

Midwives providing woman-centred care during the COVID-19 pandemic in Australia: A national qualitative study[☆]

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ABSTRACT

Background: The COVID-19 pandemic has caused isolation, fear, and impacted on maternal healthcare provision. **Aim:** To explore midwives' experiences about how COVID-19 impacted their ability to provide woman-centred care, and what lessons they have learnt as a result of the mandated government and hospital restrictions (such as social distancing) during the care of the woman and her family.

Methods: A qualitative interpretive descriptive study was conducted. Twenty-six midwives working in all models of care in all states and territories of Australia were recruited through social media, and selected using a maximum variation sampling approach. Data were collected through in-depth interviews between May to August, 2020. The interviews were recorded, transcribed verbatim, and thematically analysed.

Findings: Two overarching themes were identified: 'COVID-19 causing chaos' and 'keeping the woman at the centre of care'. The 'COVID-19 causing chaos' theme included three sub-themes: 'quickly evolving situation', 'challenging to provide care', and 'affecting women and families'. The 'Keeping the woman at the centre of care' theme included three sub-themes: 'trying to keep it normal', 'bending the rules and pushing the boundaries', and 'quality time for the woman, baby, and family unit'.

Conclusion: Findings of this study offer important evidence regarding the impact of the pandemic on the provision of woman-centred care which is key to midwifery philosophy. Recommendations are made for ways to preserve and further enhance woman-centred care during periods of uncertainty such as during a pandemic or other health crises.

Statement of significance

Problem

Midwives providing woman-centred care during the COVID-19 pandemic have demonstrated challenges and impact on women and families.

What is already known

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Woman-centred care is fundamental to midwifery practice with known benefits for women, babies, and midwives. Midwives have been protective when caring for women during a pandemic to reduce the spread of infection.

What this paper adds

Evidence of midwives' desire, capabilities and resilience in Australia to provide woman-centred care during the COVID-19 pandemic.

1. Introduction

Woman-centred care is a fundamental and identifying feature of midwifery practice borne from the professional philosophy of being 'with woman' [1,2]. The provision of woman-centred care is embedded in the National Midwife Standards for Practice [3] and is the foundational construct of the most recent strategic framework for Australian maternity services [4]. Recent primary research and reviews have contributed to the understanding of the features that exemplify woman-centred care which include: adaptability to provide individualised care, facilitation of informed decision making, advanced communication skills encompassing listening and reflection, supportive presence including touch and modification of the environment to suit the woman, authentic relationships and respect, freedom for midwives to make choices, and self-determination, and evidence-based care [5–8]. The strong emphasis on sophisticated and nuanced communication skills and physical proximity are founded in the provision of relational care that is centred on the woman and is inclusive of her partner and support people [5]. The restrictions as a result of the COVID-19 pandemic requiring physical distancing, personal protective equipment (PPE) which obscures facial expressions, as well as unprecedented limitations of numbers of support people, such as the exclusion of family and restrictions on the presence of the midwifery students who are providing continuity of care [9] are all changes that potentially impact on woman-centred care.

Providing midwifery care whilst avoiding spread of the COVID-19 virus and meeting women's needs is an ongoing balance of priorities. As midwives continue to provide care for women in isolation and during periods of lockdown, the management and collaboration with multidisciplinary teams during the pandemic has required a greater coordinated approach [10]. It is therefore imperative that midwives continue to engage with other colleagues in a collaborative multidisciplinary way to address specific needs for childbearing women arising from the COVID-19 Pandemic.

The pandemic has had a substantial impact on midwives' ability to provide usual midwifery care with the need to take on additional procedures aiming to reduce the spread of COVID-19 [10]. These involve practising in different ways such as trying to maintain social distancing during face-to-face visits, replacing antenatal assessments with telehealth, and limiting postnatal care visits [11,12]. Other research has found that midwives have been confused with major discrepancies in guidelines between hospitals and the constant changing of the guidelines and the effect of COVID-19 on pregnant women [13]. Recent Australian research has shown that prior to the pandemic, midwives were facing both physical and emotional exhaustion, with high rates of stress and burnout, often related to their inability to provide woman-centred care within medical models [14]. Now, more than ever, social connectedness for the midwifery workforce is essential [10].

