence Synthesis identified no current or ongoing scoping reviews specifically focused on mapping and classifying organisational models of midwifery-led care across healthcare systems. A scoping review is particularly appropriate when the aim is to explore the breadth and heterogeneity of evidence, clarify key concepts, and map the defining characteristics of complex interventions.[12] Given the diversity of expected evidence sources, including empirical studies, policy documents, institutional protocols and grey literature, this approach enables comprehensive identification of organisational models and their contextual determinants.

Therefore, the objective of this scoping review is to systematically map and characterise organisational models of midwifery-led care across healthcare systems, identifying their core components, adaptable features and contextual determinants. The review will generate a comparative overview of how these models are structured and implemented across settings, providing an evidence-informed basis for cross-country comparison and context-sensitive adaptation.

Review question

What organisational models of midwifery-led care are described internationally and how are they organised across different health systems?

Sub-questions:

1. What organisational configurations or types of midwifery-led care models have been described across different countries and healthcare systems?

2. What governance, workforce, care delivery and financing components define these organisational models?

3. Which components appear to be consistently present across contexts (potential core components) and which vary across settings (potentially adaptable components)?

4. What contextual characteristics (e.g., regulatory frameworks, workforce arrangements and health system structures) are reported in the literature in relation to these models?

In this review, the term *types* refers to distinct organisational configurations of midwifery-led care identified in the literature. These may include, for example, caseload midwifery, midwifery group practice, midwifery units, or other continuity-based organisational arrangements.

Inclusion criteria

Participants

This review focuses on organisational models of maternity care rather than on individual participants. However, the population context of interest is maternity care recipients.

Sources describing the organisation of midwifery-led care models involving pregnant women, birthing people, and newborns across antenatal, intrapartum, and postnatal phases will be considered. The review will focus specifically on maternity care models; therefore, midwifery roles related exclusively to other areas of practice, such as reproductive health services, abortion care, or general community health programmes, will not be included. No restrictions will be applied based on population risk status. However, models in which obstetricians or other medical specialists hold primary responsibility for coordinating and delivering maternity care will be excluded. Midwifery-led models that include referral to obstetric or specialist services when clinically indicated will remain eligible. Sources must describe an identifiable organisational model of care. Sources that address exclusively theoretical or epistemological frameworks of midwifery care, without describing an identifiable organisational model, will be excluded.

Concept

The concept of interest is organisational models of midwifery-led care. For the purposes of this review, midwifery-led care is defined as organisational arrangements in which midwives hold primary clinical and organisational responsibility for the planning, coordination and delivery of maternity care within their recognised professional scope of practice, including referral to obstetric or specialist services when clinically indicated.[1–3] In these models, midwives act as the main care providers for a defined population or phase of maternity care, exercising professional judgement and coordinating care across the antenatal, intrapartum and postnatal continuum. Women may be referred to obstetricians or other specialists when clinically indicated, provided that care coordination remains under midwifery leadership and women return to midwifery-led care following referral.

Included sources must describe an identifiable organisational model of care and provide explicit information on at least one organisational characteristic, such as governance or leadership arrangements indicating midwifery responsibility for care coordination; workforce configuration or team composition involving midwives as primary care providers; caseload allocation or continuity-of-care arrangements; referral pathways between midwives and medical specialists; or integration within a broader maternity care system. Sources in which obstetricians or other specialists hold primary responsibility for coordinating and delivering maternity care will be excluded, even if midwives participate in care provision.

This review focuses specifically on the structural and organisational dimensions of midwifery-led care models, including governance arrangements, workforce organisation, caseload structures, referral pathways and integration within maternity care systems. The clinical content of antenatal, intrapartum or postnatal consultations (e.g., screening protocols, number of visits or specific clinical interventions) falls outside the scope of this review and has been addressed in previous syntheses. Sources referring to midwifery-led care only in relation to clinical interventions, educational programmes or conceptual frameworks, without describing the organisational structure of care provision, will therefore be excluded.

