

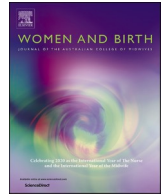


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## No one asked us: Understanding the lived experiences of midwives providing care in the north west suburbs of Melbourne during the COVID-19 pandemic: An interpretive phenomenology

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### ABSTRACT

**Problem:** Within the Victorian healthcare system, a rapid response to the COVID-19 pandemic has necessitated frequent and ongoing changes to midwifery practice.

**Background:** Midwives are a vital workforce at risk of burnout, attrition, and trauma. Emotional consequences of the pandemic for midwives remain largely unknown.

**Aim:** To understand the lived experiences of midwives providing care in the north west suburbs of Melbourne, Victoria during the pandemic.

**Methods:** Purposive and snowball sampling facilitated the recruitment of eight midwives in the north west suburbs of Melbourne, Victoria. Semi-structured interviews were audio recorded and transcribed, occurring via telephone or video between September and October 2020. Interpretive phenomenology was the methodology used, informed by the writings of Heidegger and Gadamer.

**Findings:** Insights gleaned from the data embody a range of understandings. The unknown cost of change and adaptation; waves of the virus; balancing risk; telehealth; personal protective equipment; stripping away support; the privilege of abiding by the restrictions; separation, distress, uncertainty; and, professional strength.

**Discussion:** Experiences of midwives during the pandemic are characterised by sensations of voicelessness and professional invisibility. Distinctive differences in personal wellbeing and professional satisfaction exist between midwives working with and without continuity of care.

**Conclusion:** This paper voices the lived experiences of Victorian midwives, in the midst of an extended lockdown, during the COVID-19 pandemic. Knowledge obtained from this research provides important understandings for leaders, policymakers, and healthcare systems, in planning a long-term response to the pandemic that supports the wellbeing and longevity of a vital workforce.

### Statement of Significance

#### Problem or issue

Victorian midwives are a vulnerable workforce at risk of attrition due to their unique experiences during the pandemic, alongside pre-existing rates of poor mental health outcomes such as burnout.

#### What is already known

In response to the COVID-19 pandemic, midwifery practice in

Victoria has changed significantly over a short period of time. Emerging evidence suggests these changes could have significant emotional consequences for midwives.

#### What this paper adds

New evidence that voices the experiences of Victorian midwives working at the coalface, including challenges and protective factors related to the provision of woman and family centred care during the 112-day lockdown.

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## 1. Introduction

The COVID-19 pandemic (referred to hereafter as ‘the pandemic’) was declared by the World Health Organization [WHO] on March 11th of 2020 [1]. In Australia, there have been 29,102 cases and 909 deaths recorded by late March of 2021 [2]. Of these numbers, 20,483 cases and 820 deaths were experienced in Victoria alone, where a second deadly wave of infection occurred throughout June to September of 2020 [3]. To suppress transmission of the virus and prevent catastrophic outcomes such as the devastation of our healthcare system, the Victorian government re-enforced a stringent lockdown that lasted for 112 days [4].

All Australians had previously participated in a national lockdown during the first wave of infection throughout March to May of 2020, encompassing challenges such as job loss, the redeployment of healthcare workers, and facilitation of remote learning for children [4]. Building on these requirements, the second lockdown was extended, severe, and particular to Victoria [4]. Stay-at-home directives permitted movement for essential purposes, limited to activities and infrastructure required to maintain basic human safety and wellbeing [5]. While no lives remain untouched by the pandemic, residents of Victoria have endured a significantly longer time living with the uncertainty and sacrifice required by life in lockdown [4].

Minimising the incidence of viral transmission and death in Victoria required an immediate response from our healthcare system, leaders, and workers [4]. The novel nature of SARS CoV-2 [COVID-19] necessitated the continual incorporation of new evidence and government directives, along with learnings of how to effectively care for the COVID-positive, and how to protect healthcare staff [6]. The response of our healthcare system remains ongoing and dynamic, with extensive modifications to policy and practice occurring throughout all care settings [7].