The study of midwifery practice during the Ebola epidemic in Sierra Leone may provide a comparison to midwifery during the COVID-19 pandemic [15]. In one study [15], midwives' fear of becoming infected by the Ebola virus affected both their personal and professional lives. Some midwives hid the fact that they were working in an Ebola centre from their families as they did not want to heighten their anxiety, but felt obligated to contribute in their role as citizens of their country.

Midwives believed that maternity care was severely hampered by infection control measures [15]. The midwives were working with limited guidelines that left them with ethical dilemmas about how to improve care for women, leaving them to make decisions about life and death autonomously. Midwives were motivated to use their creativity and competency to search for improved solutions for women's care under challenging circumstances; for example, innovations such as placing placentae in sawdust to avoid splashing of blood to reduce the spread of infection. Despite these limitations, midwives developed special relationships with their work colleagues including when caring for dying women [15]. Overall, it was reported that experiences during the Ebola outbreak resulted in midwives feeling better able to provide dignified and safe care for women and their families under exceptional circumstances [15].

There is therefore evidence that midwives strive to provide safe, woman-centred care even in difficult circumstances. During the early stages of the COVID-19 pandemic, widespread media reports highlighted variation in how preventative measures were implemented and interpreted around the world and their impact on women's care experiences [16]. Concurrently, a number of national and international surveys that aimed to elicit the general experiences of maternity care by women and families and by care providers were disseminated [17–20]. This study has provided further evidence on how midwives navigated these variations in their efforts to provide woman-centred care.

2. Participants, ethics, and methods

A qualitative interpretive descriptive study [21] was conducted to describe how midwives provided woman-centred care during the COVID-19 pandemic. Guided by this approach, we (midwives) based and adapted our guiding questions for the in-depth interviews on the development of the Woman-Centred Care Scale – Midwife Self Report (WCCS-MSR) [8] (see Box 1).

2.1. Participants

Midwives were selected across all models of care (including standard public / private hospital care, midwifery group practice, publicly funded homebirth, and privately practising midwives), years of experience, and states and territories across Australia. To achieve this, participants were selected according to the maximum variation method as a form of purposive sampling [22].

2.2. Recruitment

We distributed a flyer with an expression of interest via social media networks and invited midwives via the Australian College of Midwives Facebook site. As we wanted a sample to address maximum variation sampling, midwives were asked brief demographic details in the expression of interest and notified that they may not necessarily be invited to participate in an in-depth interview. Forty-seven midwives responded to the expression of interest. The sampling strategy resulted in 31 being selected and those midwives were sent an information and consent form. From the 31 midwives, 26 were interviewed, one midwife changed her mind and four did not respond to the offer for interview. The 26 midwives interviewed represented a diverse sample, from every state and territory in Australia, every model of care, and from one to 40 years of midwifery experience.

2.3. Data collection

Data were collected by in-depth interviews conducted via phone, Zoom, or Skype at the participants' choice and interviews lasted between 20–70 min. The first author interviewed 23 of the midwives and three of the other authors interviewed one midwife each.

Box 1

Questions that guided the in-depth interviews conducted with midwives regarding their experiences about providing woman-centred care during the COVID-19 pandemic.

- 1) What do you think providing woman-centred care actually looks like or can you explain what woman-centred care means to you?
- 2) Can you tell me about your experiences about providing woman-centred care during the COVID-19 pandemic?
- 3) How have you met the unique needs of the woman during the COVID-19 pandemic?
- 4) How have you balanced the woman's needs within the context of the maternity service, restrictions / regulations during the COVID-19 pandemic?
- 5) What has been your experience of ensuring midwifery philosophy underpinning practice within the context of the maternity service during the COVID-19 pandemic?
- 6) How have you used evidence to inform collaborative practice during the COVID-19 pandemic?
- 7) How have you worked in partnership with the woman during the COVID-19 pandemic?
- 8) How has COVID-19 impacted your ability to support midwifery students conducting their continuity of care experiences?
- 9) What are the take-home lessons you have learnt about providing woman-centred care during the COVID-19 pandemic?

