Contents lists available at IOCS

Science Midwifery

journal homepage: www.midwifery.iocspublisher.org

Evaluation of the continuity of care (CoC) development model in midwifery care

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ARTICLE INFO

Article history:

Received Nov 4, 2025
Revised Apr 1, 2026
Accepted Jun 29, 2026

Keywords:

Childbirth
CoC
Midwifery Care
Postpartum
Pregnancy

ABSTRACT

The Continuity of Care (CoC) development model is designed to improve the quality and continuity of midwifery services during pregnancy, childbirth, the postpartum period, infant care, and contraceptive use. Ensuring that these services are safe, effective, timely, efficient, equitable, and woman-centered can enhance maternal and neonatal health outcomes. This study aimed to evaluate the implementation of the CoC development model in midwifery services. A descriptive research design was used to assess the application of the CoC development model in three health centers: Sikumana, Alak, and Bakunase. The study population consisted of midwives working in these areas, selected using purposive sampling. Data were analyzed using univariate analysis. The implementation of the CoC development model in midwifery services was carried out well, though with varying levels of achievement across the stages of care. The implementation during pregnancy was categorized as *very good* (14.87%), during childbirth as *very good* (11.30%), and during the postpartum period as *good* (13.42%). The CoC development model has been effectively implemented in midwifery services, contributing to improved continuity and quality of care for mothers and newborns, although further enhancement is needed to ensure consistency across all stages.

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INTRODUCTION

Maternal mortality remains a major global public health challenge. According to the Sustainable Development Goals (SDGs) 2030, the target for the Maternal Mortality Ratio (MMR) is less than 70 per 100,000 live births, the neonatal mortality rate is at least 12 per 1,000 live births, and the under-five mortality rate is 25 per 1,000 live births (World Health Organization, 2019). Among the ten ASEAN countries, only half have achieved the 2030 SDG targets. Malaysia and Singapore recorded

29 and 8 maternal deaths per 100,000 live births, respectively, whereas Myanmar reported 250 deaths, Laos 185 deaths, and Indonesia 177 deaths per 100,000 live births in 2017 (The World Bank, 2021). Most maternal deaths are preventable because effective healthcare interventions to prevent or manage pregnancy-related complications are already well established (World Health Organization (WHO), 2021; Wuriningsih et al., 2017).

One strategy that has been widely promoted to improve maternal and neonatal outcomes is Continuity of Care (CoC). Continuous midwifery care refers to integrated care provided to women throughout pregnancy, childbirth, the postpartum period, newborn care, and family planning. Studies have demonstrated significant benefits among women who receive CoC services. Woman-centered continuity of care includes emotional support, participation in decision-making, psychological attention, and fulfillment of women's needs and expectations during childbirth (Sandall, 2017, 2018; Sandall et al., 2016). In Indonesia, however, the implementation of CoC remains challenging. A 2021 study conducted at the Sikumana, Alak, and Bakunase Community Health Centers found that CoC services during pregnancy, measured through the implementation of the 10T Antenatal Care (ANC) standards, achieved only 70% coverage (Saleh et al., 2022. Although overall service indicators were met, not all women received continuous care throughout the entire maternal continuum. This condition reflects persisting gaps in the quality of maternal services during pregnancy, childbirth, and the postpartum period, which directly influence the continuity and effectiveness of midwifery services (Tenggara et al., 2020).

Continuity of care is intended to provide safe, respectful, and rights-based services built upon mutual trust between women and healthcare providers. Within the CoC model, each woman should ideally be cared for by a midwife who is part of a small team consisting of four to six community-based midwives who know the woman and her family and can provide continuous support throughout pregnancy, childbirth, and the postpartum period. Antenatal, intrapartum, and postnatal care are primarily delivered by a lead midwife, with support from other midwives and physicians when necessary (Homer, 2016). Furthermore, the CoC development model emphasizes that high-quality continuity of care requires effective clinical and non-clinical interventions, alongside optimal competencies and attitudes among healthcare providers, resulting in improved health outcomes and positive experiences for women and providers. Consequently, CoC services should be safe, effective, timely, efficient, equitable, and woman-centered (Tunçalp et al., 2015, 2017).