Modifications include changes to midwifery care across hospitals and communities, with new policies predominantly focused on reducing viral transmission by minimising face to face encounters [7,8]. Key impacts for midwifery care include inconsistent advice regarding the effectiveness of personal protective equipment [PPE], particularly in high-risk areas such as birthing; inconsistent access to PPE; extensive uptake of telehealth; restrictions on the presence of partners and support people; adjustments to screening for common conditions in pregnancy; and, a temporary ban on waterbirth that was enforced during the Victorian lockdown [7,9].

In many instances, changes to care have separated women from their families [10]. Emerging evidence demonstrates that for some women, the stress inflicted by separation has increased experiences of isolation, loneliness, anxiety, depression, and birth trauma [8–11]. New research also documents the inequitable effects of restrictions for those who require greater flexibility and support to engage with care [12,13]. Inequities that can impact on a woman’s capacity to understand or comply with changes to directives include health literacy, migration, knowledge of English, poverty, substance use, homelessness, family violence, or the absence of a support network [12,14,15]. Midwives are often responsible for enforcing restrictions and may feel complicit in increasing distress and disadvantage for women during the pandemic [8].

Coping with this rapid pace of change has imposed a significant challenge for midwives in maintaining a practice that balances the pertinent requirement of conforming to COVID-19 guidelines with supporting women. Midwifery is philosophically grounded in the notion of woman and family centred care, that supports empowered and informed decision making in partnership [16]. Midwives support optimal health outcomes for mother and baby through evidence-based primary healthcare that promotes physiological labour and birth, breastfeeding, bonding, and attachment [16].

Prior to the pandemic, many midwives were already unhappy in the profession [17–21]. Within the literature, the cause of this dissatisfaction is predominantly attributed to certain features of mainstream Australian maternity care; hierarchical organisational structure,

inadequate opportunity to work in models that support continuity, and medical dominance [17,19,21–24]. Midwives experience higher rates of burnout than many other caring professions [17,21]. Symptoms of trauma and stress are frequently reported by research and are strongly associated with burnout [25]. Attrition is also significant, with workforce shortages possible by 2025 if the trajectory of burnout continues unchanged [22].

To date, little has been published specifically addressing the pandemic experiences of midwives in either Australia or the state of Victoria. A qualitative systematic review and meta synthesis of international literature surrounding the experiences of midwives, maternity nurses, and women during previous epidemics and pandemics stressed numerous learnings [26]. During preceding events, concerns encompassed inadequate access to medical supplies and PPE, feeling unprepared, feeling unsupported by healthcare systems, and navigating reactive changes to woman-centred care in context of strict infection control protocol [26].

A cross-sectional descriptive study, published by Women and Birth in March 2021, is one of the first peer-reviewed research papers to address the pandemic experiences of Australian midwives [8]. This paper reports that 97% of the 620 respondents were required to change their practice due to COVID-19, and 62% felt that physical distancing requirements had a negative impact on woman-centred care [8]. This paper acknowledges the unprecedented demands that have been placed on Australian midwives during the pandemic, as well as highlighting protective factors such as professional resilience [8]. However, data were collected nationally, meaning the distinctive experiences of Victorian midwives have not been specifically explored.

Understanding what it feels like to care for families during the pandemic, amidst constant change, is essential to improving midwifery job satisfaction, mental health, and wellbeing. This study addresses an identified gap in the literature, incorporating the voices of Victorian midwives into recommendations for improved professional practice and support in maternity care settings.

### 1.1. Research objectives

This study sought to understand how midwives providing care in the north west regions of Melbourne, Victoria experienced the pandemic. Particular research aims included understanding the lived experiences of midwives providing care during the pandemic, the potential impacts of the pandemic upon midwives’ mental health, the workplace supports available to midwives throughout the pandemic, and midwives’ perceptions of equity in maternity care. These aims aligned with interpretive phenomenology as an appropriate methodological framework for inquiry.

This research was part of a larger interpretive phenomenological study by Murdoch Children’s Research Institute [MCRI] called Listening to What Matters [L2WM]. The study as a whole aimed to understand the experiences of refugee background families accessing maternity and early parenting care during the pandemic, alongside perspectives of health and social care professionals. This paper is focused solely on the experiences of midwives [L2WM:Midwives] as a critical workforce at risk of deterioration, with pandemic impacts compounding pre-existing challenges. Findings from L2WM as a whole will be disseminated in a variety of ways, including peer-reviewed publication and policy briefs. Further information about L2WM is available online: <https://www.strongerfutures.org.au/listening-to-what-matters>.

