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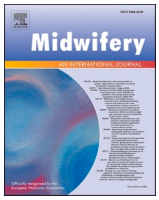

Review Article

Factors influencing the implementation of the woman-centred care model for pregnant women in a hospital setting: an integrative review

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ABSTRACT

Background: The term "Woman-Centred Care" focuses on the individual needs, aspirations and expectations of the woman herself rather than the needs of the healthcare system or professionals. The principles on which this model of care is based, are the control, choice, and continuity of care for women.
Objective: The objective of this review would like to explore and summarise the evidence currently available on the factors which influence the implementation of the care model for pregnant women in a hospital setting.
Methods: An integrative review was conducted using the method of Whittemore and Knafl and the PICOT search strategy. The Medline, PubMed and CINAHL databases were examined to identify primary studies that, between 2013 and July 2024, investigated factors influencing the implementation of women-centred care models in hospital settings. The inclusion/exclusion process and reporting followed the PRISMA 2020 guidelines. The quality of the studies was assessed according to the criteria of the Mixed Method appraisal tool.
Findings: 411 studies were eligible and 16 of those included. A total of 16 records were included. Four themes and four sub-themes influencing the implementation of Woman-Centred Care were identified: the perspective of the midwives; the care model; communication and collaboration (relationships with colleagues; relationship with women and empowerment) and, resources and support (organisation and stakeholders; management).
Discussion: The implementation of the "Woman-Centred Care" model is strongly influenced by organizational policies and midwives' awareness of their role as guarantors of "natural" childbirth.
Conclusion: The lack of a shared understanding of what Woman-Centred Care actually means can contribute to the confusion and definition with which it is proposed.

Statement of Significance

Problem or Issue:

Woman-Centred Care is a midwifery concept with implied meaning. The implementation of the model within hospital settings remains inconsistent. Persistent challenges are observed in integrating the principles of choice, control, and continuity within care pathways and clinical-organizational practices.

What is Already Known:

Some countries have already encouraged the dissemination of the "Woman Centred Care" model within maternity services.

What this Paper Adds:

We identified the facilitators and barriers to the implementation of a Woman-Centred model of Care for pregnant women in a hospital setting.

Introduction

'Woman-Centred Care' [WCC], coined by Leap in, 2009, is defined as the model in which "the woman is the focus of obstetric care, and together with the midwife, she identifies her care priorities" (Guilliland and Pairman, 2012).

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This definition is in line with the Universal Declaration of Human Rights, the right of women to make autonomous decisions regarding their own bodies (United Nations, 1948), including during labour and birth (WHO, 2018). The definition of WCC focuses on the individual needs, aspirations and expectations of the woman, giving them priority over the needs of institutions and professions. Women must be able to make an autonomous decision about her needs and the needs of her child. The model therefore acknowledges both a woman's experience in the decision-making process (choice and control, shared making) and her central role in the care process. Anyway, WCC is carried forward through different approaches, indicating that there is no universally accepted definition of that (Brady et al., 2019).

Midwifery-led care is considered the key to achieving this type of care by being '*the lead professional in planning, organising and delivering care for the woman from the first prenatal visit to the postnatal period*' (Sandall, Soltani, Gates, Shennan and Devane, 2013, p. 3). In maternity services women tend to perceive 'system-centred care' from their midwives rather than person-centred care and in part, this is steering their choice towards giving birth 'outside the system' (Rigg, et al., 2017; Jackson et al., 2020; Maillefer et al., 2015). But the Royal College of Midwives (2008) also points out that it is possible to implement this model led by midwives who provide care for women with low-risk pregnancies, in childbirth and postnatal care, responding to women's needs with a holistic approach.

The reasons for women to choose out-of-hospital care are the search for continuity of care, based on a close relationship of mutual trust between the woman and her midwife, the use of a minimal degree of medicalisation of labour and childbirth and the respect for the intimacy of the mother-child-partner triad (Bagnacani et al., 2023).

Although Brady et al. (2019) explored and synthesised studies on the WCC model in the contexts of clinical practice, maternity services, and education, currently the literature does not provide a recognisable definition of this concept.

International guidelines emphasise that the quality of maternal and neonatal care includes clinical outcomes as well as the experience of care, and they advocate for woman-centred approaches within hospital settings (WHO, 2018/2022; NICE, 2023). The literature has shown positive impacts consistent with these principles; studies on continuity of midwifery care models have reported higher rates of spontaneous vaginal births and a reduction in caesarean sections (Sandall et al., 2016), as well as more positive maternal experiences (Allen et al., 2015) and cost savings compared with other models (Callander et al., 2021). Evidence from hospital settings confirmed greater maternal satisfaction and fewer interventions with caseload midwifery models compared with standard care (Bohren, 2017; Sandall, 2024). Thus, this study aims to review and critically evaluate existing literature in supporting the implementation of the WCC within a hospital context. To reach this aim, the currently available evidence on the factors influencing the implementation of WCC in the care of pregnant women in a hospital setting has been explored and synthesised.

Methods

An integrative literature review was conducted using the method proposed by Whittemore & Knafl (2005). This method enables summarising past empirical and theoretical literature and provides a greater understanding of a particular health phenomenon or problem. This approach includes different methodologies; qualitative studies support the analysis of human experience and cultural and social phenomena whereas quantitative studies can justify the results of clinical actions and provide the basis for effective, high quality and evidence-based clinical practice (Lockwood et al., 2015; Shields & Watson, 2012). Whitener and Knafl's (2005) model involve: 1. problem identification, 2. literature search, 3. data evaluation, 4. data analysis, and presentation.

Problem identification

The formulation of recommendations produced by the 'Changing Childbirth' (Department of Health, Great Britain, 1993), brought about a process of change in maternity care services, promoting 'WCC' model. 'The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved'.

This process, however, has been described as challenging (Rigg, et al., 2017), so the literature review exploring the implementation of WCC models in hospital settings will help to identify the factors influencing this process.

Literature search

This review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews guidelines (Page et al.2021). Electronic databases, including PubMed, MEDLINE and the CINAHL, were searched to identify relevant studies published since 2013 up to July 2024 .

The string used to perform the search is provided in the online supplemental material. The search was restricted to studies published in English.

Keywords were selected using the PICOT (Problem, Intervention, Comparison, Outcomes & Time) principles: P: Implementation; I: Woman-Centred Care (WCC); C: influencing factors (barriers and facilitators), adapted as the comparator in the absence of a traditional control group; O: improvements in service delivery, continuity, maternal satisfaction, and maternal/neonatal outcomes; T: studies published from 2013 to July 2024.

Inclusion criteria:

- Studies exploring the perspectives of hospital directors/managers/staff of midwifery departments on the implementation of WCC models.
- Studies investigating factors influencing the implementation or development of WCC models.
- Studies that mention the individual intrinsic elements of WCC, i.e., those of choice, control, and continuity.
- Primary studies with quantitative or qualitative design.

Exclusion criteria:

- Studies focusing exclusively on the experience of women in WCC models.
- Studies focusing exclusively on the territorial context.
- Studies describing WCC in other service contexts, unrelated to pregnancy.
- Case reports, grey literature (e.g., conference abstracts, presentations, government publications, and dissertations/theses), commentaries, editorials, or literature reviews.

Data evaluation

Data selection

The studies were selected based on the inclusion/exclusion criteria. Two reviewers (PD and AM) independently screened titles and abstracts saved in the Excel matrix, to identify potentially eligible studies. Studies were categorized as included, not included, or not assessable for the purpose of inclusion (yes; no, does not meet criteria; or not assessable, in which case the full text was evaluated). Once identified, the full text was analysed to assess whether they met the inclusion/exclusion criteria. Any arising discrepancies were resolved, and a consensus was reached.

All the full texts included were approved by PD and AM. The study selection process followed the PRISMA 2020 guidelines (Page et al., 2021) (Fig. 1).

