Description

Midwifery Units: Features and Function

Louisa Hope Jackson (she/her) – Research and Implementation, City St George's, University of London

Laura Batinelli (she/her) – Senior Lecturer, City St George's, University of London

Published in The Practising Midwife Volume 29 Issue 3 May 2026, Pages 14-17

https://doi.org/10.55975/JTQH9821

Summary

Midwifery Units (MUs) are supported by substantial evidence demonstrating better outcomes, high service-user satisfaction and cost-effectiveness. Despite the benefits, their provision and utilisation remain limited and vary greatly across health systems. Emerging research addresses the organisational, professional and social factors shaping the implementation and sustainability of MUs. This article presents MU definitions, key characteristics and their significance in the current state of maternity care systems.



Introduction

Midwifery units (MUs) provide maternity care for healthy low-risk pregnancies, where being midwife-led is central to their function. MUs are supported by substantial evidence demonstrating better outcomes, high service-user satisfaction and

cost-effectiveness. Despite the benefits, their provision and utilisation remain limited and vary greatly across health systems. Emerging research addresses the organisational, professional and social factors shaping the implementation and sustainability of MUs. This article presents MU definitions, key characteristics and their significance in the current state of maternity care systems.

Definition and types of midwifery units

Midwifery units (MUs) offer maternity care to healthy women and birthing people with straightforward pregnancies in which midwives take primary professional responsibility for care. MUs may be freestanding or alongside an obstetric service.[1,2]

MUs are designed to support physiological birth, promote personalised care and provide an alternative to obstetric-led hospital units.

The terminology 'midwifery unit' was formally adopted in England during the Birthplace Study in England[3] and later in the Midwifery Unit Standards for Europe.[2] The term replaced 'birth centre', which was viewed as focusing too narrowly on intrapartum care.[4] 'Midwifery unit' better reflects the broader scope of these services, which include antenatal and postnatal care, positioning MUs as community hubs throughout the maternity journey.

Globally, MUs may also be known as birth centres, midwifery centres, maternity homes or family centres, with variations shaped by physical space, organisation, midwifery autonomy and cultural understandings of safety.[5] Regardless of terminology, all MUs share defining features: a bio-psycho-social philosophy of care, being midwife-led, having clear referral pathways and full integration with the wider health system to ensure responsive, safe and holistic care for women and babies.

The purpose and philosophy of MUs

MUs embody a bio-psycho-social philosophy of care, acknowledging that emotional safety, trust and supportive relationships influence birth outcomes.[6,7] The model of care underpinning MUs is relational-based and midwife-led, which recognises childbirth as a physiological and transformative process rather than a medical event.

The spatial design and sensory qualities of birth environments can significantly shape health outcomes, as they may either support or hinder physiological processes in labour and influence the likelihood of medical intervention.[8,9]

The Goodbirth Network identified three pillars of effective midwifery centers: a midwifery-led philosophy, timely risk assessment and strong integration within the healthcare system.[5] These principles aligned with the Midwifery Unit Standards for Europe, which position MUs as hubs of woman-centred, relationship-based and evidence-informed care. In contexts where midwifery autonomy is still developing, these standards help raise the profile of the midwifery profession and strengthen its role within safe, high-quality maternity care systems.[2]

Why midwifery units matter

Extensive international evidence confirms that MUs are safe, effective and cost-effective for people with uncomplicated pregnancies. The Birthplace in England study[3] demonstrated that both Alongside Midwifery Units (AMUs) and Freestanding Midwifery Units (FMUs) provide equivalent safety for babies and better clinical outcomes for mothers compared with obstetric-led units. Women planning birth in MUs were more likely to have a spontaneous vaginal birth, initiate breastfeeding and experience fewer medical interventions.

Systematic reviews have reinforced these findings: Scarf, et al.,[10] reported significantly lower odds of intervention and severe morbidity for women planning birth in MUs or at home; and Reitsma, et al.,[11] highlighted improved outcomes where midwifery-led care is well integrated within the healthcare system. Economic analyses also confirm that MUs represent a more efficient use of resources.[12]

Beyond maternal and neonatal outcomes, MUs are invaluable learning environments. They provide student and newly qualified midwives with the opportunity to develop expertise in physiological care, communication and continuity within a setting that supports autonomous midwifery practice.[13] MUs act as hubs for professional learning and reflective practice, nurturing confidence and competence in midwives and the MD team.

> "Women planning birth in MUs were more likely to have a spontaneous vaginal birth, initiate breastfeeding and experience fewer medical interventions."

