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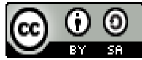

The Effectiveness of Continuity of Care in Improving Postpartum Maternal Care

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Abstract. *The postpartum period is a decisive phase in the maternal continuum, because the first weeks after birth determine whether women recover safely, establish breastfeeding, recognise danger signs, and regain physical and psychological well-being. Yet postpartum care remains fragmented in many settings, with discontinuity between pregnancy, birth, and postnatal services. This systematic literature review examined the effectiveness of continuity of care in improving postpartum maternal care, focusing on maternal outcomes, breastfeeding, psychosocial well-being, care experience, and service quality. The review was prepared using PRISMA 2020 reporting principles and a structured search of publications indexed between 2021 and 2025 in major health databases and authoritative institutional sources. Studies discussing midwifery continuity, caseload care, team continuity, and integrated postnatal follow-up were screened and narratively synthesised. The evidence consistently showed that continuity of care was associated with better postpartum service engagement, stronger breastfeeding outcomes, greater maternal satisfaction, improved emotional support, and lower levels of anxiety and depressive symptoms. Several studies also reported lower intervention rates during labour and better neonatal indicators, which indirectly supported healthier postpartum recovery. However, effectiveness depended on relational continuity, manageable caseloads, interdisciplinary referral pathways, and supportive health systems. This review concludes that continuity of care is an effective strategy for improving postpartum maternal care and should be strengthened through midwife-led, woman-centred, and integrated care models, especially in settings where routine postnatal care is still fragmented or underutilised.*

Keywords*: Continuity Of Care, Maternal Health, Midwifery, Postnatal Care, Postpartum.*

1. BACKGROUND

Postpartum maternal care is increasingly recognised as a central determinant of maternal survival, functional recovery, newborn well-being, breastfeeding success, and long-term family health. The postnatal period is not merely a short recovery stage after childbirth (Fox-Harding, 2024). It is a biologically and socially complex phase marked by uterine involution, wound healing, breastfeeding initiation, hormonal adjustment, sleep disruption, pain, fatigue, and role transition (Azarkish & Janghorban, 2023). The World Health Organization has emphasised that postnatal care should move beyond a narrow focus on survival and include a positive postnatal experience characterised by effective clinical care, emotional support, responsive communication, family involvement, breastfeeding support, mental health attention, and timely referral when complications arise (Christiansen et al., 2023).

Despite this recognition, postpartum care in routine practice is frequently fragmented (Fitzgerald, Kang, & Black, 2025). Many women receive separate antenatal, intrapartum, and postnatal services from different providers, in different places, and with inconsistent communication across levels of care (Willis et al., 2025). In fragmented systems, important

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information can be lost between discharge and follow-up, mothers may not understand warning signs, and opportunities for lactation counselling, psychological screening, contraceptive counselling, and newborn support may be missed (Kusumaningrum, Nursalam, Triharini, & Soares, 2025). This discontinuity is especially problematic in the first six weeks after birth, when postpartum haemorrhage, infection, hypertensive disorders, breastfeeding difficulties, depression, and anxiety can emerge or worsen (Aksari & Sukmawati, 2022).

Continuity of care has therefore become an important organising principle in maternal and newborn health. In the maternity context, continuity of care generally refers to sustained, coordinated, and relationship-based care provided across pregnancy, labour, birth, and the postpartum period by the same midwife or a small known team of providers. The concept includes relational continuity, informational continuity, and management continuity. Relational continuity allows trust and familiarity to develop between women and providers; informational continuity ensures that history, preferences, risks, and prior decisions are consistently available; and management continuity ensures that care plans remain coherent across episodes of care. These dimensions are highly relevant to postpartum care because recovery after birth requires both technical assessment and sustained personal support (Silvia et al., 2022).

Continuity-based models, especially midwife-led caseload or team midwifery models, have been studied for their effects on birth interventions, maternal satisfaction, preterm birth, breastfeeding, mental health, and care utilisation. Earlier evidence already suggested that women who receive midwife-led continuity of care are less likely to experience unnecessary intervention and more likely to report positive care experiences. More recent evidence has extended this discussion by examining continuity models in diverse health systems, vulnerable populations, regional service networks, and women with psychosocial or medical complexity. These newer studies are particularly important because they help translate the continuity concept into practical postpartum service improvement (Sukmawati, Wijaya, & Hilmanto, 2024).