Data extraction

The evaluation phase involved an initial stage of organising the results using the Excel data collection tool for the included studies (Russell, 2005; Beyea and Nicoll, 1998; Ganong, 1987; Torraco, 2005), to support the writing of a narrative summary (Garrard, 2017). In addition to the author, country and year of publication of the article, the extracted data include the aim and design, a brief sample summary, the methods, intervention, outcomes, and main findings inherent to the research question. The summary of the included studies is shown in Table 1. According to Whittemore & Knafl (2005), the assessment of study quality in an integrative literature review must be meaningful to the purpose of the review; therefore, as the purpose of the study is to gather a variety of empirical and theoretical literature sources, the 'Mixed method appraisal tool - 2018′ [MMAT] (Calvo-Schimmel et al., 2021) was used. The MMAT is a tool designed to assess the methodological quality of five categories of studies: qualitative research, randomised controlled trials, non-randomised studies, quantitative descriptive studies, and mixed method studies.

Data analysis and presentation

Data analysis was performed using the systematic four-stage process described by Whittemore and Knafl (2005). In the first reduction phase, the data from the primary studies were selected, simplified, and organised into subcategories based on the study design.

A thematic analysis, guided by Braun and Clarke (2006), was then conducted. Two reviewers repeatedly read the included articles; extracted meaning units related to the implementation of WCC within hospital settings; coded them line by line; and organised codes in a spreadsheet. Codes were compared for patterns and relationships and iteratively grouped into sub-themes and themes. The thematic structure was refined through constant comparison, and the findings were reviewed until the authors agreed that the synthesis adequately captured the evidence.

Following thematic analysis, four themes and four sub-themes describing facilitators and barriers to implementing a WCC model in hospital maternity care emerged. For data display, we produced a comparative summary matrix (Table 1) to align themes and categories across studies and to support conclusion drawing (Miles and Huberman, 1994, pp. 1–11). In the verification step, data from primary sources were re-examined to confirm thematic relationships (Whittemore and Knafl, 2005), and conclusions were agreed by the authors.

Results

A total of 411 eligible studies were identified, and 16 of those included. Eleven had qualitative studies, one had a quantitative study and four had Mixed-Method studies. Methodological quality was assessed by two independent reviewers [PD and AM] using the MMAT. Three studies received the highest methodological rating (5/5) (Avan et al., 2023; Dzomeku et al., 2023; Moridi et al., 2020), seven studies were rated with quality of 4/5 (Cellissen et al., 2022; Hewitt et al., 2022; Hunter et al., 2017; Lundgren et al., 2020; Maputle et al., 2018; Mgawadere et al., 2019; Turner et al., 2022) and the remaining included studies were rated with a quality of <3/5. No studies were excluded based on the quality assessment.

The sample population investigated were midwives, other healthcare personnel and women. The outcomes concerned the perceptions and experiences of healthcare professionals and women on WCC models, and the factors facilitating or limiting the implementation of such models in the hospital.

Four significant themes emerged along with four sub-themes (Fig. 2):

- - The midwives' perspectives.
- - The care model.
- - Communication and collaboration: Relationships with colleagues; Relationship with women and empowerment.
- - Resources and support: Organisation and stakeholders; Management.

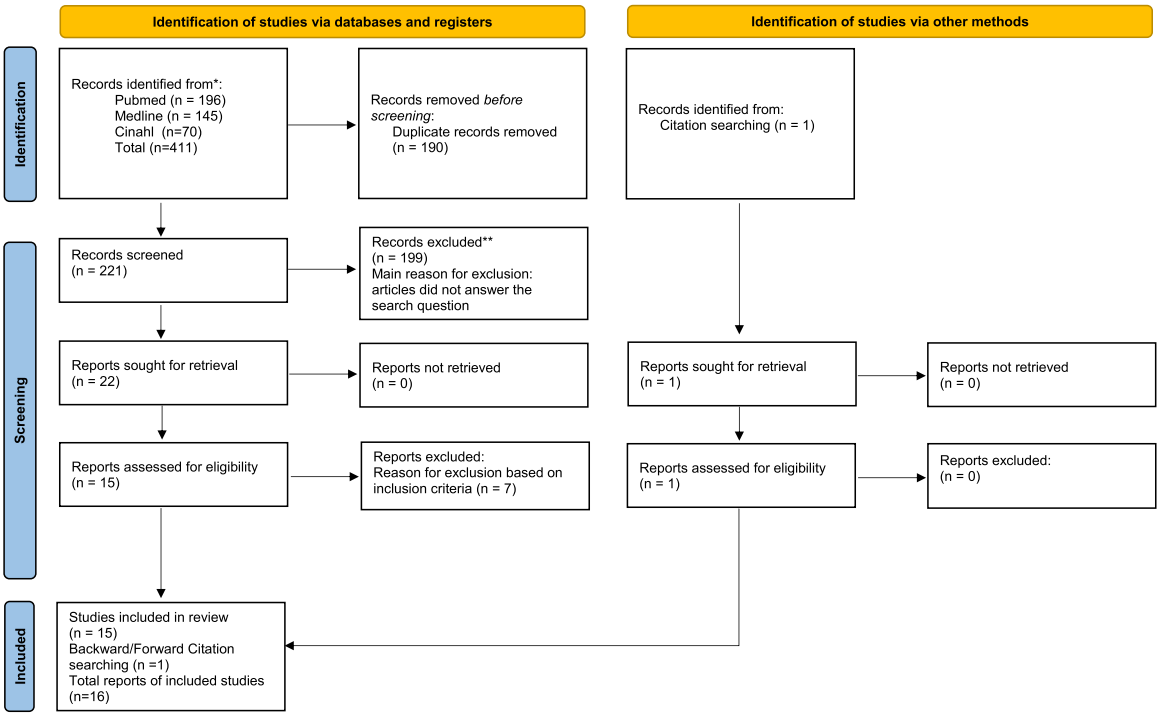

Fig. 1. PRISMA 2020 flowchart of the study selection process.

Table 1
Summary of included studies.