2.4. Data analysis

All the interviews were recorded and transcribed verbatim. The data were analysed to provide description of the data with as much richness as possible, and interpretation with ongoing reflection about what this data conveyed. As the first author conducted most of the interviews, the author was able to build a solid and coherent line of inductive reasoning by connection of ideas throughout the midwives' stories [21]. The first author analysed seven of the interviews and each of the other authors analysed between two to three interviews each. The constructions of the data were framed around the guiding questions which were asked of every participant. Open codes were created for all the interviews to enable organisation of the data collected into a manageable form [21]. Initially, the first author identified the key themes that related to all these codes and then the first and last author themed the entire set of interviews together, enabling constant reflection that entailed an iterative reasoning process that identified the implications of aligning ideas in various ways. In this way, the authors were able to make sense of the ideas that were core to what we were studying. This analysis enabled scaffolding that supported the goal of this study [21]. These codes were analysed and reanalysed, until a final consensus was reached between the two authors following many reiterations. This final step led to a thematic summary that was agreed upon by the two authors in alignment with a qualitative interpretive descriptive study [21]. This final feedback was sent to all of the authors to check agreement on the final overarching themes and sub-themes.

2.5. Reflexive positioning of researchers

As all of the authors were midwifery academics, this placed the researchers in a position to side with the midwives' views and perceptions, that could have reflected on the research study's findings. Reflexivity enabled the researchers to stand back and look at our thinking and why we chose those particular themes and sub-themes. The high number of authors also discussing and agreeing on the findings provided a level of rigour to our study.

2.6. Ethical considerations

Ethics approval was first gained from the primary researcher's institution (H13846) with reciprocal approval gained from the universities of all other authors.

3. Results

3.1. Demographic characteristics

Twenty-six midwives were interviewed from May to August, 2020. All states and territories of Australia were represented in the sample. Midwives worked in all models of care. Participants had between one to 40 years of midwifery experience. Table 1 demonstrates the characteristics of the midwives in our sample.

3.2. Qualitative results

The two overarching themes were identified: 'COVID-19 causing chaos' and 'Keeping the woman at the centre of care'. The 'COVID-19 causing chaos' theme included three sub-themes: 'quickly evolving situation', 'challenges to provide care', and 'affecting women and families'. The 'Keeping the woman at the centre of care' theme included three sub-themes: 'trying to keep it normal', 'bending the rules and pushing the boundaries', and 'quality time for the woman, baby, and family unit' (see Fig. 1).

3.3. COVID-19 causing chaos

3.3.1. Quickly evolving situation

For midwives, the COVID-19 pandemic was a quickly evolving situation that required regular policy changes. These changes resulted in midwives constantly adapting to new management decisions which were at times driven by misinformation and fear. The midwives worked in environments that were confusing, as management were making decisions that were not perceived to be evidence-based and incongruent with best practice. Responses to the COVID-19 pandemic initiated changes that were being instigated almost every few hours to a daily basis. As these midwives described:

It changes so regularly, I'm confused, it's just an ever moving feast, isn't it? Everything with this pandemic, just changes. It's been head spinning how quickly it's changed. It's just got to the point where it was so exhausting listening to, "Now we're going to do this, now you're going to do that." (P12)

Oh goodness me, it's like screaming into a storm isn't it? They hear my concerns, they've seen the evidence, but for our purposes water births are temporarily paused [for fear of transmission]. (P17)

Midwives reported poor communication and inconsistent information from management as noted here:

Table 1
Characteristics of midwives.

Numbers of midwives / Areas of care	State or Territory of Australia	Years of experience as a Midwife	Primary model of midwifery practice
10 midwives 1 midwife in Birthing only	South Australia, Queensland, New South Wales, Victoria, Northern Territory, Western Australia, Australian Capital Territory	1–5	Midwifery Group Practice / Standard public hospital care
All others in all areas			
4 midwives 1 midwife worked Postnatal/ Birthing/ Special Care Nursery	New South Wales, Victoria	6–10	Midwifery Group Practice / Standard public/ private hospital care
1 midwife worked Postnatal and Antenatal			
All others in all areas			
6 midwives 1 midwife worked Postnatal only	New South Wales, Victoria, Western Australia	11–15	Privately Practising Midwife/ Standard public hospital care/ Midwifery Group Practice
1 midwife worked Antenatal and Birthing			
All others in all areas			
3 midwives 1 midwife worked Birthing and Postnatal	Queensland, Australian Capital Territory, Tasmania	16–20	Privately Practising Midwife/ Midwifery Group Practice/ Standard public hospital care
All others in all areas			
1 midwife All areas	New South Wales	21–25	Midwifery Group Practice
2 midwives			
1 midwife worked Postnatal only	Queensland	34–40	Publicly funded homebirth/Standard public hospital care
1 midwife worked in all areas			

And the whole governance and having to have everything correct. I understand governance. But I think it's just sort of taken over, the fear pandemic. Management aren't always going to be in a space to listen. (P23)