Defining a well-functioning midwifery unit

Functionality within a midwifery unit refers to how effectively the unit's systems, environment and relationships work together to provide safe, effective and evidence-based care. A well-functioning MU achieves a balance between structure: the organisational elements of governance, leadership and policy, and culture: encompassing shared philosophy, professional relationships and client-centred care.[14,15]

A well-designed physical space, bio-psycho-social philosophy of care, continuity of care and effective leadership can support the delivery of personalised, relational care. The ability to integrate or collaborate with broader healthcare systems and having established referral pathways further strengthens safe delivery of care and professional collaboration, while maintaining the distinct identity of the midwifery unit.[16,17]

Professional autonomy of the midwife and self-determination of the service user are synonymous with the midwifery model of care and lend to professional satisfaction and staff retention.[7,18] Understanding the elements that contribute to midwifery unit functionality can support MU implementation and ongoing improvement, increasing successful and sustainable MU models.

Core characteristics of well functioning midwifery units

Purposeful environment

A well-functioning midwifery unit is characterised by a physical environment that enables both the philosophy and practice of midwifery-led care. A home-like atmosphere and an unhurried pace is associated with the facilitation of physiological birth and positive care relationships.[18,19,20] Spaces that are purposefully designed to promote calm and privacy through low lighting, music and equipment such as birthing pools, gym mats, balls and stools invite intuitive movement and mobility in labour. An environment that evokes feelings of warmth, comfort and confidence can shape the practice culture within an MU.

Designing the configuration of rooms to allow midwives to remain with families post-birth supports the transition to parenthood and reinforces the unit's nurturing ethos.[21] Time and thoughtful design underpin not only the quality of interpersonal care but also the unit's overall functionality by allowing midwives to work responsively and attentively.[15,19]

The location of the MU further contributes to its operation. Well-defined boundaries are vital for protecting the midwifery model of care and maintaining professional autonomy.[16,21]

Cohesive workforce

Strong interprofessional relationships are consistently linked to effective functioning and sustainability. Collaboration between midwives, obstetricians and other professionals enhances coordination, satisfaction and quality of care.[17] Key facilitators include clear role definition, supportive protocols and familiarity among colleagues.[21] Strong leadership and governance are pivotal to the operational quality of the MU. Visible, supportive leaders cultivate confidence and collaboration within teams, while mitigating hierarchical constraints.[7] Leadership roles enhance professional visibility across hospital systems, enabling cross-pollination of expertise and influencing care culture beyond the MU itself.[17]

Adequate and appropriate staffing models ensure the sustainability of midwife-led care and maintain safety and quality.[15] Balance between workload, cost-effectiveness and the preservation of core midwifery principles is critical to function.[21] Models that allow flexibility, self-management of timetables and sufficient staff numbers promote continuity and a sense of professional ownership.[19,22]

Bio-psycho-social model of care

At the heart of well-functioning MUs lies a shared bio-psychosocial philosophy grounded in holistic, person-centred care. Midwives' happiness and sense of professional identity are increased by working within settings that reflect their

philosophy.[18] Midwifery units can provide a cohesive philosophy by centring a relational-based midwifery model of care, considering the emotional and social experience of service-users alongside their physical care needs.[21,22]

Continuity of care embodies this philosophy in action. Identified across numerous studies as essential to MU function, continuity fosters familiarity and trust.[7,19] Both provider continuity and continuity of philosophy contribute to a sense of safety and belonging.

Service user autonomy and supported decision-making reflect the culmination of all preceding characteristics. Equal partnerships and thorough informed consent are central to high quality, personalised care.[20,23] Respect for agency, collaboration and cultural inclusion reinforces the MU as a space where service users feel safe, recognised and empowered.[24]

Conclusion

Midwifery units are essential to a safe and sustainable maternity system, supporting physiological birth while offering relational, personalised care and genuine birthplace choice. They are not optional add-ons but protected spaces where midwives practise to their full scope, develop expertise in physiology, and where future midwives learn that birth is not inherently pathological. Their effectiveness depends on supportive operational models, strong multidisciplinary collaboration and system-level commitment within integrated maternity services. As evidence continues to demonstrate their benefits, midwifery units must be protected, resourced and championed. Embedded within the maternity system, they safeguard healthy pregnancies from unnecessary medicalisation while ensuring equitable access to high-quality, evidence-based care. **TPM**

> “Midwifery units are essential to a safe and sustainable maternity system, supporting physiological birth while offering relational, personalised care and genuine birthplace choice.”