Author, Year and Country	Aim	Design	Population	Intervention/Method	Outcomes	Main Results
Åhlund et al. (2018) Sweden	To investigate how midwives experienced the implementation of WCC during the second stage of labour.	Qualitative descriptive design (focus group discussions (FGD)/ interviews).	Targeted sample of midwives from 2 different labour/birth rooms in Stockholm (one with 6000 deliveries and one with 4000 deliveries per year). Interviews: No 20 midwives.	Three FGDs and interviews were conducted with midwives who had implemented a woman-centred model of care in the second stage of labour to prevent perineal injuries. The 47 to 120- minute audio-recorded interviews included two midwives interviewed together and one individual interview.	The experience of participation in a research project and its recruitment for the study. Obstacles to participation. Influence on the midwife's professional role.	Increased awareness of the role as a midwife, gaining more confidence and understanding of the importance of both the partnership with the woman and working in a team.
Avan et al. (2023) Pakistan	Exploring maternity practitioners' perspectives on change mechanisms resulting from a supportive and respectful maternal care intervention (S-RMC).	Qualitative descriptive and explicative design with a realistic evaluation approach (semi-structured interviews).	No 36 participants: No 4 gynaecologists, No 15 nurses, midwives and healthcare assistants, No 7 non-clinical support staff, No 3 orderlies and janitorial staff No 2 security guards No 5 administrators of the maternity section of the secondary level public facilities in Thatta and Sujawal, Sindh, Pakistan.	After a 3-day S-RMC training course, individual in-depth semi-structured interviews of 60–70 min each were carried out and audio recorded.	Staff perspectives on the different elements of supportive and respectful maternal care.	The S-RMC training facilitated: collaboration between clients and professionals, acknowledgement of different professional roles, and improvement in the coordination of professional teams. Gathering feedback from women at the time of discharge gave them a sense of dignity and empowerment, and helped providers identify any service gaps. The high number of assisted women compared to the number of operational staff hindered supportive and dignified maternity care.
Binfa et al. (2016) Chile	Evaluate the implementation of the 'Model of Integrated and Humanised Health Services' and the Clinical Guide for Humanised Attention during Labour and Childbirth.	Mixed method study: cross-sectional and descriptive, qualitative (focus group).	Convenience sample: No 40 midwives, No 29 obstetricians with $\geq$ 3 years of service and supervisory role. No 1729 women (quantitative phase). No 27 women (qualitative phase). No 26 focus group discussions (FGDs) in regional and metropolitan hospitals for the qualitative phase, in Chile.	In the quantitative phase, a structured audio-recorded interview with the study participants was conducted. In the qualitative phase, the Focus Groups were divided into those of midwives, gynaecologists and women. The interviews were audio-recorded and transcribed when possible.	Quantitative: obstetrical care processes using the "Intrapartum Data Set" developed by the American College of Nurse-Midwives, translated into Spanish, and adapted to the Chilean ambience. The maternal-neonatal well-being in labour is measured with the: 'Maternal Well-Being Scale' created and validated in Chile. Qualitative: Perceptions of women, midwives, and gynaecologists regarding the discrepancy between national guidelines and actual practice.	Lack of midwifery autonomy in the physiological management of childbirth. Absence of a trusting relationship between woman - midwife in decision making regarding procedures or interventions to be performed, due to lack of information. Hospital facilities not supporting a more personalised model of care. Midwife-gynaecologist teamwork associated with fewer medical interventions resulted in higher scores in maternal well-being. Barriers in practice and staff attitudes due to gynaecologists' training which did not include the personalised approach to care.
Author, Year and Country	Aim	Design	Population	Intervention/Method	Outcomes	Main Results
Cellissen et al. (2022) Holland	To gain insights into how professionals in the Dutch MCCs (Maternity Care Collaborations) integrate women's voices into quality improvement as part of	Qualitative descriptive design (individual semi-structured interviews).	Targeted sample N° 12 (of which N°6 midwives, N°2 obstetricians and N°4 managers) (N°22 MCC care professionals invited to participate).	45 to 60-minute individual semi-structured interviews via videoconference (due to COVID-19 restrictions) were conducted. After the first three interviews,	The experiences, motivations and viewpoints of care professionals on the integration of women's voices for quality improvement within MCCs through the	Integrating women's care experiences into quality improvement is demanding in terms of time and training. Factors that help are: more formal, flexible, and experienced

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	the Integrated Maternity Care Standard and what the role the midwives have.			the question outline was refined. Printed transcripts were sent to participants for verification. Saturation after 10 interviews.	reports provided as part of the StEM study.	management structures. -the involvement of external entities such as professional associations or government-funded organisations to support professionals Lack of time, financial resources, and expertise in the interpretation of the results all hinder the collection and definition of women's experiences.
Clerke et al. (2023) Australia	To develop, test and evaluate the feasibility and acceptability of a shared decision-making training intervention (SDM).	An explanatory study design in 2 phases: Phase 1: quantitive (post-workshop participation and post-training survey) -Phase 2: qualitative (individual semi-structured interviews).	Intentional sample. Online workshops: No 26 (No 13 in each workshop): No 16 obstetricians, consultants and obstetric trainees and No 10 midwives from three public maternity hospitals in two local health districts (LHDs) in Sydney. survey 1 and 2: No 26: (No 9 midwives and No 17 obstetricians).	The intervention included: A 45-minute online vodcast on SDM concepts, - A 7-minute video of an SDM intervention for a planned birth, and the pre-reading of two publications on SDM. - A 2-hour practice workshop - A 30-minute summary of concepts, - 60-minute multidisciplinary discussion rooms with 3 participants roleplaying (45 min - Facilitated feedback and discussion of the entire workshop, audio-recorded and transcribed. - Two online surveys to measure outcomes. Qualitative study: 33 to 45-minute semi-structured individual interviews. 2 months after the workshop, recorded on Zoom and transcribed.	Acceptability and feasibility of training. Attitudes, Trust, Intentions and Skills of 'shared decision-making' as interpreted by the 2 online surveys. Physician-patient satisfaction with shared decision-making. Experiences in 'shared decision-making.	Flexibility in a professional role encourages the involvement of women in the decision-making process, but the lack of time to perform the SDM process is a barrier to the implementation of the intervention. The sharing of work in a multidisciplinary team without judgment helps the SDM process. Limits to SDM intervention have been identified in a paternalistic practice oriented towards the biomedical model, as well as in the balancing of autonomy of both the physician's and the woman's competencies, in addition to the fear of medico-legal repercussions and poor results.
Author, Year and Country	Aim	Design	Population	Intervention/Methods	Outcomes	Main Results
Dzomeku et al. (2023) Ghana	To explore the awareness and role of the midwives responsible for the promotion of Respectful Motherhood Care (RMC).	An exploratory-descriptive qualitative design (semi-structured interviews).	Targeted sample N 9 midwives in charge of the maternity ward of a tertiary health facility in Kumasi, Ghana, who had participated in RMC training modules.	Audio-recorded face-to-face interviews of approximately 60 min. The data collection tool was designed according to an RMC module (RMC-M). Saturation was reached at the ninth interview.	The awareness and role of the midwives responsible for the promotion of RMC.	Respectful maternity care is equivalent to WCC. Awareness of the leadership role of midwives responsible for the promotion of RMC services and their clinical experience supports midwives' training in RMC. Monitoring and supervision of the model are helpful in identifying any gaps. A trusting relationship with the midwife, characterised by the provision of equal opportunities to all clients visiting the facility for childbirth, supports decision-making.
Floris et al. (2023) Switzerland	To explore the overall perception of WCC of health professionals from different specialties including their views on facilitators and barriers to the implementation of this model in their practice.	A sequential Mixed method approach of an explanatory nature. Semi-structured interviews: A cross-sectional and descriptive study,	Targeted sample: No 15 (out of 715 eligible) No 7 midwives, No 2 midwifery or nursing team managers or advanced practitioners No 2 junior and No 2 senior obstetricians No 1 paediatrician	A self-report questionnaire, for quantitative and qualitative use, supplemented by two open-ended questions on the WCC Leap model. To facilitate the understanding of the model, The semi-structured interviews	Professionals gain knowledge regarding women's satisfaction. Positive impact on obstetrical practice (spontaneous deliveries and improved neonatal adaptation, analgesia, episiotomies). Job satisfaction of	WCC could enhance the feeling of professional value and job satisfaction. This would bring positive outcomes both in the collaboration between healthcare professionals and parents, as well as in women's satisfaction, encouraging them to