Response from management was pretty poor. If they had the anticipated numbers, they would have been in a world of trouble. Late to respond to anything and nothing was enforced. Our communication down here and support for midwives has been really bad. (P8)

Fear of the pandemic drove decisions being made that were not always evidence-based. Midwives described not accepting some of the new rules that were being handed down to them and continued to practise in alignment with existing evidence-based guidelines in order to provide safe woman-centred care. As this midwife describes:

Our workplace was actually telling us that the baby and the woman needed to be showered and bathed immediately after birth or as quickly as possible after the birth, and we were sort of like, "What are you talking about?" ... We said, "That's not what we're going to do. It's not evidence-based and we don't believe that it's a right thing for that woman and that baby." Don't tell our boss. (P12)

Other examples of non-evidence based decisions were reported, as this midwife states:

[They] decided to stop all water births, saying that they were protecting the midwives. Of course, we were absolutely up in arms immediately and said, "Well, where's your evidence to support this? Because we actually feel safer having a water birth because we're at a greater distance. (P16)

Due to the rapidly changing environment, midwives were inconsistent in the way they were working with each other and with women. These midwives describe the situation:

It does come down to the midwives who are on the shift, so if a partner is unable to leave the hospital and come back in, sometimes depending upon who was around at the time, we will make some allowance for it, depending on the situation. (P21)

There was only eight in the Group Practice. [...]. In the first four to six weeks, four of us were wearing a mask and gloves [...] and the other four wouldn't. I just said to us that were wearing it, "It's pointless us doing it. It's just confusing the women. If the other four aren't going to do it, we might as well not do it." (P22)

Some midwives discussed how they were ostracised for expressing their opinion and received feedback from management, as noted here by a midwife providing continuity of care,

We were shut down very harshly for our questioning of what they were asking us to do. But they just couldn't see it. They just jumped on the thing that you're claiming you're special. (P23)

The time restrictions midwives were 'allowed' to spend with women affected their services and the way in which they provided their care. Midwives were required to shorten their home visits to 15 min, limiting their face-to-face time with women. This was viewed as incongruent when they had spent 12 h in labour with the women in the preceding days and when midwives in the hospital were not socially distancing when providing care for women. These limitations restricted midwives' provision of woman-centred care.

We've spent 12 h with someone in labour. And the next day, try and limit to 15, when we're already at close contact. Why are we saying we only can be in the home for 15 min? No one was socially distancing in the hospital. (P23)

Fifteen minute face-to-face consults, so would do most of the visit over the phone, we limited the number of visits with women and the time spent with them face-to-face. (P18)

In some health services, midwifery continuity of care models were reduced or cut back with no explanation as to why this decision had been

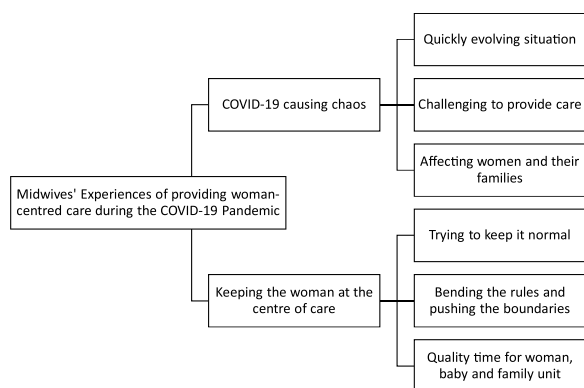


Fig. 1. Themes and sub-themes: Midwives' experiences of providing woman-centred care during the COVID-19 pandemic.

made. Despite the rapid changes, there was no rationale provided as to why reducing midwifery continuity of care would improve the COVID-19 situation. Midwives and managers from continuity of care models described feeling excluded about how their services were being modified.

Even though we do a third of the births, our manager gets left out of discussion about the way things are going to go. [They feel] continuity is this little add-on, and those continuity midwives are a bit rogue. (P7)

Another midwife relayed how continuity of care was stopped to make the space that they were working in available for COVID-19 patients.

We lost our one-on-one continuity, which is very sad and we've seen the impacts of it pretty much immediately, we didn't get to keep the women that we've been looking after....It was very sad not to have had any warning about the changes. Why were we the first to go? (P13)

Other services were affected, resulting in antenatal classes being changed from face-to-face to online platforms, or in some cases stopped. Education was often delivered ad hoc using online methods that included Zoom classes or short videos.