Context

All geographic regions and healthcare system contexts will be considered, including primary care, hospital-based services, community-based services and integrated maternity care networks. Both high-, middle- and low-income country contexts will be eligible, and no restrictions will be applied based on cultural or health system characteristics.

Standalone analyses of birth centres will be excluded. Although birth centres often represent midwifery-led care settings, their organisation and outcomes have been extensively described in the literature. The present review focuses instead on broader organisational models of midwifery-led maternity care across the continuum of antenatal, intrapartum and postnatal services, including their governance, workforce configuration and integration within health systems.

Contextual factors related to health system organisation, regulatory frameworks, financing arrangements and service delivery environments will be documented and analysed during the synthesis phase.

Types of sources

This scoping review will consider experimental and quasi-experimental study designs, analytical observational studies, descriptive observational studies, qualitative studies, mixed-methods studies, implementation studies, policy analyses, systematic reviews, and text and opinion papers. Grey literature including policy documents, professional association reports, institutional protocols and governmental publications will also be included. Systematic reviews will not be treated as primary units of analysis. Instead, they will be used as an instrumental source to support backward citation searching. The reference lists of relevant systematic reviews will be screened to identify additional primary studies and other eligible sources that meet the inclusion criteria. This approach aims to enhance search sensitivity and reduce the risk of missing relevant evidence, while avoiding double counting of data during the mapping of organisational models.

Methods

The proposed scoping review will be conducted in accordance with the JBI methodology for scoping reviews.[12] Reporting will follow the PRISMA-ScR guidelines.[13] This protocol has been registered in the Open Science Framework (OSF) (Registration DOI: 10.17605/OSF.IO/DV6QB).

Search strategy

The search strategy will aim to locate both published and unpublished sources. A three-step search strategy will be used.[12] First, an initial limited search of MEDLINE (PubMed) and CINAHL will be undertaken to identify relevant articles. Text words contained in titles and abstracts and index terms used to describe the articles will inform the development of a comprehensive search strategy. Second, the search strategy will be adapted for each database. The databases to be searched will include MEDLINE (PubMed), CINAHL (EBSCO), Embase, Scopus, and Web of Science. Third, the reference lists of all included sources will be screened for additional relevant evidence.

Studies published from January 2000 onwards will be included to capture organisational descriptions of midwifery-led care models within contemporary maternity care systems. This period reflects major global developments in maternity care policy, professional regulation of midwives, and the expansion of continuity-based models of care. Earlier organisational models may still be captured if they are described or evaluated in publications produced during this period. No language restrictions will be applied at the search stage. Sources published in languages not spoken by members of the review team will be assessed using translation tools where feasible.

Grey literature will be systematically searched, including governmental and Ministry of Health websites, institutional reports, and open policy repositories. Relevant international, regional, and professional organisations will also be consulted, including the International Confederation of Midwives (ICM), European Midwives Association (EMA), World Health Organization (WHO), OECD health system reports, UNFPA, and national midwifery associations. Given the breadth and heterogeneity of international grey literature, targeted grey literature searches will follow a purposive country selection strategy. This will include countries represented within the project consortium, countries with well-established midwifery-led care systems, and additional countries identified through database searches as reporting relevant organisational models. This approach is intended to balance international relevance, feasibility, and transparency in the identification of grey literature sources.

The full MEDLINE search strategy and detailed grey literature search strategy are available as extended data in the Open Science Framework (OSF) repository associated with this protocol.

Study/Source of evidence selection

All identified records from database searches and grey literature sources will be collated and uploaded into Zotero (Corporation for Digital Scholarship, USA) for reference management, and duplicates will be removed. Grey literature records will include policy documents, governmental and Ministry of Health publications, regulatory frameworks, professional association reports, institutional protocols, and other relevant organisational documents identified through structured website searches and targeted retrieval.

Following a pilot calibration exercise to refine the eligibility criteria, titles and abstracts (where available) will be screened independently by two reviewers using Rayyan (Qatar Computing Research Institute). For grey literature sources lacking abstracts, executive summaries or equivalent descriptive sections will be screened. Inter-reviewer agreement during the pilot screening phase may be assessed to ensure consistency in the application of eligibility criteria.