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			No 1 anaesthetist from the University Hospitals of Geneva in Switzerland.	are audio-recorded and transcribed.	health workers and positive feelings about their professional value.	follow the recommendations for their own and their child's health. In their description of the model, most participants overlooked the importance of the control and competence that women have in informed decision-making. The different models adopted by the various professional categories could create possible tensions.
Hewitt et al. (2022) Australia	To clarify what constitutes an optimal management and leadership in sustaining midwifery group practice (MGP) in Australia.	An interpretative qualitative approach with (interviews and focus groups).	No 5 Managers of MGP centres No 15 CMCs (clinical midwife consultants), No 3 Operational and strategic department managers.	.Face-to-face or web conference interviews were conducted. They lasted from 27 to 62 min and were audio-recorded. The questions were based on previous studies examining the role of the, MGP manager.	The factors hindering the implementation and sustainability of the MGP model.	The manager must have confidence in the model and possess inclusive leadership. Relationship skills both with the women and the midwives, involving the former in responding to their need for satisfaction, and valuing the latter in their professional role, working alongside them at the same time. The emotional effort sustained by the manager requires the support of the management and the other midwives. A financial management competence could enable them to show the financial benefits of a MGP service to stakeholders.
Author, Year and Country	Aim	Design	Population	Intervention/Methods	Outcomes	Main Results
Hunter et al. (2017) Ireland	To explore the concept of WCC during pregnancy and childbirth. To identify the key elements of WCC through the experiences and perspectives of women and doctors in Ireland.	A qualitative descriptive design. Interviews and focus groups (FGDs) divided up by profession	Targeted sample No 31: No 11 women, No 10 midwives, No 5 obstetricians No 5 general practitioners from 2 maternity units: an urban hospital (approx. 8000 births/year and a regional hospital (approx. 4000 births/year), both with similar philosophical and organisational approaches.	32-minute individual face-to-face or telephone interviews and two FGDs, one with No 4 midwives and one with No 5 general practitioners. All were transcribed and analysed by a team of four researchers not involved in conducting the interviews.	The experiences and perspectives of women and midwives regarding the WCC model	Units led by midwives protect the normality of pregnancy. The women-professional partnership, sustained by the woman's education in decision-making, promotes continuity of care in the perinatal journey. Empowerment is the precursor to women-centred care because it encourages women's choice and autonomy. The lack of shared ethics is currently a barrier to WCC.
Lundgren et al. (2020) Sweden	To explore the usefulness of adopting a woman-centred midwifery model of care (MiMo) in birthing rooms, from the viewpoint of different health professionals.	A qualitative descriptive design (focus groups before and after the intervention).	Total: No 43 Pre-intervention: No 6 assistant nurses, No 5 obstetricians, No 5 midwives, No 4 managers Post-intervention: No 5 assistant nurses No 3 obstetricians No 7 midwives No 4 MiMo midwives, No 4 managers of a hospital in Sweden which has three labour wards (for normal deliveries, one for	Interventions: 1. The midwives were given an 8-hour training course on the model and a MiMo Card with guidance on ward interventions and practice guidelines. A 4-hour group discussion between researchers and midwives to discuss the model and its use in practice. 2. A one-hour meeting to present the model to	Opinion on the usefulness of the MiMo model from a practical point of view. Midwives' opinion about their professional role in WCC).	The core of the model should continue to be focused on midwifery, although the main concepts of the birthing atmosphere and mutual relationship can be shared by all, to facilitate cooperation with other professionals. Experience and safety are important when working with other professionals. For midwives, the standardisation of the

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			high-risk pregnant women and one for normal deliveries located in a separate hospital building in another part of town).	groups of gynaecologists, nursing assistants and managers. 3. Regular reflections with midwives during the study period (6 times per midwife, 90 min each time).No 9 FGDs, transcribed verbatim, to present MiMo and two open questions before and after to assess outcomes.		GLs may place limits on the model. Not all professionals find it easy just to be present without intervention. The implementation of MiMo is hampered by workloads and stress, which prevent continuity of care during deliveries.
Lundgren et al. (2022) Sweden	To assess the influence of the implementation of a woman-centred obstetric model of care (MiMo) The use of oxytocin for labour augmentation and women's experiences of childbirth.	Mixed method: pre- and post-implementation quantitative and qualitative study (focus groups with midwives and analysis of two quantitative measures).	No 6882 primiparous women: oxytocin augmentation outcome No 810 primiparous women: birth experience No 11 midwives 2 FDGs: midwives' opinions on the use of MiMo vs oxytocin augmentation and birth experience.	The intervention from Lundgren's (2020) study (see above). During the implementation (March 2015 to March 2016), midwives in the intervention ward were not obliged to use the model in their daily practice. Assistance in the check-up ward did not undergo any changes.	Oxytocin augmentation. Childbirth experience for women as measured by the: Childbirth Experience Questionnaire (CEQ2)). The midwives' opinions on the usefulness of the model in practice and on their role in WCC. Secondary outcomes: Birth outcome (non-instrumental vaginal/ instrumental).Epidural use (yes/no).	Midwives using the MiMo tool were able to reflect on their own role and the partnership relationship they establish with the woman, recognising the importance of the woman's involvement in the decision-making process, and normalising the birthing event. However, lack of time prevented midwives from building trusting relationships with the woman. This would require support from the management. Decreased use of oxytocin and childbirth experience showed no significant differences. Significantly higher rates of epidural use (p = 0.002) and instrumental deliveries (p = 0.016) were observed in the pre-intervention ward. Instrumental deliveries decreased significantly only in the post intervention ward (p = 0.009) Further studies are needed to assess the potential of MiMo.
Author, Year and Country	Aim	Design	Population	Intervention/Methods	Outcomes	Main Results
Maputle (2018) Africa	To evaluate the support given to women by midwives during their intrapartum care at a public tertiary hospital in Limpopo Province, South Africa.	A qualitative participant approach: (Semi-structured observational guide/ field notes of all events and conversations/ Visual Analogue Scale to supplement observations/ informal unstructured interviews).	Purposive and convenience sample No 24 women admitted to hospital for labour and birth. No 12 midwives	The observations made from the active stage of labour up to the third stage, focused on the interaction between the woman and the midwife and the obstetrical care provided. Informal unstructured conversations between the midwife and the woman were audio-recorded during labour. The field notes of the events and the conversations were transcribed.	In the midwife-woman relationship mode, informational and emotional support activities are carried out. The physical comfort measures are provided for pain which is measured on the VAS scale and completed independently by the woman and the midwife when the cervical dilatation is 0–3 cm, 4–7 cm and >8 cm. Assistance during labour and birth.	A relationship between the woman and her midwife achieved through the continuity of information, encourages the woman's decision-making process. Emotional support, support in labour and individual care by midwives appear to be limited due to the need to care of more than one mother simultaneously. Midwives and mothers' interpretation of pain in labour was perceived differently, with similar values only in the last stage of labour.
Mgawadere et al. (2019) Malawi	To identify facilitating factors and barriers for providing good quality care in childbirth.	A qualitative descriptive design Focus Group Discussions (FGD)	Targeted sample No 134 women and No 27 Key Informant interviews with health workers from two districts in	No 14 FGDs with women (No 7 for each district) and No 27 Key Informant interviews with healthcare workers. The interviews	Women and health professionals' experiences and perceptions defining the care quality and	Women perceive the quality of care in terms of good interpersonal relationships, but the health care providers felt unable to provide it due

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			Malawi comprising 14 health facilities	were both audio-recorded and transcribed.	childbirth care experiences.	to staff shortages causing stress, fatigue and frustration. According to the women, health workers were more interested in compliance towards procedures than in meeting their needs and/or facilitating good communication. The often-overcrowded public health facilities with an inadequate number of birthing beds make privacy impossible.
Moridi et al. (2020) Iran	To explore the midwives' perspectives regarding. respectful maternity care during labour and childbirth.	A qualitative design (semi-structured interviews, field notes and observations.	Targeted sample No 24 midwives from two non-university public hospitals in Tehran, Iran.	Eighty-minute interviews were audio-recorded and transcribed. They were conducted using a semi-structured guide. The first question was specific to the midwives' personal perceptions regarding respectful care towards women in labour. Subsequent questions generalised the provision of respectful care during labour. The interviews were replayed to participants to verify their accuracy.	Midwives' perceptions of the respectful care to be given to women in labour.	Friendly relationships and being close to women create a family atmosphere which facilitates decision-making. Midwives' knowledge of different cultures can help provide equitable care for women. The often-overcrowded wards, the absence of waiting spaces for companions and the prohibition of their access to the labour room are all barriers. The timeliness of personalised care facilitates WCC. Difficult relations with the doctor regarding compliance with the WCC model for their medicalised birthing care.
Author, Year and Country	Aim	Design	Population	Intervention/Methods	Outcomes	Main Results
Roemer et al. (2024) Kenya	To understand the feasibility of implementing a Respectful Maternal and Newborn Care (RMNC) training toolkit and evaluate its outcomes for providers and women.	A quantitive pre-post cross-sectional survey of the patients and training participants.	RMNC training courses: No 22 members of staff from 2 maternity wards in Kenya and No 24 members of staff from 1 maternity ward in Tanzania (nurses, Medical Doctors, midwives, anaesthetists, and others). Random sample for the patient survey: No 47 pre and No 91-post completed in Kenya No 149 pre and No 80 in Tanzania.	The toolkit included :Online module (45–60 min) available in several languages. - In-person workshop (8 h) post e-learning. Online self-report questionnaire in English (before RMNC training, immediately after, 90 and 180 days after). Patient survey by phone (20–25 min) by trained contact centre agents using computer-assisted personal interviews (CAPI) and an electronic data capture system (Kobo Toolbox) on tablets to record responses.	The feasibility and satisfaction of the RMNC training providers. The satisfaction and experience of respectful care as measured by the Mothers on Respect index (MOR) and the Mistreatent Index (MIST).	The RMNC training has contributed to practitioners' recognition of episodes of abuse and violence in maternity settings, but the transferability of the intervention into the clinic was reduced over time (100 % of the practitioners strongly agreed with the usefulness of the training immediately after the training and 76.2 % at 180 days after the training). Women observed no significant difference in the reporting of abuse between pre- and post-intervention.
Turner et al. (2022) United Kingdom	To develop a theoretical framework that explores the viewpoints and experiences of midwifery managers who have led, or are leading, MCoCer (Midwifery Continuity of Care) models within the UK National Health Service (NHS).	A qualitative design using the constructivist grounded theory by Charmaz (2014).	Targeted sample Total No 5: No 3 experienced midwives in non-clinical midwifery roles, No 2 midwives running a continuity care model.	The face-to-face interviews, which lasted 50–90 min were audio recorded and transcribed. Field notes were also made. The first interview was prompted by a series of semi-structured questions, however, as the interviews progressed, the	Perspectives of midwifery managers who have led, or are currently leading, MCoCer models on the managerial and leadership objectives that successfully implement and sustain MCoCer models.	To take care of women, midwives must have a foundation of feminist values and care. The 'choice' and 'control' granted to women is facilitated by a transformational leadership that sustains the model. The leaders stay in touch with their staff and use their status to try and establish the