Education was stopped, so we're no longer providing classes. The main issue being the face-to-face classes, not having extra people supporting you. (P11)

Midwives found their workloads increased due to the restriction of face-to-face antenatal classes and they were providing more antenatal education for women on an individual basis.

Now we are having to go through everything, which takes a bit of extra time. (P21)

I've tried to facilitate as many options for education. So I sourced multiple, different types of online education... Calm birthing, sea birthing, hypnobirthing, they feel a lot more prepared. (P19)

The changes to the permitted number of visitors and support people imposed difficult decisions upon the birthing women and women were forced to make decisions to include or exclude their partners or their other children: 'some women have actually chosen their mother over their partner' (P11). Midwives felt their woman-centred care role was compromised, 'it's our job as midwives ... to advocate for the women, it's really hard to keep it fair for all women.' (P25)

Midwifery students are significant providers of woman-centred care. COVID-19 also impacted midwives' ability to support students in how they continued to provide their continuity of care experiences as a requisite of their midwifery degree. Some institutions permitted students to continue with their continuity of care experiences, 'the hospital hasn't restricted their access. They've been brilliant. Having the students has been really lovely, because it does give women the familiar face'. (P2)

but some did not 'we were not allowing any students into the clinic, or if they were a continuity of care student, they were not even allowed to attend the labour and birth'. (P21) Some midwives advocated to retain the student in the woman's care as a means of providing woman-centred care, however, women would sometimes ultimately have to prioritise their friends and family over having a student present.

3.3.2. Challenges to provide care

Midwives found it challenging to provide care as they quickly had to change from all face-to-face home visits or appointments to a hybrid model that also included phone calls. This required reorganisation and negotiation with other health professionals and administration staff about how best to provide and plan their care for women. Without face-to-face contact, midwives found it challenging to build rapport and properly inform women, especially those women with vulnerabilities, and for whom English was not their first language. The changes required for midwives to revert to using telehealth services was perceived by the midwives as a barrier to providing woman-centred care.

The way we support these vulnerable people, and we used to go and pick them up and bring them to clinics. We'd drop things off, we really put a lot of energy in, especially if you've got diabetes and struggling with that, we know all the social dynamic things of remote communities. So you really try to support, we won't be able to do it in the same way. And I'm still wrestling with that. (P1)

Two of the midwives spoke about how challenging it was not to be able to touch women as they felt that touch was pivotal to their role as a midwife providing care for women.

I just found the greatest barrier I'm having is that lack of touch, because the woman can always respond to the hands-on, the midwives touch her arm or her shoulder, being quite close to the woman and just speaking softly to her. (P20)

So, it was all very new to us and social distancing and not really touching her much, [especially] in labour. (P3)

Midwives found it difficult to individualise the care for women, felt unable to meet their needs and as though they had lost an important connection with women.

It's really hard. It's not the same. You're not getting that connection. The women aren't really getting to know the whole team. It's not personal doing a telehealth visit. It really isn't. (P22)

Midwives stated how difficult it was to maintain social distancing as quality midwifery care was not conducive to social distancing.

I don't try to stay a hard one point five metres away from the women I'm caring for all the time. Because I can't help them breastfeed that way, and I can't effectively reassure somebody from one point five metres away if it looks like you're keeping your distance. That's not actually part of how relational care works. (P2)

Midwives were implementing other COVID-19 measures and were very conscious of cleaning and sanitising all the equipment in use but felt that wearing a mask was a barrier to establishing calm connections with the women and were reluctant to request that women come into the hospital. Some midwives found it difficult to communicate with women without having access to appropriate telehealth resources, and different communication platforms were not supported by management. Other midwives found the extra technology that they were using quite challenging, especially with connection problems and even though Zoom meetings were useful, the way midwives were communicating was different.

3.3.3. Affecting women and families

Midwives reported challenges building rapport with the woman's family that affected how they provided woman-centred care. Limited time restrictions with appointments with women and children also meant that children were waiting in other areas such as car parks resulting in fragmented care that was not woman-centred. Midwives reported that the COVID-19 pandemic had negatively affected women and their families; increasing their anxiety levels and this anxiety was a barrier in providing woman-centred care. Midwives felt that women were isolated, unprepared, and concerned about their own baby's wellbeing as appointments were restricted and they were seeing less of their midwives. This lack of woman-centred care resulted in missed opportunities and other poor outcomes such as unsuccessful breastfeeding.