Potentially relevant sources will be retrieved in full and assessed independently by two reviewers against the inclusion criteria. All full-text sources meeting eligibility criteria, including policy and organisational documents, will undergo data extraction using the predefined extraction tool. Reasons for exclusion at the full-text stage will be recorded and reported in the final review. Disagreements between reviewers at any stage will be resolved through discussion or consultation with a third reviewer. The selection process, including both peer-reviewed and grey literature sources, will be documented and presented using a PRISMA-ScR flow diagram.[13]

Data extraction

Data will be extracted from all included sources by two independent reviewers using a structured data extraction tool developed for this review and informed by the Intervention Component Analysis (ICA) framework.[14] Given the organisational focus of this review, the unit of analysis will be the organisational model rather than the individual publication. Where multiple sources (e.g., empirical studies, policy documents, institutional reports) describe the same identifiable midwifery-led care model, data will be aggregated at the model level. In such cases, all relevant documents will contribute to a consolidated model description, and the contributing sources will be documented.

Sources will be considered to describe the same organisational model when they refer to the same identifiable service configuration within a specific country or health system and share key organisational characteristics, such as the model name (when available), governance structure, workforce configuration, or service delivery arrangement. Where ambiguity exists, reviewers will compare descriptions of organisational structure, care pathways, and implementation context to determine whether sources refer to the same model. Decisions regarding model aggregation will be discussed between reviewers and documented to ensure transparency. Grey literature sources, including governmental reports, Ministry of Health publications, regulatory documents, and professional association reports, will be considered eligible if they provide sufficient description of an identifiable organisational model. Documents that are purely normative in nature, such as strategic policy statements or high-level recommendations without description of governance structures, care coordination mechanisms, workforce configuration, or service delivery organisation, will be recorded but will not undergo full data extraction.

The extracted data will include information on: 1) Contextual characteristics: country and healthcare system context; 2) Model identification: model name, scope (national, regional, institutional), target population and eligibility criteria; 3) Governance and leadership: governance and regulatory frameworks, leadership structure (formal and/or functional midwifery responsibility); 4) Service organisation: workforce configuration, caseload arrangements, referral and integration pathways; 5) Financing: funding or financing arrangements (if reported); 6) Model components: core components and adaptable/context-dependent features; 7) Contextual factors: contextual facilitators and barriers

influencing the organisation of the model (if reported); 8) Reported explanatory rationale: any explanation provided by source authors regarding how the model is intended to operate or achieve its aims (if described); and 9) Sources: documents contributing to the model description.

A draft data extraction form is available as extended data in the OSF repository associated with this protocol. The extraction tool will be implemented in a structured spreadsheet (e.g., Microsoft Excel) to support systematic charting and comparison of organisational models across sources. The draft form will be piloted on a purposive sample of sources representing different document types (e.g., peer-reviewed articles, policy documents, institutional protocols) and refined accordingly. Consistent with JBI guidance for scoping reviews, the extraction instrument may be iteratively adapted during the review process to capture additional relevant characteristics of organisational models as they emerge. Any modifications to the extraction tool will be documented and reported in the final review.

Disagreements between reviewers during data extraction will be resolved through discussion or consultation with a third reviewer. Critical appraisal of individual sources will not be undertaken, consistent with JBI guidance for scoping reviews.

Data analysis and presentation

Data will be synthesized using descriptive mapping and thematic categorization. The analytical process will involve three stages: 1) descriptive mapping of identified organisational models and their characteristics; 2) conceptual grouping of models based on shared organisational features; and 3) cross-country comparison through the development of comparative matrices.

Organisational models will be grouped into typologies based on structural and organisational characteristics identified in the literature. Typology development will follow an inductive approach, whereby categories of models emerge from the data, while being informed by the analytical domains derived from the Intervention Component Analysis framework.[14]

A comparative matrix will be developed to map models across countries against identified core components, adaptable features, and contextual determinants. Findings will be presented through: 1) summary tables of model characteristics; 2) a typology of midwifery-led organisational models; 3) comparative cross-country matrices; and 4) a narrative synthesis explaining similarities, differences, and contextual influences. This synthesis will inform the co-construction of an international comparative framework of midwifery-led care models.