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Table 1 (*continued*)

		structure of the questions changed becoming more open-ended, focused to allow the exploration of emergent codes.	model in the culture of the organisation. Leader training can help ensure that other stakeholders such as midwives and board members, feel they are active participants. Management that does not invest in supporting midwives, in terms of time and finances, negatively impacts the implementation of the model.

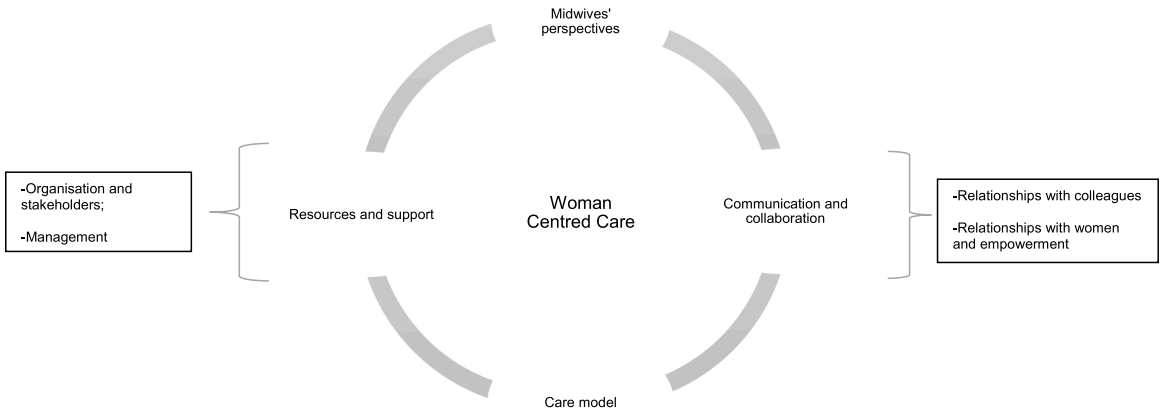

Fig. 2. Facilitators and barriers to "Woman-Centred Care".

A summary of the factors that would influence the implementation of the model is presented in Table 2.

The midwives' perspectives

Midwives value the WCC of care (Åhlund et al., 2018; Avan et al., 2023; Dzomeku et al., 2023; Floris et al., 2023; Lundgren et al., 2022; Turner, 2022).

The characteristics of the individual midwife are believed to be a key element in establishing a partnership with the woman (Åhlund et al., 2018; Hunter et al., 2017; Lundgren et al., 2020; Moridi et al., 2020) and are considered essential to WCC and it is for this reason Hunter et al. (2017) recognise the need to improve midwifery skills since their professional training has also an impact on women's education, thus influencing the decisions made throughout their pregnancy. Applying the WCC model gives midwives greater awareness of their professional role, and in some cases, leads to empowerment, thus improving teamwork within the service (Åhlund et al., 2018; Avan, 2023; Binfa et al., 2016) highlight the importance to midwives of support, appreciation, and recognition as autonomous professionals in clinical practice. Although the midwives' role and expertise in managing labour is acknowledged, there is also a need for medical professionals to be trained in WCC as there can be issues arising which do not necessarily require active intervention but can be resolved through a good relationship between the professional and the woman (Lundgren, 2020).

The care model

Studies (Åhlund et al., 2018; Binfa et al., 2016; Clerke, 2023; Floris et al., 2023; Hunter et al., 2017; Moridi et al., 2020) highlight the predominance of the biomedical model in maternity services. WCC provided by a midwife known to the mother has a positive impact in terms of maternal satisfaction and no negative outcomes. The application of the model, however, may lead to tension between hospital health professionals due to the different working modalities: i.e., the biomedical model vs. the WCC model (Clerke et al., 2023; Floris et al., 2023). On the one hand, it is certainly difficult for the medical category to imagine themselves waiting in the birthing room without actively intervening (Åhlund et al., 2018; Binfa et al., 2016; Lundgren et al., 2020), but on the other hand, the midwives oriented towards the WCC model feel isolated in a medicalised care context (Turner et al., 2022). Hunter et al. (2017) observed women's need for easy access to services and introduced the theme of continuity of care throughout the pregnancy. Nevertheless, from a woman's viewpoint, '*the constant presence of the doctor during pregnancy is considered synonymous with good quality care*'; moreover, the care received in parallel from different providers with limited communication between primary care, hospital services and midwifery-led units appears fragmented (Hunter et al., 2017).

Communication and collaboration

- *Relationships with colleagues*: the importance of good communication and collaboration between midwives and medical staff has emerged as a subcategory in some of the studies (Åhlund et al., 2018; Binfa et al., 2016; Clerke et al., 2023; Floris et al., 2023; Hunter et al., 2017; Turner et al., 2022).

  Interprofessional communication, particularly between midwives and gynaecologists, can have a negative impact on the quality of WCC due to a lack of shared ethics and understanding between the professions (Hunter et al., 2017; Lundgren et al., 2020). It is for this

Table 2
DATA ANALYSIS MATRIX: Factors influencing the implementation of the Woman Centred Care model in the care of pregnant women in a hospital setting.