Not putting your hands on their belly for that long period of time, the women started to worry were they big enough? Were they too small? Was the baby really head down? I just think they weren't prepared enough. We were doing the best that we could. (P22)

Women have been sent home very quickly. 'I've been seeing women face-to-face in that clinic and I'm seeing women being sent home with babies who are under three kilos, who haven't established breastfeeding or they're

jaundiced. They're not getting that face-to-face education, they're turning to the formula'. (P10)

3.4. Keeping the woman at the centre of care

3.4.1. Trying to keep it normal

Midwives kept the woman at the centre of their care, and this was evidenced by them trying to keep everything as normal as possible.

I have just tried to keep everything as normal as possible, in everything that I do. I will not lose sight or focus; my job is the same. I am a Midwife. (P6)

We tried to give them the best care just as routine care, so it was the same practice for me. Pandemics will happen and we've still got to just carry on and do our job, just keep going in and birthing babies. (P26)

Midwives found strategies to become creative in their practice. They advocated for women in special circumstances and spent extra time with them.

I think they're just so vulnerable, and I just felt like I was that most important person that could make a huge difference, and provide all of what they needed, [...], so that they can feel a little bit more reassured and just that voice, to listen to what's really going on, and what they want... at a time that was really vulnerable and uncertain, I provided that certainty. (P14)

Midwives tried to keep up the communication and de-escalated women's fears and concerns.

I guess talking to women. I think what we've found is setting expectations, letting women know. Communicating with them about what's happening. (P12)

Midwives were checking the evidence so that they could keep the women informed about the appropriate advice. Two midwives described that their ability to provide woman-centred care actually improved and it made them more mindful about their role as a midwife.

My ability to provide woman-centred care kind of improved in some ways, because I was seeing them [women] in their home. There were some things about it that just felt a lot more connected, a more intimate service. (P5)
It has made me a lot more mindful as a midwife to make myself aware of those extra needs, I have found that without those extra support people, I have found that I am getting a lot more involved. We are having to engage a lot more with the women during the shift and it has been quite rewarding. It has kind of allowed us to get back to why we actually got into the profession for! I've found that it has made me a better midwife, you really do have to focus on what that woman actually needs. (P21)

Midwives who were working in continuity of care models were protective and supportive of woman-centred care as they were able to be more flexible and autonomous.

I found I was doing lots and lots of emotional support, which was great in our capacity within midwifery group practice, we can facilitate that. We could tailor some of the restrictions that were placed on us. (P19)

I think that that's been a particular benefit to having women on midwifery group practice. Well, I think I feel quite proud that we've been able to adjust our model even more to suit the woman's needs. And not so much the COVID[-19] being the centre of care. (P15)

3.4.2. Bending the rules and pushing the boundaries

Midwives described bending the rules and pushing the boundaries to ensure that women received quality care that was woman-centred. They worked around the system to ensure that women could still achieve what they wanted, despite the fear of the pandemic.

We broke all the rules and had two support people in labour. Spending the extra time with the women and trying to reassure them that they're safe and their babies are safe. (P8)

Midwives were passionate about supporting the women and continued to practise in accordance with evidence-based guidelines, especially when there was still so little known about COVID-19. They wanted to support women with their decisions to ensure their pregnancy and birth were not compromised.

Just contacting women, a lot more than I usually would between appointments and just texting or calling and saying, just checking in, making sure you feel like you've seen us enough. (P3)

Midwives were also very conscious of meeting the women's cultural needs to ensure that their loved ones and support people were included in their care.

We have a lot of culturally diverse overseas visitors having their babies with us who would ordinarily have their family fly over for when they're having their baby for support, because culturally, that's what you do. That wasn't able to happen. So we had a lot of women who felt that they didn't have the support that they needed. It meant that we were doing a lot of births on Zoom and Facetime. (P24)

3.4.3. Quality time for woman, baby, and family unit

Midwives reported that they felt they had better quality time caring for the woman and that women also appreciated the quiet time with their babies, without having to see visitors. Midwives believed that this quality time enabled women to concentrate on breastfeeding and bond with their babies without distractions.

More hands on, more time breastfeeding, when you're working in a fragmented postnatal ward. Now it's just the parents and there's been a lot more opportunity for education and time spent with women. (P25)

Midwives also noticed that women were choosing homebirth over hospital birth so that they could accommodate and spend time with their loved ones. Women choosing to have a homebirth improved midwives' capacity to provide woman-centred care.