Ethics and consent

Ethical approval and consent were not required for this study protocol, as it does not involve human participants, collection of personal data, or primary data collection.

Team positionality and reflexivity

The research team comprises midwives, nurses and researchers from four countries — Portugal, Belgium, Spain and Canada — bringing diverse professional, linguistic and health system perspectives to this review. Several team members have direct clinical and research experience in midwifery-led care and maternity services, positioning them to critically appraise and contextualise the evidence. The international and interdisciplinary composition of the team strengthens the cultural and contextual sensitivity of the analytical process, particularly in the interpretation of how organisational models are shaped by different health system contexts and professional regulatory frameworks.

This review prioritises the mapping of models across diverse health system contexts and will document contextual factors that may mediate equitable access to midwifery-led care. Findings will be reported transparently regarding the geographic and contextual scope of the included literature, and limitations related to language restrictions or underrepresentation of certain health system contexts will be explicitly acknowledged in the discussion.

Data availability

Underlying data

No underlying data are associated with this article. This article is a scoping review protocol and does not report results from primary data collection or data analysis.

Extended data

The extended data are openly available from Zenodo: https://doi.org/10.5281/zenodo.20377469.[15]

The extended data include the MEDLINE search strategy, the grey literature search strategy, and the draft data extraction instrument. The extended data are available under the terms of the Creative Commons Attribution 4.0 International licence (CC BY 4.0).

The protocol has been registered in the Open Science Framework (OSF): https://doi.org/10.17605/OSF.IO/DV6QB.[16]

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References

1. International Confederation of Midwives: **Midwifery-led care: the first choice for all women. Position statement.** *Revised at the Toronto International Council meeting.* 2017.
2. World Health Organization: *Transitioning to midwifery models of care: global position paper.* Geneva: World Health Organization; 2024.
3. Sandall J, Fernandez Turienzo C, Devane D, *et al.*: **Midwife continuity of care models versus other models of care for childbearing women.** *Cochrane Database Syst. Rev.* 2024; **2024**: CD004667.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**
4. Sriram S, Almutairi FM, Albadrani M: **Midwife-led versus obstetrician-led perinatal care for low-risk pregnancy: a systematic review and meta-analysis of 1.4 million pregnancies.** *J. Clin. Med.* 2024; **13**.
Publisher Full Text
5. Kuipers Y, Aitken-Arbuckle A, Jenkins H, *et al.*: **Midwife continuity of care: a systematic review and meta-analysis of case-control and cohort studies.** *Int. J. Nurs. Stud.* 2026; **174**: 105300.
PubMed Abstract | **Publisher Full Text**
6. Raipuria HD, Lovett B, Lucas L, *et al.*: **A literature review of midwifery-led care in reducing labor and birth interventions.** *Nurs. Womens Health.* 2018; **22**(5): 387–400.
PubMed Abstract | **Publisher Full Text**
7. Bradford BF, Wilson AN, Portela A, *et al.*: **Midwifery continuity of care: a scoping review of where, how, by whom and for whom.** *PLOS Glob Public Health.* 2022; **2**(10): e0000935.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**
8. Liebregts J, Goodarzi B, Valentijn P, *et al.*: **Organising maternal and newborn care in high-income countries: a scoping review of organisational elements and their association with outcomes.** *BMJ Open.* 2025; **15**(12): e107624.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**
9. Eri TS, Berg M, Dahl B, *et al.*: **Models for midwifery care: a mapping review.** *Eur J Midwifery.* 2020; **4**: 30.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**
10. Gonçalves AS, Ferreira IM, Pestana-Santos M, *et al.*: **Antenatal care policy in high-income countries with a universal health system: a scoping review.** *Sex. Reprod. Healthc.* 2022; **32**: 100717.
PubMed Abstract | **Publisher Full Text**
11. Paz S, Gonçalves A, Freitas CM, *et al.*: **Midwifery theories: a scoping review.** *Midwifery.* 2025; **140**: 104219.
Publisher Full Text
12. Peters MDJ, Godfrey C, McInerney P, *et al.*: **Chapter 11: Scoping reviews.** Aromataris E, Munn Z, editors. *JBI reviewer's manual.* Adelaide: JBI; 2017.
13. Page MJ, McKenzie JE, Bossuyt PM, *et al.*: **The PRISMA 2020 statement: an updated guideline for reporting systematic reviews.** *BMJ.* 2021; **372**: n71.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**
14. Sutcliffe K, Thomas J, Stokes G, *et al.*: **Intervention component analysis (ICA): a pragmatic approach for identifying the critical features of complex interventions.** *Syst. Rev.* 2015; **4**: 140.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**
15. Lopes M, Moreira R, D'Haenens F, *et al.*: **Extended data for: Midwifery-led care models across health systems: a scoping review protocol of organisational arrangements and core components.** *Zenodo.* 2026.
Publisher Full Text
16. Lopes M, Moreira R, D'Haenens F, *et al.*: **Extended data for: Midwifery-led care models across health systems: a scoping review protocol of organisational arrangements and core components.** *Open Science Framework.* 2026.
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✔ **Elizabeth Newnham**
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Thank you for the opportunity to review this scoping review protocol of organisational arrangements and core components of midwifery-led care models. This is an interesting endeavour that sets out to map and categorise the organisational models of midwifery-led care across health systems in order to identify adaptable components for comparison and implementation across jurisdictions. It has the potential to contribute new insights into the important subject of the organisational structure and management of midwifery models of care.