The urgency of this topic is reinforced by the fact that postpartum care is often the least utilised component of the maternal continuum, especially in low-resource or transition settings. Policy discussions still focus heavily on antenatal coverage and facility birth, while postpartum contact quality, frequency, and continuity remain uneven. Even when women attend services, the content of care may be incomplete, and their subjective needs may be overlooked. A review of quality measures for postnatal care has shown that many health systems still lack comprehensive tools to measure women’s actual experiences, continuity, and functional

recovery. As a result, postpartum improvement efforts may overlook the relational and coordination elements that make services meaningful and effective.

From a professional standpoint, continuity of care also highlights the strategic role of midwives. Midwives are uniquely positioned to integrate preventive, promotive, supportive, and referral functions across the maternal journey. In postpartum care, midwives assess bleeding, pain, breastfeeding, mental health, neonatal adaptation, family support, and birth spacing needs while also serving as educators and advocates. When continuity is present, this role becomes stronger because care is not reduced to isolated clinical encounters. Instead, the midwife can anticipate postpartum needs based on antenatal and intrapartum knowledge, provide tailored support, and identify deviations from normal recovery earlier.

The novelty of the present review lies in its specific focus on continuity of care as a strategy for improving postpartum maternal care, rather than maternity care in a broad sense. Many reviews discuss continuity across the entire perinatal period or focus primarily on labour and birth outcomes such as caesarean section or preterm birth. Although those outcomes matter, postpartum maternal care deserves independent attention because it is the phase in which women translate their birth experience into recovery, caregiving confidence, breastfeeding practice, and emotional adaptation. A postpartum-focused synthesis is therefore needed to clarify how continuity contributes to postnatal care quality, maternal well-being, and service effectiveness.

Based on that gap, this article aimed to systematically review the effectiveness of continuity of care in improving postpartum maternal care. The review specifically examined how continuity-based models influence postpartum follow-up, breastfeeding, maternal satisfaction, psychosocial health, service responsiveness, and broader maternal-neonatal outcomes that shape recovery after childbirth.

2. THEORETICAL REVIEW

The theoretical foundation of continuity of care is rooted in person-centred care, quality of care, and integrated service delivery. Person-centred care emphasises that women should receive respectful, responsive, and tailored care that reflects their needs, values, and preferences. In the postpartum context, person-centredness requires more than checking vital signs or documenting uterine involution. It requires listening to women’s concerns, supporting feeding choices, acknowledging fatigue and emotional strain, involving families where appropriate, and ensuring that women know when and how to seek further care.

Continuity of care complements this perspective by making care more coherent over time. Relational continuity builds trust and reduces the emotional burden of repeatedly retelling one's story to new providers. Informational continuity protects clinical safety by ensuring that key information, such as birth complications, anaemia, perineal trauma, mental health history, or breastfeeding difficulties, is carried into the postpartum phase. Management continuity strengthens coordination and prevents fragmented advice. In maternal health, these functions are mutually reinforcing and can improve both experience and outcome.

The Quality Maternal and Newborn Care perspective also supports continuity as a mechanism for better postpartum care. This framework proposes that quality care should combine preventive and supportive practices, strengthen women's capabilities, avoid unnecessary intervention, and ensure a healthy start for newborns. Continuity-based midwifery models align closely with this philosophy because they integrate education, surveillance, psychosocial support, and referral across the continuum. Rather than treating postpartum visits as isolated tasks, continuity models conceptualise the postpartum period as part of an ongoing relationship between the woman, her family, and the care team.

Another useful lens is the continuum-of-care framework in public health. This framework traditionally links care across time, from pre-pregnancy to pregnancy, childbirth, the postnatal period, and childhood, as well as across places of care such as home, community, and facility. However, continuity of care adds a relational and organisational layer to the continuum. It is not only about whether services exist at different time points, but also about whether women experience them as connected, consistent, and intelligible. This distinction matters because postpartum dropout may occur not only from lack of access, but also from poor trust, conflicting advice, or weak follow-up systems.

Theories of therapeutic relationship and social support are equally relevant. Known-caregiver relationships can reduce anxiety, improve disclosure of symptoms, and enhance adherence to postpartum recommendations. Emotional safety may encourage women to discuss breastfeeding pain, depressive symptoms, sexual health concerns, domestic strain, or contraception preferences that they might not disclose in impersonal settings. In this way, continuity functions not only as a service arrangement but also as a psychosocial intervention embedded in routine care (Firoz et al., 2022; Sukmawati et al., 2024).