They all elected to have homebirths. Our homebirth rates have escalated, which I think it's amazing because it's a beautiful place to have a baby. We're a low risk model of care. The reason for many of the homebirths, our hospital, women could only have one support person. (P4)

4. Discussion

This study is the first to explicitly explore midwives' experiences of providing woman-centred care during the COVID-19 pandemic. Factors that have hindered and enabled woman-centred care have been described. Midwives reflected on the rapid and radical changes to the provision of maternity care necessitated by the global pandemic. The frustration, confusion, and anxiety related to the frequent changes that were described by midwives in our study has been confirmed in professional commentary [23] and in the findings of an Australian cross-sectional study with 620 midwives and an Australian qualitative study about women's experiences that explored the impacts of COVID-19-related service changes to maternity care [12,17].

Midwives in our study described the move to telehealth services as disruptive and a barrier to woman-centred care. Findings from a recent Australian study of 3364 women revealed that more than half of the participants had experienced a move to telehealth for antenatal or postnatal care during the pandemic, which left them feeling deprived of their anticipated maternity experience [12]. Globally, a move to telehealth for antenatal and postnatal care has also intersected with reports of an overall reduction in the number of visits provided to women [24]. A recent scoping review has revealed that these changes are likely to

come at the expense of quality care [24]. Further research is recommended to explore the impact of the provision of maternity care via telehealth services which would provide essential evidence regarding ways to support and care for women during the current and future health crises.

The system-orientated policies that required women to be separated from their families including partners, support people, and children impacted midwives' provision of woman-centred care. Midwives described the challenges of providing care to women when they were unable to be attended by their loved ones or supported by their extended family members. The perspective of partners and support people was recently explored in a study that surveyed 44 partners and support people who reported feelings of isolation, psychological distress, and a sense of missing out [25]. A qualitative study of women's experiences of becoming a new mother during the pandemic in Australia also reiterated the distress that was caused to women through the required separation from their support people [26]. Further research into the impact of separating women from their support people during the important childbearing period warrants further exploration. Strategies to provide inclusive care such as 'family - bubbles' that limit repeated entry and exit from health services, rapid testing, enhanced PPE provision and environmental modifications have all been suggested [27]. If, during acute periods, in-person support is not possible, then virtual attendance and support should be facilitated at a minimum to preserve the opportunity for sharing of significant experiences between women and their partners.

COVID-19 also impacted midwives' ability to support students in how they continued to provide their continuity of care experiences. Students are required to complete a mandated number of continuity of care experiences as a requirement of their midwifery education in Australia [28]. Continuity of care experiences in midwifery education are also practised (but not necessarily mandated) in other countries such as Canada, Indonesia, the Netherlands, New Zealand and Norway [29]. During the pandemic in Australia, midwifery students were able to complete their continuity of care experiences despite having some form of restrictions during their clinical placements [9]. However, some institutions excluded students from their continuity of care experiences and midwives navigated the system by knowing what team leader midwives would include and accommodate the students, enabling some students to participate in their continuity of care experiences [9]. Women's satisfaction of being with a student in a continuity of care relationship has been measured as high with women valuing the opportunity to spend their time with a familiar caregiver during their childbearing experience [30,31]. Ensuring midwifery students continue providing continuity of care is important during pandemics when women are unable to have other support people present [9]. As practising midwives provide role models, if woman-centred care is not routinely practised, midwifery students do not learn how to be involved in woman-centred care [7]. This can be problematic, to be able to prepare students for their future roles as midwives, especially during a pandemic.

The current study found that some midwifery continuity of care models were reduced or cut back with no explanation as to why this decision had been made as a way of improving the COVID-19 situation. Midwifery continuity of care improves clinical outcomes for mothers and babies [32], provides personalised care and trust through the midwife-woman relationship and increases women's satisfaction with their care [33]. Consequently, midwifery continuity of care should be available to women when they are experiencing changes to maternity care that include not being able to have selected people present, feeling overlooked and under-informed, and experiencing a lack of woman-centred care [12]. Midwifery continuity of care is an important model to ensure woman-centred care and is articulated in the international definition of a midwife [34].

Our study found midwives felt it was challenging to provide quality care to women during the early months of the COVID-19 pandemic.