Despite growing evidence supporting the benefits of CoC, several important gaps remain inadequately addressed. First, previous studies have predominantly focused on antenatal care coverage rather than evaluating continuity across the entire maternal continuum, including pregnancy, childbirth, postpartum, newborn care, and family planning as an integrated service package. Second, limited evidence exists regarding the determinants that influence successful CoC implementation, including maternal characteristics, family support, accessibility to healthcare facilities, midwives' competencies, workload, and health system readiness. Third, most studies have measured service utilization without comprehensively assessing the quality of care from a woman-centered perspective, such as respectful maternity care, shared decision-making, trust, and women's experiences. Fourth, the feasibility of implementing midwife-led team models within primary healthcare settings, particularly in low- and middle-income countries, remains insufficiently explored. Finally, although CoC is expected to improve maternal and neonatal outcomes, empirical evidence linking the completeness and quality of CoC implementation to measurable maternal and neonatal outcomes in Indonesian primary healthcare settings remains limited.

RESEARCH METHOD

This study employed a quantitative research design with a descriptive approach. The research aimed to describe the variables as they occur naturally, supported by numerical data from actual

conditions. The purpose of this study was to evaluate the implementation of the *Continuity of Care (CoC)* development model in midwifery services.

The population in this study consisted of all midwives working within the service areas of the Sikumana, Alak, and Bakunase Community Health Centers. The sample included respondents who met the inclusion criteria, namely: midwives who routinely provided continuous midwifery care, had a minimum educational qualification of a Diploma III in Midwifery, and had previously served as enumerators or participated in research activities. The exclusion criteria were midwives who were ill or unavailable during the study period. The sampling technique used in this study was purposive sampling.

The study utilized primary data obtained directly from the respondents. The research instrument was a questionnaire designed to assess midwives' opinions and attitudes toward implementing the Continuity of Care (CoC) development model across the antenatal, intrapartum, and postpartum periods. The questionnaire employed a five-point Likert scale consisting of response options: Very Good (VG), Good (G), Fair (F), Poor (P), and Very Poor (VP). Respondents were asked to select the option that best reflected their opinions and experiences related to each statement provided.

Operationally, the implementation of the CoC development model was categorized into five levels based on respondents' scores and the extent to which CoC practices were achieved. A score of 81–100% was categorized as Very Good, indicating that the implementation was highly achieved and consistently practiced; 61–80% was categorized as Good, indicating that the implementation was adequately achieved and generally practiced; 41–60% was categorized as Fair, indicating that the implementation was moderately achieved and inconsistently practiced; 21–40% was categorized as Poor, indicating that the implementation was inadequately achieved and rarely practiced; and 0–20% was categorized as Very Poor, indicating that the implementation was minimally achieved or not practiced at all.

Data analysis was conducted using univariate analysis to describe the characteristics of respondents and the distribution of each variable. The results were presented in the form of frequency tables, percentages, and mean values.

RESULTS AND DISCUSSIONS

This study aimed to evaluate the implementation of the *Continuity of Care (CoC)* development model in midwifery services. A total of 33 respondents participated in the study. The research was conducted at the Sikumana, Alak, and Bakunase Community Health Centers (Puskesmas) from June 11 to August 30, 2025. The results of the study can be seen in the table below:

Table 1. Distribution of respondents by last education and length of work

Category	f	%
Last Education		
Diploma III in Midwifery	29	88
Bachelor of Midwifery	3	9
Master of health	1	3
Length of Work		
< 10 years	14	42
10 – 20 years	15	46
> 20 years	4	12
Total	33	100

Table 1 shows that the majority of respondents held a Diploma III in Midwifery (88%) and had worked for 10–20 years (46%). Education level and length of service are important factors influencing the knowledge, attitudes, and skills of health professionals, including midwives, in delivering high-quality midwifery care. A Diploma III qualification indicates that most

respondents have met the minimum competency standards for midwives in Indonesia. According to the Regulation of the Minister of Health of the Republic of Indonesia No. 28 of 2017 concerning Licensing and Implementation of Midwifery Practice, graduates of Diploma III in Midwifery possess the competencies required to provide essential midwifery services, including antenatal, intrapartum, postpartum, and newborn care.

Higher levels of formal education generally correlate positively with increased knowledge and the ability to apply evidence-based practices. Notoatmodjo (2018) asserts that the higher a person's education, the easier it becomes for them to acquire and develop knowledge, including in the application of safe and effective midwifery care principles. Furthermore, research by (Ramadani et al. (2024) demonstrates that education level is significantly associated with midwives' ability to provide continuity of care. This implies that the higher a midwife's education, the better the quality of care delivered.