Previous studies have examined continuity models from several angles. Reviews of midwife-led continuity care have consistently identified lower intervention rates and improved women's experiences. Scoping work has shown that continuity models have been implemented in both high-income and low- and middle-income settings, with variation in team structure,

caseload size, risk criteria, and service integration. Emerging studies among women with mental health conditions, social disadvantage, or preterm birth risk suggest that continuity may be particularly valuable for women who need coordination, advocacy, and sustained support. Nevertheless, the postpartum-specific mechanisms of benefit are still not always unpacked in detail.

3. RESEARCH METHOD

This article used a systematic literature review design to examine the effectiveness of continuity of care in improving postpartum maternal care. The review was prepared in line with the PRISMA 2020 reporting approach. A structured search strategy was developed using combinations of the following terms: continuity of care, midwifery continuity, caseload midwifery, postpartum care, postnatal care, maternal outcomes, breastfeeding, maternal mental health, and maternal satisfaction. The search prioritised recent publications from 2021 to 2025 and was complemented by key guideline and framework papers necessary to interpret continuity and postnatal care quality.

The review considered articles from indexed journal databases and authoritative institutional sources that discussed continuity-based maternal care models with relevance to the postpartum period. Eligible studies included systematic reviews, scoping reviews, cohort studies, quasi-experimental studies, mixed-method studies, and implementation evaluations. The inclusion criteria were: (1) studies addressing continuity of care in maternity or midwifery services; (2) studies reporting postpartum maternal care outcomes directly or indirectly related to recovery, breastfeeding, psychosocial well-being, or women's experience; (3) studies published in English; and (4) studies with sufficient methodological description and findings to allow narrative synthesis. Editorials, opinion pieces, and studies without relevance to postpartum outcomes were excluded.

Titles and abstracts were screened for relevance, followed by full-text review when sufficient information was available. The final synthesis prioritised studies that represented different methodological approaches and health-system contexts, including evidence from systematic reviews, implementation studies, cohort studies, and regional model evaluations. Data extraction focused on the author, year, country or setting, study design, continuity model, postpartum-related outcome domains, and principal conclusions.

Because the included studies were heterogeneous in design, intervention components, and reported outcomes, meta-analysis was not attempted in this manuscript. Instead, a narrative synthesis approach was used. Findings were grouped into four domains: clinical and service

outcomes, breastfeeding and newborn-related outcomes, psychosocial and experiential outcomes, and implementation or health-system implications. This approach made it possible to compare studies that used different outcome measures while still identifying consistent patterns relevant to postpartum maternal care.

Quality appraisal was conducted pragmatically by considering study design strength, clarity of methods, coherence of findings, and consistency with broader evidence. Systematic reviews and controlled observational studies were treated as higher-level evidence, while implementation reports and descriptive evaluations were used to enrich contextual interpretation. The main limitation of the method is that postpartum outcomes were not always the primary endpoint in the included studies; therefore, some conclusions were drawn from broader continuity models that covered the entire perinatal period. Even so, those studies remain relevant because postpartum maternal care is an integral component of the continuity pathway.

4. RESULTS AND DISCUSSION

Study characteristics

The studies reviewed show that continuity of care is not a single uniform intervention. It includes caseload midwifery, team midwifery, regional continuity models integrated across several birthing sites, and targeted programmes for women with mental health conditions or preterm birth risk. The evidence base also includes guideline papers and measurement reviews that clarify what quality postnatal care should contain. This diversity is useful because postpartum care improvement depends not only on whether continuity works in principle, but also on how it is operationalised within real health systems.

A general pattern across the literature is that continuity models perform well when they provide sustained provider relationships, clear referral pathways, and follow-up that extends beyond the birth event. Where continuity is reduced to name-only assignment without accessible contact, manageable workload, or postpartum connection, the expected benefits become weaker. Thus, the organisational design of the model matters as much as the continuity label itself.