Some described an increased workload as a result of antenatal classes being cancelled, unclear messaging from their managers and inconsistencies of practice and PPE-wearing amongst colleagues. Excessive midwifery workloads have been known to lead to burnout and staff leaving the profession [35]. In particular, midwives have demonstrated that a lack of autonomy and a medicalised workplace further impact their ability to provide quality care to women [14]. Within a workplace environment with existing staff shortages, the knee-jerk reactions resulting in many of the policy decisions that impacted midwives during the pandemic could have future devastating results for the retention of the Australian midwifery workforce. Given the pandemic will likely have ongoing implications, certain COVID-19-related policies that are not woman-centred may remain in place for the foreseeable future, such as wearing of PPE and restriction of support people. Despite these challenges, midwives in our study tried to practise by keeping everything as normal as possible, which provides take-home lessons for the future.

Midwives in this study were aware that many of the new policies appeared to be implemented as 'risk management' strategies to limit viral transmission. The possible consequences of introducing non-evidence-informed maternity policies have been discussed by some researchers who state, 'The loss of key evidence-informed aspects of safe, quality care will have long-lasting consequences for individuals, families, and wider society' [36]. As the restrictions placed on maternity care facilities have heightened during the COVID-19 pandemic, it is now more important than ever to warrant that restrictions in clinical practice are aligned to evidence-based recommendations [37]. Risk averse policies also promote the possibility of further centralisation of services and limitations on women's options for maternity care, including woman-centred midwifery-led continuity of care models. However, midwives in our study showed creativity in their practice, as shown in the sub-theme, *Bending the rules*.

In order to accommodate women's wishes, midwives juggled to provide woman-centred care as well as adhere to the ever-changing policies in their workplaces. It was apparent that midwives with more autonomy in their roles, such as those in midwifery group practice models, were more able to adapt their practice to suit women's needs than midwives working in standard hospital based shift work models. This type of midwifery practice has been discussed many years ago by one author who described midwives 'doing good by stealth' [38]. In our study, one example of *bending the rules* was spending more time with women than the new policy stated, especially in relation to helping to establish breastfeeding. Overall midwives described providing strong advocacy for women during the early months of the COVID-19 pandemic, which although embedded into the Australian midwifery code of conduct [39], sometimes was at odds with institutional non-woman-centred policies.

5. Strengths and limitations

Even though this sample of 26 midwives provided a diverse sample of midwives' experiences practising in Australia during the COVID-19 pandemic in 2020, the findings may not be representative of midwives practising during the Delta strain of COVID-19 in 2021 and across the globe. A strength of this study is the collaborative analysis process and team discussion to agree on final themes.

6. Conclusion

The relevance of woman-centred care to the provision of midwifery care has been previously emphasised. Descriptions from the diverse cohort of midwives in our study provide unique insights into the impacts of the rapid and radical changes and the challenges to the provision of maternity care on the provision of woman-centred care in Australia. These novel findings facilitate an understanding of ways that philosophically-aligned midwifery care may be sustained during the

pandemic and potentially during other periods of health crises. Midwives in our study continued to provide woman-centred care by trying to keep everything as normal as possible and by bending the rules and pushing the boundaries to enable the provision of safe and quality midwifery care.

Conflict of interest

Linda Sweet and Allison Cummins have editorial duties with this journal. To reduce any real or perceived conflict of interest, neither of them had a role in the processing or peer review of this paper.

Ethical statement

Ethics approval was obtained from Western Sydney University Human Research Ethics Committee, reference number H13846 with reciprocal approval gained from the universities of all other authors.

Midwives were offered to participate in the study and assured of the voluntary nature of the research, the ability to withdraw, maintenance of confidentiality and written consent was obtained from those willing to participate.

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Author contributions

Virginia Stulz - Conceptualisation, methodology, recruitment, data collection, data curation, data interpretation, formal analysis, writing, reviewing, editing.

Zoe Bradfield, Allison Cummins, Linda Sweet, Rhona McInnes - Conceptualisation, methodology, data interpretation, formal analysis, writing, reviewing, editing.

Christine Catling - Conceptualisation, methodology, data collection, data interpretation, formal analysis, writing, reviewing, editing.

Karen McLaughlin - Conceptualisation, methodology, data collection, data interpretation, formal analysis, reviewing, editing.

Jan Taylor, Donna Hartz - Conceptualisation, methodology, data interpretation, formal analysis, reviewing, editing.

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Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:<https://doi.org/10.1016/j.wombi.2021.10.006>.

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