Length of service or tenure often serves as an indicator of work experience. Respondents with 10–20 years of service are considered experienced practitioners in midwifery care. Robbins and Judge (2017) note that work experience influences decision-making speed, clinical proficiency, and the capacity to manage complex cases, as individuals learn from previous professional encounters. In the midwifery context, extensive experience enhances clinical sensitivity in identifying maternal and neonatal problems and increases confidence in implementing appropriate interventions (Hilmah et al., 2025). However, Jaoza & Fitria, 2025) and Triana, 2021) emphasize that while experience is crucial, ongoing competency development through continuous professional training remains essential to ensure that midwives stay current with advancements in midwifery science and updated care standards.

Table 2. Implementation of the continuity of care (CoC) during pregnancy

No	Indicator	Mean	Category
1	Comprehensive Continuity of Care (CoC) services	3.70	Good
2	Healthcare services that minimize risks and harm	3.39	Fair
3	Providing care based on current scientific knowledge and evidence-based practice	4.70	Very Good
4	Reducing delays in providing and receiving healthcare services	3.70	Good
5	Optimizing services provided by midwives or midwifery teams during service days	3.61	Good
6	Providing equitable healthcare services to all pregnant women	4.21	Very Good
7	Providing care that considers women's preferences, aspirations, and cultural values	4.30	Very Good
8	Providing psychological support and motivation to pregnant women in every service encounter	3.55	Good
9	Providing consultation and referral services for pregnant women with pathological conditions	3.55	Good
	Overall mean	3.86	Good

Table 1 shows that the overall implementation of Continuity of Care (CoC) during the antenatal phase was categorized as good, with an overall mean score of 3.86. This finding indicates that maternal healthcare services during pregnancy have integrated clinical, psychosocial, and social dimensions of care. The highest score was observed in providing care based on current scientific knowledge and evidence-based practice (mean = 4.70), followed by providing care that considers women's preferences and cultural values (mean = 4.30), and providing equitable healthcare services to all pregnant women (mean = 4.21). In contrast, healthcare practices aimed at minimizing risks and harm received the lowest score (mean = 3.39).

These findings suggest that the implementation of CoC during pregnancy has been well established and reflects the adoption of a comprehensive antenatal care approach that integrates evidence-based practice, woman-centered care, and equitable service delivery. The high performance observed in evidence-based practice indicates that midwives have successfully

incorporated scientific evidence into clinical decision-making processes. Evidence-based antenatal care is considered a fundamental strategy for improving maternal and neonatal outcomes because it enables healthcare providers to deliver safe, effective, individualized, and high-quality care. Symon et al. emphasized that evidence-based practice is one of the essential components underpinning successful continuity of care models. The high score observed in care that considers women's preferences and cultural values also demonstrates the integration of woman-centered care principles into antenatal services. Contemporary maternity care has shifted from provider-centered approaches toward collaborative partnerships that actively involve women in healthcare decision-making. According to Fontein-Kuipers et al. (2019), woman-centered care enhances women's autonomy, promotes shared decision-making, and contributes to positive maternity experiences throughout the reproductive continuum

Despite these strengths, risk reduction and harm prevention received comparatively lower scores than other indicators. This finding suggests that early risk identification, preventive interventions, and comprehensive risk management strategies require further strengthening. The World Health Organization (Tunçalp et al., 2017; World Health Organization (WHO), 2016) emphasizes that high-quality antenatal care should prioritize early risk assessment, timely interventions, regular monitoring of maternal and fetal conditions, and family involvement to prevent maternal and neonatal complications. In the context of midwifery care, continuity during pregnancy is particularly important because it facilitates early detection of complications, improves health education delivery, and enhances maternal preparedness for childbirth.

The findings of this study are consistent with those reported by (Sandall et al., 2024a), who demonstrated that midwife-led continuity of care models improve maternal confidence, reduce unnecessary medical interventions, and increase women's satisfaction with maternity services. Furthermore, sustained relationships between women and midwives strengthen communication, foster trust, and create a supportive environment in which women feel more comfortable discussing their concerns and healthcare needs throughout pregnancy (Sandall, n.d., 2017)

From a practical perspective, these findings indicate that strengthening antenatal Continuity of Care should prioritize improving risk screening systems while maintaining evidence-based, woman-centered, and equitable approaches. Such strategies may contribute to sustaining high-quality maternal healthcare and improving maternal and neonatal outcomes, particularly in geographically diverse settings such as Eastern Indonesia.