References

1. Rowe R, Kurinczuk JJ, Locock L, Fitzpatrick R. Birthplace terms and definitions: consensus process. Birthplace in England research programme. Final Report part 2. https://www.npeu.ox.ac.uk/assets/ downloads/birthplace/Birthplace_Report_2_-_Terms_and_definitions. pdfx6yW34J3BqxT5e83S. NIHR Service Delivery and Organisation Programme. Published November, 2011.
2. Rocca-Ihenacho L, Batinelli L, Thaels E, Rayment J, Newburn M, McCourt C. Midwifery Unit Standards. City, University of London. https://www. midwiferyunitnetwork.org/wp-content/uploads/PDFs/LY1309BRO-MUNEtStandards-PRINT-opt.pdf. Published 2018.
3. Hollowell J, Puddicombe D, Rowe R, et al. Perinatal and maternal outcomes by planned place of birth. BMJ. 2011;343:d7400. doi.org/10.1136/ bmj.d7400.
4. Ackerman BP, Cooke P, Hutcherson A. Standards for birth centres in England. RCM. Published 2009.
5. Stevens JR, Alonso C. Commentary: creating a definition for global midwifery centers. Midwifery. 2020;85:102684. doi.org/10.1016/j. midw.2020.102684.
6. Walsh D, Spiby H, McCourt C, et al. Mapping midwifery and obstetric units in England. Midwifery. 2018;56:9-16. doi.org/10.1016/j. midw.2017.09.009.
7. Rocca-Ihenacho L, Yuill C, McCourt C. Relationships and trust: Two key pillar of a well-functioning freestanding midwifery unit. Birth. 2021;48(1):104-113. doi.org/10.1111/birt.12521.
8. Aburas R, Pati D, Casanova R, Adams NG. The influence of nature stimulus in enhancing the birth experience. HERD. 2017;10(2):81-100. doi. org/10.1177/1937586716665581.
9. Setola N, Iannuzzi L, Santini M, et al. Optimal settings for childbirth. Minerva Ginecol. 2018;70(6):687-699. doi.org/10.23736/s0026- 4784.18.04327-7.
10. Scarf VL, Rossiter C, Vedam S, et al. Maternal and perinatal outcomes by planned place of birth in high-income countries: a systematic review and meta-analysis. Midwifery. 2018;62:240-255. doi.org/10.1016/j. midw.2018.03.024.
11. Reitsma A, Simioni J, Brunton G, kaufman K, Hutton EK. Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses eClinicalMedicine. 2020;21:100319. doi.org/10.1016/j.eclinm.2020.100319.
12. Schroeder E, Petrou S, Patel N, et al. Cost effectiveness of alternative planned places of birth. BMJ.

2012;344:e2292. doi.org/10.1136/bmj.e2292.
13. Hunter B, Fenwick J, Sidebotham M, Henley J. Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors. Midwifery. 2019;79:102526. doi.org/10.1016/j.midw.2019.08.008.
14. Behruzi R, Klam S, Dehertog M, Jimenez V, Hatem M. Understanding factors affecting collaboration between midwives and other health care professionals in a birth center and its affiliated Quebec hospital: a case study. BMC Pregnancy Childbirth. 2017;17:1-14. doi.org/10.1186/s12884- 017-1381-x.
15. McCourt C, Rance S, Rayment J, Sandall J. Organising safe and sustainable care in alongside midwifery units: Findings from an organisational ethnographic study. Midwifery. 2018;65:26-34. doi. org/10.1016/j.midw.2018.06.023.
16. Remvik-Larsen L, Gran AMW, Dahl B. Midwives' experiences facilitating normal birth in midwifery units. Eur J Midwifery. 2023;7:40. doi. org/10.18332/ejm/173388.
17. Murray-Davis B, Grenier LN, Malott AM, et al. Exploring midwives' experiences within Canada's first alongside midwifery unit: impacts and implications for midwifery practice. J Midwifery Womens Health. 2025;70(3):486-493. doi.org/10.1111/jmwh.13740.
18. Norris S, Murphy F. A community of practice in a midwifery-led unit. How the culture and environment shape the learning experience of student midwives. Midwifery. 2020;86:102685. doi.org/10.1016/j. midw.2020.102685.
19. Nørstebø HS, Nilsen ABV, Blix E, et al. Births in freestanding midwiferyled units in Norway. What women view as important aspects of care. Sex Reprod Healthc. 2023;36:100857. doi.org/10.1016/j.srhc.2023.100857.
20. Murray-Davis B, Grenier LN, Mattison CA, et al. Promoting safety and role clarity on Canada's first alongside midwifery unit (AMU). A mixed-methods evaluation. Midwifery. 2022;111:103366. doi.org/10.1016/j. midw.2022.103366.
21. Rocca-Ihenacho L An Ethnographic Study of the Philosophy, Culture and Practices Within an Urban Freestanding Midwifery Unit: Part 2 – Staff Perspectives. TPM. 2023;26(10):26-30. doi.org/10.55975/XDKI4487.
22. MacDougall C, Johnston K. Client experiences of expertise in midwifery care in New Brunswick, Canada. Midwifery. 2022;105:103227. doi. org/10.1016/j.midw.2021.103227.
23. Shakes R, Sidebotham M, Donnellan-Fernandez R. Birth houses in Australia: discovery of safe, transformative birthplaces. Women Birth. 2024;37(6):101831. doi.org/10.1016/j.wombi.2024.101831.
24. McCourt C, Rayment J, Rance S, Sandall J. Place of birth and wellbeing. Anthropol Action. 2016;23(3):17-29. doi.org/10.3167/aia.2016.230303.

Category

1. Basics
2. TPM Articles
3. TPM Journal

Tags

1. 2026
2. midwifery led units
3. midwifery-led
4. midwifery-led care

Date Created
5th May 2026