N	Study	Method	Population	MM AAT	Results			
					Midwives' perspectives	Care model	Communication and collaboration	Resources and support
1	Åhlund, 2018	Qualitative Descriptive.	No 20 midwives	3/5	-FACILITATORS An increased awareness of the role as a midwife and gain in confidence.	-BARRIER Intrapartum care is highly medicalised and the use of epidural analgesia and technology such as continuous foetal monitoring is part of standard care.	RELATIONSHIPS WITH COLLEAGUES :FACILITATORS: working in a team ensures effective communication RELATIONSHIPS WITH THE WOMEN (and empowerment) -FACILITATORS: understanding the importance of partnership with women.	MANAGEMENT :BARRIER: the simultaneous management of a multiple women in labour in an average obstetric shift.
2	Avan, 2023	Qualitative descriptive and explicative design with a realistic evaluation approach.	No 36 participants of which were medical and non-medical.	5/5	-FACILITATORS: Acknowledgement of the professional role and an improvement in team coordination.		RELATIONSHIP WITH THE WOMAN (and empowerment) -FACILITATORS: understanding women's needs and expectations leads to greater collaboration thus increasing their satisfaction.	-BARRIER: The high number of assisted women compared to the number of operational staff hindered supportive and dignified maternity care. -FACILITATORS Gathering feedback from women at the time of discharge gave women a sense of dignity and empowerment and helped providers identify any service gaps.
3	Binfa, 2016	Mixed-method study: cross-sectional and descriptive qualitative (focus group).	Convenience sample: No 40 midwives, No 29 obstetricians No 1729 women No 27 women in the qualitative phase.	3/5	FACILITATORS: Appreciation and acknowledgement as professionals capable of autonomy in clinical practice.	-BARRIER: Lack of midwifery autonomy in the physiological management of childbirth. University and post-university training courses do not include the personalised approach to care.	RELATIONSHIPS WITH COLLEAGUES :FACILITATORS: Teamwork between midwives and gynaecologists was associated with fewer medical interventions and higher scores in maternal well-being. RELATIONSHIPS WITH WOMEN (and empowerment). -BARRIER: Absence of trusting woman-midwife relationships in decision-making regarding procedures or interventions.	ORGANISATION AND STAKEHOLDERS: BARRIER: Hospital structures are inadequate to support a more personalised care model. MANAGEMENT :BARRIER: Barriers in practice and in staff attitude.
4	Cellissen, 2022	Qualitative descriptive.	Targeted sample: No 6 midwives, No 2 obstetricians and No 4 managers.	4/5				ORGANISATIONS AND STAKEHOLDERS :FACILITATORS: The involvement of stakeholders such as professional associations or government-funded organisations supporting healthcare professionals in the MCC. MANAGEMENT :BARRIERS: Lack of time, financial resources, and knowledge of the healthcare system.

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Table 2 (*continued*)

N	Study	Method	Population	MM AAT	Results			
					Midwives' perspectives	Care model	Communication and collaboration	Resources and support
5	Clerke, 2023	Mixed method.	Intentional sample: No 26 of which No 16 obstetric, consultants, and obstetric trainees, and No 10 midwives. Participating in the survey No 9 midwives and No 17 gynaecologists.	2/5		-BARRIERS: The paternalistic practice could hinder the implementation of the SDM. The balancing of the autonomy of both the physician's and the woman's competences, against the fear of medico-legal repercussions and poor results.	RELATIONSHIPS WITH COLLEAGUES :FACILITATORS: Sharing work with a multidisciplinary team without judgement where each member has flexibility in their own role. RELATIONSHIPS WITH WOMEN (and empowerment) -FACILITATORS: The involvement of women in decision-making gives them knowledge, which in turn, helps them negotiate the best care following their wishes.	MANAGEMENT: BARRIERS: Lack of time to follow the SDM process.
6	Dzomeku, 2023	Qualititive descriptive.	Targeted sample: No 9 midwives in charge of the maternity ward.	5/5	-FACILITATORS The charge midwives' awareness of their leadership and responsibility in the training of the RMC services and in setting a good example in clinical practice.		RELATIONSHIPS WITH WOMEN (and empowerment) :FACILITATORS: a trusting relationship characterised by the provision of equal opportunities to all clients visiting the facility for childbirth.	MANAGEMENT :FACILITATORS: Monitoring and supervision of the model to easily identify any gaps in the promotion of RMC to its clients.
7	Floris, 2023	Sequential mixed method approach of an explanatory nature and a cross-sectional and descriptive study.	Targeted sample: No 15 of which No 7 midwives, No 2 midwifery or nursing team managers or advanced practitioners, No 2 junior obstetrician gynaecologists, No 2 senior obstetrician gynaecologists, No 1 paediatrician, No 1 anaesthetist.	3/5	-FACILITATORS: The practice of WCC could enhance the feeling of professional value and increase job satisfaction.	-BARRIERS: The WCC could create tensions due to differences in work culture.	RELATIONSHIPS WITH COLLEAGUES :FACILITATORS: The WCC improves relations and collaboration between the parents and healthcare workers, suggesting a better quality of care. RELATIONSHIPS WITH WOMEN (and empowerment) -FACILITATORS: The WCC could contribute to women's satisfaction, encouraging them to follow the recommendations for their own and their child's health. -BARRIERS: The lack of knowledge of the key features of WCC: the importance of women's control and competence in informed decision-making were almost absent from the definitions provided by the practitioners.	MANAGEMENT: BARRIERS: Administrative overload and lack of time are considered a hindrance to the implementation of the model.
N	**Study**	**Method**	**Population**	**MM AAT**	**Results**			
					Midwives' perspectives	Care model	Communication and collaboration	Resources and support
8	Hewitt, 2022	Interpretative qualitative approach.	No 5 managers of MGP centres No 15 CMC (clinical midwife	4/5			RELATIONSHIPS WITH WOMEN (and empowerment) :FACILITATORS:	MANAGEMENT :FACILITATORS: The manager must have confidence in the WCC

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Table 2 (*continued*)

			consultants) No 3 department managers.				The manager builds a relationship with the woman to involve her in the process and respond to her need for satisfaction.	and its benefits and possess inclusive leadership, thus building a trusting relationship with the midwives by giving value to their role and working alongside them. ORGANISATION STAKEHOLDERS :FACILITATORS: The manager promotes MGP services to stakeholders by collecting and using statistics. -BARRIERS: Lack of training in financial management for managers.
9	Hunter, 2017	Qualitative descriptive.	Targeted sample: No 31 of which No 11 women, No 1 midwife, No 5 obstetricians, No 5 general practitioners	4/5	-FACILITATORS Protecting the normality of pregnancy with the enhancement of a midwife's role.	-BARRIERS: Fragmentation of care affecting communication (woman-operators and operators-operators of related services), (continuity of perinatal care).	RELATIONSHIPS WITH COLLEAGUES :FACILITATORS: Training the medical profession in the WCC model and sharing clinical information to improve mutual understanding and share respective approaches. -BARRIERS: Lack of shared ethics and mutual understanding between different professions.	ORGANISATION STAKEHOLDERS MANAGEMENT -BARRIERS: The organisational structures lack of flexibility, the absence of choice in birth plans and an inadequate relationship between midwifery staff and women all limit women's emancipation (disempowerment).
10	Lundgren, 2020	Qualitative descriptive.	Total: No 43, of which No 16 midwives, No 12 obstetricians, 11 nurses and 4 managers.	4/5	-FACILITATORS: Medical training based on the woman-centred midwifery model is beneficial in acknowledging the role of the midwives. The women's choice and involvement regarding the proposed care interventions is facilitated by the presence of the midwife in the birthing room, to help the woman to feel she is in a calm and comfortable environment.	-FACILITATORS: The main concepts regarding the childbirth environment and mutual relationships can be shared in all professions. -BARRIERS: For some professionals, their physical presence alone, without any active intervention may be difficult.	RELATIONSHIPS WITH COLLEAGUES :BARRIERS: Working with people from different professions is complex and can interfere with each profession. RELATIONSHIPS WITH WOMEN (and empowerment) :BARRIERS: The absence of a quality relationship between the midwife and the woman limits the woman's participation in decision-making.	ORGANISATION STAKEHOLDERS MANAGEMENT -BARRIERS: The hospital has neither the staff nor the resources necessary for a continuous presence of healthcare workers during all deliveries.
N	**Study**	**Method**	**Population**	**MM AAT**	**Results**			
					Midwives' perspectives	Care model	Communication and collaboration	Resources and support
11	Lundgren, 2022	Mixed method: Qualitative (FG) before and after the implementation.	To evaluate:-the outcome of oxytocin augmentation, No 6882 primiparous women. -the birth experience, N°810 primiparous women. -the midwives' opinions on the use of MIMo about oxytocin augmentation and birth experience:	3/5	-FACILITATORS MiMo allows midwives to reflect on their role and on the mutual relationship they establish with the woman. This enables the midwife to recognise the elements that can disturb labour and to normalise the event.		RELATIONSHIPS WITH WOMEN (and empowerment) -FACILITATORS: Involvement of women in the decision-making process.	MANAGEMENT -BARRIERS: Lack of time hindered the establishment of trusting relationships with women.