Table 3. Implementation of the continuity of care (CoC) during childbirth

No	Indicator	Mean	Category
1	Comprehensive Continuity of Care (CoC) services	4.24	Very Good
2	Healthcare services that minimize risks and harm	3.42	Good
3	Providing care based on current scientific knowledge and evidence-based practice	3.42	Good
4	Reducing delays in providing and receiving healthcare services	4.18	Good
5	Optimizing services provided by midwives or midwifery teams during service days	4.48	Very Good
6	Providing equitable healthcare services to all mother giving birth	4.45	Very Good
7	Providing care that considers women's preferences, aspirations, and cultural values	3.21	Fair
8	Providing psychological support and motivation for mothers in labor in every service encounter.	3.61	Good
9	Providing consultation and referral services for mother in labor with pathological c conditions.	3.73	Good
	Overall mean	3.86	Good

The implementation of Continuity of Care (CoC) during childbirth was categorized as good, with an overall mean score of 3.86. The highest scores were observed in service optimization

by midwives or midwifery teams (mean = 4.48), equitable service delivery (mean = 4.45), and comprehensive CoC services (mean = 4.24). In contrast, care that considered women's preferences and cultural values obtained the lowest score (mean = 3.21).

These findings indicate that CoC during childbirth is primarily characterized by strong teamwork, coordinated service delivery, and integrated maternity care. Childbirth is a critical phase that requires rapid clinical decision-making, effective communication, and timely responses from healthcare professionals. The high score observed in team optimization highlights the importance of collaborative midwifery practice in maintaining continuity throughout labor and delivery. Bradford et al. (2022) reported that small-group midwife continuity models strengthen therapeutic relationships and improve women's childbirth experiences.

Equitable care also emerged as a major strength, suggesting that women received consistent standards of care regardless of their backgrounds. Equitable maternity care is a fundamental principle recommended by the World Health Organization (WHO, 2022) to reduce disparities in maternal outcomes and ensure high-quality maternity services for all women.

However, woman-centered care received comparatively lower scores than other indicators. This finding suggests that clinical priorities during labor may sometimes overshadow women's preferences, expectations, and cultural needs. Similar challenges have been documented globally, where ensuring clinical safety often takes precedence over individualized and respectful maternity care (Miller et al., 2016). Therefore, strengthening communication skills, respectful maternity care practices, and shared decision-making processes should become priorities to optimize Continuity of Care during childbirth. These findings are consistent with those reported by (Renfrew et al., 2014; Sandall et al., 2024b), who demonstrated that midwife-led continuity of care models significantly reduce unnecessary medical interventions, including labor induction, episiotomy, and cesarean section, while increasing the likelihood of spontaneous vaginal birth and maternal satisfaction. Continuous relationships between women and midwives enable healthcare providers to better understand women's clinical histories, personal preferences, and psychosocial needs, thereby facilitating individualized and responsive care.

From a woman-centered care perspective, CoC implementation during labor also strengthens the role of midwives as primary companions who provide not only clinical care but also emotional and informational support. The continuity established between the antenatal and intrapartum periods fosters trust, enhances women's sense of security, and promotes collaborative decision-making between women and midwives. Nevertheless, the slightly lower CoC performance during childbirth compared with the antenatal phase may be associated with several practical challenges, including workforce shortages, shift rotations, and emergency situations that require referral to higher-level healthcare facilities. The effectiveness of CoC during labor therefore depends not only on individual midwives but also on integrated management systems and effective referral coordination (NSW Ministry of Health, 2023).

Overall, the findings suggest that CoC during childbirth has been effectively implemented and reflects strong professional relationships between women and midwives as well as integrated maternity care services. Future improvement efforts should prioritize strengthening interprofessional coordination, preserving woman-centered approaches, and maintaining service continuity during emergency and referral situations.