Table 1. *Summary of studies included in the narrative synthesis (continued).*

Study	Design	Continuity model focus	Main postpartum-related contribution
Kuipers et al. (2025)	Systematic review and meta-analysis	Midwife continuity of care across	Higher spontaneous vaginal birth; lower

		pregnancy, birth, and postpartum	caesarean, induction, preterm birth, low birthweight, and neonatal admission
Cibralic et al. (2023)	Systematic review	Midwifery continuity and maternal mental health	Improved maternal anxiety, worry, and depressive symptoms during the perinatal period
Turienzo et al. (2023)	Process evaluation of pilot trial	Continuity pathway linked with specialist obstetric clinic	Model was feasible, acceptable, and implementable with high fidelity
Adelson et al. (2023)	Regional model evaluation	Caseload midwifery across five sites	Positive women's experiences and favourable birth outcomes in integrated regional services
Shahinfar et al. (2024)	Quasi-experimental study	Team midwifery continuity	Higher vaginal birth and exclusive breastfeeding; better neonatal indicators
Cummins et al. (2024)	Cohort study	Continuity for women with perinatal mental health conditions	Associations with breastfeeding and vaginal birth, and lower intervention risk
Lundborg et al. (2024/2025)	Matched cohort study	Midwifery continuity during pregnancy, birth, and postpartum	Lower intervention rates and improved selected maternal outcomes
Bradford et al. (2022)	Scoping review	Global midwifery continuity models	Positive outcomes across settings, with strong variation in implementation

Galle et al. (2023)	Scoping review	Measures of postnatal care quality	Measurement gap remains for experience, continuity, and content of postnatal care
Larsson et al. (2022)	Observational study	Continuity and fulfilment of expectations	Continuity mattered to women and supported more positive birth/postpartum experiences
Hildingsson et al. (2021)	Experimental cohort	Continuity of midwifery care	Improved childbirth experience, likely shaping postpartum confidence and recovery
Al Hadi et al. (2022)	Review of postnatal follow-up	Women's utilisation and satisfaction with postnatal care	Satisfaction depends on accessibility, information, responsiveness, and continuity
Lundborg et al. (2025)	Matched cohort study	Midwifery continuity during pregnancy, birth, and postpartum	Lower intervention rates and improved selected maternal outcomes

Continuity of care and postpartum service quality

One of the clearest messages from the literature is that continuity improves the quality and coherence of postpartum services. The WHO postnatal care guideline highlights that women and newborns need coordinated contacts, effective counselling, and individualised support during the postnatal period. Continuity-based models are well aligned with these requirements because the same provider or small team can track unresolved issues from pregnancy and labour into the postnatal phase. This reduces duplicated assessment, contradictory advice, and delays in recognition of complications.

The review by Galle and colleagues is especially important for interpreting these findings. Their work demonstrated that although many measures of postnatal care exist, substantial gaps remain in capturing women's actual experiences of quality, continuity, and support. This means that conventional service indicators may underestimate the value of continuity. A woman may technically receive a postpartum visit, but if the encounter is rushed, impersonal, or disconnected from prior care, the quality of that contact may be low. Continuity therefore improves quality not merely by increasing contact, but by increasing the relational and informational value of each contact.

In practical terms, continuity supports better discharge preparation, clearer postnatal instructions, more efficient referral, and better follow-up adherence. Women who know their provider are more likely to ask questions, seek help earlier, and return for follow-up when symptoms persist. From a systems perspective, continuity can reduce fragmentation costs by improving care planning and decreasing missed opportunities in postpartum counselling, especially for breastfeeding, contraception, mood symptoms, and danger-sign awareness.

Effects on maternal clinical outcomes

The strongest quantitative synthesis in recent years is the 2025 meta-analysis by Kuipers and colleagues, which found that midwife continuity of care was associated with a higher likelihood of spontaneous vaginal birth and lower risks of caesarean section, labour induction, episiotomy, preterm birth, low birthweight, low Apgar scores, and neonatal admission. Although several of these outcomes occur before the postpartum period, they are highly relevant to postpartum maternal care. A woman who experiences fewer interventions, less surgical morbidity, and fewer neonatal complications begins the postpartum period with a lower burden of recovery and caregiving stress.

Clinical postpartum recovery is influenced by the pathway leading to birth. For example, avoidance of unnecessary caesarean section may reduce pain, mobility restrictions, wound complications, and dependence in the early postnatal period. Lower preterm birth and neonatal admission also decrease maternal separation, stress, and breastfeeding disruption. Thus, continuity of care improves postpartum maternal care both directly through follow-up and indirectly through healthier intrapartum and neonatal trajectories (Wu, Lu, & Tsay, 2023).