We have a few suggestions that we think will help to improve the overall project.

It is good to see the heterogeneity between models acknowledged – indeed, this is a catalyst for the review; however, it would be good to provide a clearer definition of the concept of midwifery-led care. In the introductory section, continuity of care is mentioned as a frequent attribute of midwifery-led services, but not as a key component, leading us to wonder what sort of midwifery-led services the authors are wanting to examine. Continuity of care (or carer) is arguably central to most midwifery-led perinatal services. If continuity of care is one of the characteristics to be included in the review it might be worth specifying this in the title of the paper.

If continuity is not central, then perhaps the authors are referring to any model organised and staffed by midwives, even if it sits within an obstetric service (for example, a 'midwifery-led' hospital antenatal clinic, or breastfeeding clinic, or postnatal pelvic floor clinic, or similar). While these services are to an extent 'midwifery-led' in that they are staffed and managed by midwives, they would not necessarily be considered a midwifery model of care with the corresponding components of woman-centered philosophy, continuity of care, or midwifery autonomy.

We therefore recommend that the authors consider refining the key terms and the inclusion

criteria. The inclusion criteria in the full protocol state that obstetric models will only be excluded where obstetricians 'hold primary responsibility for coordinating and delivering maternity care', which suggests that such hospital clinics where midwives deliver the majority of the care could be included in the analysis, even though they may have little continuity, relatively little relational care, and are ultimately under obstetric oversight.

To this end, it may be worth using the terminology 'midwifery models of care' rather than 'midwifery-led care', which is rather more ambiguous and may refer to midwifery clinics that sit under obstetric services, and to reconsider whether hospital-based services should be included in the review. If including hospital-based services, we recommend some clarification about how a midwifery-led service is determined (i.e. level of continuity, autonomy) as hospital services are largely obstetric-led.

In the context section, it would be good to give references for the statement that analyses of birth centers have been extensively described in the literature, and a clearer rationale for why extant analyses of birth centers (if they include the requisite focus on organisation and management) should be excluded. It seems a missed opportunity for relevant data. It is unclear how text and opinion papers will be useful inclusions in relation to the protocol questions.
We wish the authors every success in carrying out this scoping review.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Yes

Are sufficient details of the methods provided to allow replication by others?

Yes

Are the datasets clearly presented in a useable and accessible format?

Not applicable

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Midwifery; qualitative methods; humanising childbirth; maternity care systems

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.