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Table 2 (*continued*)

			FGD (2), N° 11 midwives					
12	Maputle, 2018	Qualitative descriptive	Purposive sample: No 24 women during labour and birth No 12 midwives	4/5			RELATIONSHIPS WITH WOMEN (and empowerment) :FACILITATORS: Continuity of information in the woman-midwife relationship encourages women's decision-making progress.	MANAGEMENT :BARRIERS Lack of individual care due to the need to assist other mothers at the same time.
13	Mgawadere, 2019	Qualitative descriptive.	Targeted sample N° 134 women N° 27 healthcare workers Key informant interviews.	4/5			RELATIONSHIPS WITH WOMEN (an empowerment) -FACILITATORS: The women describe the quality of care in terms of good interpersonal relationships.	ORGANISATION AND STAKEHOLDERS :BARRIERS: The majority of birthing rooms lacked privacy due to their poor design. MANAGEMENT: BARRIERS: The healthcare staff do not feel able to provide quality interpersonal relationships due to staff shortages. Due to a heavy workload, which in turn causes stress, fatigue, and frustration in health workers, it is inevitable that women can be left alone at times. The women's prevailing opinion was that health workers were more interested in complying with instructions rather than meeting their needs and/or facilitating good communication.
N	**Study**	**Method**	**Population**	**MM AAT**	**Results**			
					Midwives' perspectives	Care model	Communication and collaboration	Resources and support
14	Moridi, 2020	Qualitative	Targeted sample: No 24 midwives	5/5	FACILITATORS: A prior knowledge of different cultures can help provide equitable care for women. Timeliness of personalised care.	-BARRIERS: Medicalised childbirth assistance does not promote personalised care.	RELATIONSHIPS WITH WOMEN: (and empowerment) :FACILITATORS: Establishing friendly relationships and closeness to the women create a family atmosphere which in turn, facilitates empathy. The information women acquire when involved in the care process and the decision-making process will enable them to give their informed consent to care procedures.	ORGANISATION AND STAKEHOLDERS : BARRIERS: Lack of a comfortable environment for labour care in overcrowded wards prevents the protection of women's dignity which means their privacy, confidentiality and equality are not being respected.
15	Roemer, 2024	Cross-Sectional Studies	RMNC TRAINING: Maternity staff: No 22 from Kenya and No 24 from Tanzania. Random sample for the women's survey: No 47 pre and No	1/5			RELATIONSHIPS WITH WOMEN (and empowerment) :FACILITATORS: In terms of patient experience, statements tended towards patient-centred care: in	

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Table 2 (*continued*)

			91 post intervention patients (Kenya) No 149 pre and No 80 post intervention patients (Tanzania)				Tanzania, providers had improved the relationship with clients, providing information on procedures to be performed, respecting patient choice, and maintaining a certain level of privacy.	
16	Turner, 2022	Qualititive grounded theory.	Targeted sample: No 5 midwives of which No 3 experienced in non-clinical roles and No 2 who manages a continuity care model.	4/5	-FACILITATORS: Greater awareness of the midwife's role and the WCC philosophy.	Midwives who support women's choices within a hierarchical system feel more isolated and pressurised by cultural 'norms' and this has been identified as a vulnerability within the model	RELATIONSHIPS WITH COLLEAGUES :FACILITATORS: An open, honest, and fair culture where midwives can trust in professional relationships and share values as a maternity service favours the model. RELATIONSHIPS WITH WOMEN (and empowerment) :FACILITATORS: Trusting relationships between the midwife and the woman which have developed through repeated contact over time	MANAGEMENT :FACILITATORS: The elements of 'choice' and 'control' for women are facilitated by transformational leadership that supports the model. Leaders stay in touch with their staff while also using their managerial status, working with board members to gain support for change in practice. BARRIERS: Apathetic management that does not invest in midwifery support, time, and finances

reason that the implementation of a WCC model in a hospital setting requires training for professions other than midwifery to facilitate mutual understanding (Hunter et al., 2017; Lundgren et al., 2020), as shared values within the maternity service favours the model in question (Turner et al., 2022). Hunter et al. (2017) suggest that the continuity of care provided by a known midwife would improve communication and collaboration among related health services, thus reducing communication breakdowns, and consequently providing better service delivery and outcomes for women.

- *Relationship with women and empowerment*: All studies, except for Cellissen et al. (2022), highlight the importance of building a relationship between midwives and women to improve the delivery of WCC. The timeliness of personalised care is recognised as a facilitator of this model (Moridi et al., 2020). In Lundgren's study (2022), the MiMo tool, which applies the woman-centred midwifery care model, enabled midwives to focus more on building a partnership-based relationship with women and on providing greater presence alongside her in labour, maintaining a psychologically safe environment during childbirth at the same time. The concept of a relationship with the woman goes hand in hand with that of empowerment, involving the woman in a shared decision-making process that considers her individual preferences and needs throughout the entire course of care.(Avan et al., 2023; Binfa et al., 2016; Clerke et al., 2023; Dzomeku et al., 2023; Floris et al., 2023; Hunter et al., 2017; Lundgren et al., 2022; Maputle, 2018; Moridi et al., 2020).

Women's empowerment has been achieved through the development of trust, the building of relationships and working in partnership while fully respecting the individuals involved. (Floris et al., 2023; Moridi et al., 2020). It is seen as a precursor to the provision of WCC, as a means to protect physiological birth and the woman's ability to achieve this goal.

Resources and support

- Organisation and Stakeholders: Organisations can be both facilitators and barriers to the implementation of a woman-centred model of care; for example, the lack of appropriate infrastructures for family participation in childbirth is a barrier to the humanisation of childbirth (Binfa et al., 2016; Hunter et al., 2017; Lundgren et al., 2020; Mgawadere et al., 2019; Moridi et al., 2020).

Hewitt et al. (2022) also refer to strategies applied outside the group, therefore far from those of group practices, to improve the sustainability of the model. To ensure its implementation, support for WCC must be provided by involving the whole system rather than by individuals.

- Management: Structural requirements are not the only criteria that may hinder the model; care workload, defined by the ratio of midwives to women, may also limit the implementation of personalised, woman-centred interventions (Åhlund et al., 2018; Avan et al., 2023; Cellissen et al., 2022; Clerke et al., 2023; Floris et al., 2023; Lundgren et al., 2020, 2022; Maputle, 2018; Mgawadere et al., 2019). Lack of time is acknowledged as a barrier to building a relationship with women (Cellissen et al., 2022; Clerke et al., 2023; Lundgren et al., 2022; Turner et al., 2022). Lack of support given by management about policy and leadership changes is a barrier to the implementation of the model (Binfa et al., 2016; Dzomeku et al., 2023; Lundgren et al., 2022; Hewitt et al., 2022; Maputle, 2018; Turner et al., 2022). Managers should be proactive in acknowledging midwives' concerns and intervene through policy initiatives during the implementation phases of the WCC model (Hewitt et al., 2022; Turner et al., 2022). Midwifery leader training appears to be a prerequisite for the implementation of a WCC model (Dzomeku et al., 2023; Hewitt et al., 2022; Turner et al., 2022).

A further barrier to the implementation of the model is the current organisational systems which emphasize the safety and the timely treatment of women in labour rooms (Hunter et al., 2017; Mgawadere et al., 2019): the support for significant changes in practices can be achieved by directing care towards the restoration of normality rather than subjecting patients to an almost ubiquitous medical intervention even when unnecessary.

The absence of support from the organisational system affects both

the midwife's working conditions (Åhlund et al., 2018) and consequently, the time she has available to build a trusting relationship with the woman (Lundgren et al., 2022). Midwives report difficulty in providing one-to-one care to mothers as they attend to multiple women simultaneously (Maputle, 2018). Management that does not invest in supporting midwives, will eventually become a barrier to the implementation of WCC models (Cellissen et al., 2022; Lundgren et al., 2020; Turner et al., 2022).