Evidence from observational and quasi-experimental studies supports this interpretation (Lee et al., 2022). Shahinfar and colleagues reported that women receiving team midwifery care had significantly higher rates of normal vaginal birth and exclusive breastfeeding, and their newborns showed better selected indicators than those receiving routine care. Likewise, regional evaluations of caseload models have found positive women's experiences and

acceptable birth outcomes, suggesting that continuity can be implemented beyond single urban pilot sites (Cai, Lu, Kang, & Chen, 2025).

However, the literature also shows that effect sizes depend on context. Continuity is not a magic intervention that removes all risk. Women with medical or psychosocial complexity still require specialist input, and continuity models must operate with clear pathways for escalation. The POPPIE process evaluation is instructive here: the model combined continuity with access to specialist obstetric support and was found feasible and acceptable. This suggests that postpartum maternal care improves most when continuity is integrated with, not isolated from, multidisciplinary services (Ni Kadek Ratna Dewi, I Gusti Agung Ayu Novya Dewi, & Sri Rahayu, 2025).

Effects on breastfeeding and maternal-infant adaptation

Breastfeeding is a key indicator of postpartum care effectiveness because it reflects maternal support, practical counselling, confidence, and the quality of early mother-infant interaction. Continuity models appear advantageous in this domain. Studies involving continuity for women with mental health conditions and team midwifery care have reported higher exclusive breastfeeding rates or more positive breastfeeding-related outcomes. This is plausible because continuity allows providers to offer repeated anticipatory guidance, observe feeding challenges over time, and tailor support according to prior contact and known family circumstances (Martin & Gurven, 2022).

Breastfeeding support is often undermined in fragmented services (Sukmawati et al., 2024). Women may receive inconsistent messages about latch, supplementation, pumping, nipple pain, or infant cues from different professionals in hospital and community settings. A continuity model reduces this inconsistency and allows follow-up after discharge, when many feeding problems actually emerge (Maretalinia et al., 2023). Known midwives can also address the emotional dimension of feeding, helping mothers interpret infant behaviour, regulate expectations, and seek help before problems escalate to early cessation.

More broadly, continuity supports maternal-infant adaptation. Early skin-to-skin contact, confidence in newborn care, and realistic preparation for postpartum demands are all easier to support when the provider relationship begins before birth and extends afterwards. In this sense, continuity of care contributes to postpartum maternal care by strengthening caregiving competence as well as clinical safety.

Effects on psychosocial outcomes and maternal experience

The psychosocial dimension of postpartum care is one of the most compelling justifications for continuity. A 2023 systematic review on the impact of midwifery continuity

of care on maternal anxiety and depression found improvements in maternal worry, anxiety, and depressive symptoms across the perinatal period. These findings are highly relevant to postpartum care because the postnatal phase is when emotional vulnerability often becomes clinically visible. Sleep disruption, pain, feeding stress, and identity transition can amplify distress, particularly when women feel unsupported or unseen (Ramayani & Amelia, 2025).

Continuity may protect against this deterioration through several mechanisms. First, a known provider can identify emotional changes earlier because she understands the woman's baseline coping style and pregnancy history. Second, trust makes disclosure of depressive symptoms or intrusive thoughts more likely. Third, continuity reduces the stress associated with retelling one's history to unfamiliar providers. Fourth, relational safety can increase a woman's confidence that her concerns will be taken seriously. These mechanisms are particularly important for women with prior mental health conditions or social vulnerability.

The cohort study by Cummins and colleagues supports this reasoning by showing positive associations between continuity models and outcomes such as breastfeeding and vaginal birth among women with perinatal mental health conditions, together with lower intervention risk. The significance of this finding lies not only in the outcomes themselves but also in the demonstration that continuity remains beneficial for women with additional psychosocial complexity. This is important because postpartum care systems often fail those who need support the most (Oksa, Kaakinen, Savela, Ellonen, & Oksanen, 2021).

Women's experiential accounts reinforce these quantitative findings. Studies on fulfilment of expectations and childbirth experience indicate that continuity matters to women, even when they do not achieve continuity at every single contact. Women consistently value being known, listened to, and supported by caregivers who understand their circumstances. Positive birth experience often spills over into postpartum adjustment, whereas disempowering or fragmented care may complicate emotional recovery. Therefore, postpartum maternal care quality cannot be fully understood without considering women's experience of relational continuity before and after birth.