Table 4. Implementation of the continuity of care (CoC) during the postpartum phase

No	Indicator	Mean	Category
1	Comprehensive Continuity of Care (CoC) services	3.06	Fair
2	Healthcare services that minimize risks and harm	3.67	Good
3	Providing care based on current scientific knowledge and evidence-based practice	3.30	Fair
4	Reducing delays in providing and receiving healthcare services	3.61	Good
5	Optimizing services provided by midwives or midwifery teams during service days	3.06	Fair

No	Indicator	Mean	Category
6	Providing equitable healthcare services to all postpartum mother	3.39	Fair
7	Providing care to postpartum mother that considers their preferences, aspirations, and cultural values	4.24	Very Good
8	Providing psychological support and motivation for postpartum mothers in every service encounter.	4.06	Good
9	Providing consultation and referral services for postpartum mother with pathological conditions.	4.18	Good
	Overall mean	3.62	Good

Based on Table 3, the postpartum phase demonstrated the lowest overall Continuity of Care (CoC) score compared with the antenatal and intrapartum phases, with an overall mean score of 3.62. The highest scores were observed in care that considered women's preferences and cultural values (mean = 4.24), consultation and referral services (mean = 4.18), and psychological support (mean = 4.06). In contrast, comprehensive CoC implementation and service optimization by midwives received the lowest scores (mean = 3.06).

These findings indicate that maintaining continuity after childbirth remains one of the greatest challenges within the maternal continuum. Although the overall implementation was categorized as good, the lower scores compared with the antenatal and intrapartum phases suggest that continuity of care tends to decline once women return home after delivery. This pattern highlights a potential gap between facility-based maternity services and community-based follow-up care. The strong performance observed in woman-centered care and psychological support suggests that midwives recognize the multidimensional needs of postpartum women. During this period, women simultaneously experience physical recovery, emotional adjustment, breastfeeding adaptation, and changes in family and social roles. Therefore, postpartum care should extend beyond clinical assessment to include emotional, informational, and social support.

However, the lower scores for overall continuity and service optimization indicate potential fragmentation of postpartum services. This finding is consistent with the World Health Organization (WHO, 2022), which reported that postpartum care remains one of the most neglected components of maternal healthcare globally, even though a substantial proportion of maternal complications occur within the first six weeks after childbirth.

Within the CoC framework, continuity during the postpartum phase means that midwives continue providing support and monitoring to the same women they assisted throughout pregnancy and childbirth. Sustained relationships between women and midwives foster trust, improve communication, and strengthen individualized care. Previous studies have shown that continuity of care during the postpartum period enhances maternal satisfaction, supports recovery, and promotes successful breastfeeding and mother–infant bonding (NSW Ministry of Health, 2023; Sandall, 2018). Nevertheless, several barriers may hinder optimal implementation, including the low frequency of postpartum visits, workforce shortages, and limited maternal awareness regarding the importance of follow-up care. Similar findings were reported by (Rayment-Jones et al., 2020), who emphasized that sustained relationships between women and midwives significantly contribute to improving maternal well-being after childbirth.

Overall, these findings suggest that postpartum care should become a strategic priority for strengthening Continuity of Care. Expanding home visit programs, implementing digital follow-up systems, and increasing family involvement in maternal and newborn care may help sustain continuity beyond childbirth and improve maternal health outcomes.

CONCLUSION

The implementation of Continuity of Care (CoC) was generally categorized as good across the antenatal, intrapartum, and postpartum phases. However, each phase demonstrated different

strengths and challenges. Evidence-based practice was the strongest component during pregnancy, while teamwork optimization and equitable service delivery were prominent during childbirth. In contrast, the postpartum phase showed the lowest overall performance, indicating challenges in maintaining continuity of care after women return home. These findings suggest that CoC implementation is dynamic across the maternal continuum and requires phase-specific strengthening strategies. Improving risk assessment during pregnancy, integrating woman-centered care during childbirth, and prioritizing postpartum follow-up services may enhance the quality and sustainability of maternal healthcare. Strengthening Continuity of Care through integrated, culturally responsive, and woman-centered approaches has the potential to improve maternal health outcomes, particularly in underserved settings such as Eastern Indonesia.

ACKNOWLEDGEMENTS

The research team would like to express their deepest gratitude to Poltekkes Kemenkes Kupang for the financial support provided through the 2025 research grant. The authors also extend sincere appreciation to the midwives and all staff members of the community health centers who participated and made valuable contributions to the implementation of the evaluation of the Continuity of Care (CoC) development model in midwifery services.

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