Discussion

The themes identified in the literature are midwives' perspectives, the care model, communication and collaboration, resources and support. They are associated with the structure and delivery of maternity services and with the need for change in maternity culture. Some countries have encouraged the dissemination of the WCC model within maternity services (Council of Australian Government Health Council [COAG], 2019; WHO, 2018, 2021; RCM, 2016; Canadian Midwives Organisation [CAN], 2011) through political directives and joint position statements. Difficulties in enacting such interventions in hospital settings have been identified and include, for example, the predominance of the biomedical model in maternity services, lack of time to build a midwife–woman relationship, and high care workloads. The absence of a shared definition of WCC represents one of the first barriers encountered in this path of change.

Professional identity and agency of midwives

Midwives' descriptions of WCC emphasise attentiveness, support, and respect for women's preferences, consistent with its relational dimension, but these aspects do not encompass the full construct. A fuller articulation of WCC includes structured shared decision-making and continuity of care embedded in organisational policies and workflows, rather than left to discretionary individual practice (Brady et al., 2019; Renfrew et al., 2014). In the literature, Respectful Maternity Care is sometimes used as a proxy for relational domains, yet it should be regarded as necessary but not sufficient to fully realise WCC, as it does not systematically include continuity and shared decision-making (Hameed, 2023; Fontein-Kuipers, 2019). Within this framework, midwives' professional identity and agency remain crucial, but they are effective only when supported by formal recognition of autonomy, clearly defined professional boundaries, and institutionalised processes of shared decision-making and midwife–woman partnership within multidisciplinary teams and hospital protocols (Fontein-Kuipers, 2019; Renfrew et al., 2014). Full acknowledgement of the scope of midwives' practice and autonomy is a facilitator for implementing the above-mentioned model. This theme suggests that policies should encourage cultural change by clearly highlighting distinct lines of responsibility within midwifery departments, especially when interdisciplinary teamwork and care coordination are required. Many of the included studies have confirmed that the availability of person-centred care offers women choice, control and empowerment, and that such aspects are the result of relationships of trust established between midwives and women. The development of the woman–midwife partnership is related to the degree of choice and control that women have. Furthermore, this relationship plays a key role in women's satisfaction with their experience (Hundley et al., 1997; Sandall, 1995). Walsh (1999) suggested that women's perceptions of labour and birth were significantly influenced by relationships developed over time with their midwives. Attending to women's preferences and providing support, rather than merely adhering to established care routines, are widely recognised as foundations of a trusting midwife–woman relationship. A systematic review and meta-synthesis by Perriman et al. (2018) have demonstrated that this relationship underpins maternity care grounded in trust, respect and empowerment. Similar to other studies, midwifery leadership, recognition of midwives' professional autonomy and WCC-oriented management emerge as facilitators, particularly when they support continuity of care, teamwork and the reorganisation of care pathways towards the 'normality' of birth (Zarbiv, 2025).

Integrating woman-centred philosophy within biomedical systems

Across maternity care services, there is no internalised and mutually recognised way of providing woman-centred care (Fontein-Kuipers, 2019). Indeed, there is considerable variability in how woman-centred care is interpreted (Brady et al., 2019). The healthcare providers associate WCC with individual aspects of its definition, often omitting the concept of 'woman's control in informed decision-making' as a characterising element of a WCC model (Floris et al., 2023). In hospital settings, WCC is in tension with standardised protocols that constrain autonomy, personalisation and shared decision-making. WHO guidance for a positive childbirth experience calls for information, informed consent, continuous support and respectful relationships (WHO, 2018). Integrating WCC within biomedical systems requires rebalancing what is offered and how/by whom care is delivered, privileging the promotion of physiology, respectful relationships with effective communication, continuity and pathway integration, alongside appropriate and timely interventions (Renfrew et al., 2014). In high-complexity clinical contexts, negotiation between a woman-centred philosophy and risk-management protocols is crucial. The review by Naughton et al. (2021) shows that, in complex pregnancies, providing woman-centred care requires shifting the decision-making fulcrum towards the woman's informed choices while safeguarding clinical surveillance and appropriateness; This highlights the structural tensions inherent to the biomedical model. More recent theoretical work describes how midwives translate this approach into practice in such settings, highlighting the capabilities required, the necessary compromises among care options, and the organisational constraints typical of hospital environments (Naughton et al., 2025).

Relational continuity and communication as facilitators of WCC

Evidence from multiple settings shows that midwifery continuity of carer strengthens access and navigation across services, reduces care fragmentation, and enhances women's reported experience, with benefits extending to clinical outcomes and no signal of harm (Sandall et al., 2024; Dixon et al., 2023; Fernandez Turienzo et al., 2021, 2023). Continuity also sustains trust, informational coherence, and timely referral, aligning everyday hospital practice with the relational and participatory tenets of WCC (Bradford et al., 2022; Middlemiss et al., 2024). Complementarily, shared decision-making, supported by structured tools, improves communication quality, team alignment, and perceptions of respect and autonomy in intrapartum care, indicating a practical route to embed WCC within multidisciplinary workflows (Yuill et al., 2020; López-Toribio et al., 2021; Spigel et al., 2022; Weiseth et al., 2022). In this way, relational continuity and structured communication processes function as mutually reinforcing mechanisms to translate WCC into routine hospital care.

Organisational leadership and resource support for implementation

A lack of understanding between professions, particularly between midwives and gynaecologists, negatively influences a WCC model. Heavy workloads, time constraints and inconsistent managerial support hinder one-to-one care and the development of meaningful partnerships. Previous studies have shown that difficulties related to staffing shortages and excessive patient loads have been further exacerbated by the lack of an adequate skill mix for managing obstetric complications (Bradley, 2015). Interprofessional misunderstandings and the predominance of the biomedical model constrain collaboration and shared decision-making. In contrast, interprofessional collaboration between midwives and physicians is perceived positively in relation to

woman-centred care outcomes (Cornthwaite et al., 2013; Aquino et al., 2016). For these reasons, implementation in hospital settings remains uneven. Recent syntheses on midwifery continuity models identify structural and process barriers, rostering, resourcing, value alignment, governance, and an underestimation of policy and institutional factors that shape adoption (Middlemiss et al., 2024; Bradford et al., 2022), consistent with our findings. Without dedicated organisational levers, the WCC philosophy remains marginal within systems oriented to risk management and standardisation.

Strengths and limitations

This integrative review synthesised qualitative and quantitative studies to produce a comprehensive understanding of the facilitators and barriers to implementing the woman-centred care (WCC) model in hospital settings.

The research was systematic and the methodology otherwise rigorous, therefore the results highlighted by this review could serve to support and strengthen the concept of WCC in policy development and planning of maternity services.

The main limit of this study is linked to a potential lack in the research phase of the studies evaluating WCC. The chosen search terms may not have completely identified the multiple interpretations and definitions of WCC as a theoretical construct and the search for studies in English only, with the use of only three databases, and the omission of grey literature could have exacerbated this limitation. It is also worth considering the variability in the planning and organisation of maternity services across low-, middle- and high-income countries, together with cultural differences that are likely to shape the meaning of woman-centred care.

Conclusions and implications for practice

Woman-Centred Care (WCC) represents a cornerstone of high-quality maternity care and should underpin all models of obstetric and midwifery practice. However, the persistent lack of a shared operational definition continues to hinder its consistent implementation across hospital settings. Translating WCC into practice requires a clear articulation of its relational, organisational and professional dimensions. For midwives, this means fostering partnership-based relationships that promote trust, continuity, and informed participation, while maintaining the midwifery philosophy of pregnancy and birth as normal physiological processes.

Supportive management and clinical leadership are essential to embed WCC principles within institutional policies, care pathways, and interprofessional collaboration. Continuous professional development on communication, shared decision-making, and cultural competence can strengthen midwives' ability to operationalise WCC and enhance women's engagement in their own care. In doing so, maternity services can move beyond individual good practice towards a system-wide adoption of woman-centred values.

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Declaration of competing interest

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

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2025.104650.

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