Table 2. *Conceptual pathways through which continuity of care improves postpartum maternal care*

Continuity component	**How it works in postpartum care**	**Expected benefit**
Relational continuity	Trust, emotional safety, easier disclosure, personalised support	Higher maternal satisfaction; lower anxiety; better help-seeking

Informational continuity	Shared understanding of history, risks, preferences, and prior decisions	More coherent counselling; safer postpartum follow-up; fewer missed issues
Management continuity	Coordinated care planning and referral across services	Better linkage between facility, community, lactation, and mental health support
Accessible follow-up	Repeated contact after discharge and early problem-solving	Improved breastfeeding support and earlier recognition of warning signs
Small-team model	Backup coverage without losing familiarity	Feasible continuity with reduced disruption of woman-provider relationship

Implementation implications for midwives and health systems

The evidence suggests that continuity of care should not be treated as an optional enhancement but as a service design principle (Babu et al., 2024). For midwives, continuity strengthens professional autonomy, clinical reasoning, and the ability to practise holistic care. It allows the postpartum assessment to be interpreted in context: the midwife knows how the pregnancy evolved, what happened during labour, what concerns the woman expressed previously, and what type of support network is available at home. This contextual knowledge improves judgement and the quality of counselling (Chen et al., 2022).

For health systems, the main challenge is implementation. Continuity requires workforce planning, realistic caseloads, protected communication systems, and compatibility with referral services. Large institutions may struggle if continuity is added without structural redesign . The literature indicates that small teams, flexible coverage arrangements, and explicit communication pathways are essential. Overloaded caseloads can undermine continuity by limiting availability and increasing burnout, which may then weaken postnatal follow-up quality (Ellyzabeth Sukmawati & Titi Alfiani, 2025).

There are also equity implications. Continuity may be especially valuable for women facing language barriers, socioeconomic hardship, migration stress, adolescent motherhood, mental health conditions, or obstetric complexity. In such populations, fragmented services can magnify exclusion. Continuity creates a more navigable and humane system by providing a reliable contact point. This supports not only postpartum care utilisation but also women's confidence in the health system.

Gap analysis and interpretation

Although the overall evidence is favourable, several gaps remain. First, many studies continue to report broad perinatal outcomes without fully isolating postpartum-specific endpoints such as postpartum pain, pelvic floor recovery, sexual health, contraceptive uptake, readmission, or long-term maternal functioning. Second, outcome measures for postnatal care are not yet standardized (Han, Kang, & Lee, 2020). This makes it difficult to compare continuity models across settings. Third, most higher-quality evidence comes from high-income health systems, while routine postpartum fragmentation is often greatest in low-resource settings. Fourth, implementation studies rarely provide detailed economic analysis, even though continuity likely changes workforce deployment and service flow (Shafaei, Mirghafourvand, & Havizari, 2020).

These gaps should not be interpreted as weaknesses of the continuity concept, but rather as priorities for further research and service development. Future studies should examine which elements of continuity matter most for postpartum outcomes: number of known contacts, availability of home visits, team size, communication technology, referral integration, or continuity into family planning. More evidence is also needed on continuity for specific vulnerable groups, including women after complicated birth, women with severe mental health risk, and women in rural or under-resourced settings.

Overall, the available literature supports a coherent interpretation: continuity of care improves postpartum maternal care because it connects clinical care with trust, information continuity, and coordinated follow-up. Its effectiveness is therefore both technical and relational. This is precisely why continuity remains one of the most promising models for strengthening maternal care after birth.

5. CONCLUSION AND SUGGESTIONS

This systematic literature review indicates that continuity of care is an effective strategy for improving postpartum maternal care. Across the reviewed studies, continuity was associated with better service coherence, stronger breastfeeding outcomes, more positive maternal experiences, improved emotional support, and reduced anxiety or depressive symptoms. The evidence also suggests that continuity contributes indirectly to better postpartum recovery by lowering intervention rates and supporting more favourable neonatal outcomes. The main strength of continuity of care lies in its capacity to connect care over time. Postpartum care becomes more effective when women are supported by the same midwife or a small known team who understand their pregnancy history, birth experience, preferences, and

vulnerabilities. This relationship strengthens trust, facilitates early recognition of problems, and allows counselling to be tailored rather than generic. As a result,

This review has limitations because postpartum-specific outcomes were not uniformly reported across all included studies, and some evidence came from broader perinatal continuity models. Future research should assess postpartum-focused indicators more explicitly, including maternal functional recovery, readmission, contraceptive uptake, and long-term psychosocial adaptation. Even so, the current evidence is sufficiently consistent to recommend continuity of care as a strategic model for improving postpartum maternal care in both policy and practice.

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