## 2. Methodology

This study used interpretive phenomenology to understand the lived experiences of midwives providing care during the pandemic. While phenomenology is simultaneously a philosophy and a methodology with many differing schools of thought [27], the methodological structure of this research has primarily drawn on the hermeneutic writings of Martin

Heidegger and Hans Gadamer [28,29]. Particular concepts used to guide the research process include ‘fore-structure’, the ‘hermeneutic circle’, and the ‘fusion of horizons’ [28,29].

Interpretive phenomenology is ontologically dominant, meaning that understanding ‘being’ is a fundamental component of the research question [27]. The manner by which humans relate to, understand, and exist in the world are relative to their context [30]. Language, religion, friendship, profession, and identity; the factors that contextualise our lived experience may be limitless [30]. Heidegger termed such factors fore-structures, and his hermeneutic circle the catalyst for attaining fore-structural awareness [28]. Rather than aiming for objectivity, interpretive phenomenology compels reflective recognition of factors that influence our way of thinking and living in the world [28,30].

In this study, the hermeneutic circle was used to guide the research process. The journey toward understanding lived experience began with myself as the researcher, continually moving back and forth between data, philosophy, literature, and reflective exercises [30]. Repetition was key to understanding, requiring the researcher to re-read, re-write, re-think, and re-engage [30]. This cyclical theory of understanding reinforced the ontological assertions of the methodology. There is no single truth, forestructures are innumerable, and lived experience is subjective [28,30].

Sharing lived experience with participants is usual in interpretive phenomenology [30]. It is essential to note that this feature is considered a unique strength of the methodology rather than poor practice [31]. In my role as researcher, I was situated inside the research, which was instrumental to increasing my insight [30,31]. During each interview, researcher and participant experienced Gadamer’s fusion of horizons, or a state of mutual understanding and harmony as midwives in the midst of a pandemic [29]. The fusion of horizons also encapsulates the researcher’s ability to use their own lived experience to make new meanings and extend their thinking throughout the analysis [29].

### 3. Reflexivity and rigour

In an interpretive phenomenological investigation, shared experiences, biases, or pre-understandings are overtly acknowledged [30,32]. As a midwife myself, during the pandemic I too provided maternity care in the north west suburbs of Melbourne. I bring an equity-informed approach to my clinical practice and enjoy working with women and families that require greater flexibility and support to engage with their care. Providing respectful care in partnership, within the public health system, is fundamental to my professional values. Within this research, my own lived experience provided important insight to the phenomenon and enhanced trust and connection with participants. My clinical knowledgebase, or preunderstandings, enriched interpretations of the data. Following the hermeneutic circle as a research process ensured my ongoing engagement in reflexive and reflective exercises including debriefing, supervision, contemporaneous record-keeping of early analytical assertions, and journaling.

Rigour signifies the thoroughness, worth, and integrity of qualitative research [33]. The practical application of generic criteria in evaluating the rigour of an interpretive phenomenological investigation can be problematic, due to incompatibility between philosophical foundations and standard measures [34,35]. For example, Sandelowski’s (1986) notion of ‘confirmability’ depicts freedom from bias as a central component of rigour [35,36]. In context of interpretive phenomenology, bias or shared experiences are overtly acknowledged rather than eliminated, which is congruent with a thorough methodological approach, opposed to a lack of rigour [32,34,35]. Ensuring rigour is essential, due to the direct implications for legitimacy and relevancy of the findings. De Witt and Ploeg’s *Interpretive Phenomenological Framework for Rigour* was used to inform study design and researcher conduct, due to its affinity with interpretive phenomenology as the overarching methodological approach [35]. The model includes criteria such as ‘balanced integration’; meaning that philosophical concepts are entwined with

methods, participant voices, and research findings [35].

## 4. Methods

### 4.1. Eligibility and recruitment

This study was conducted with registered midwives who provided maternity and/or early parenting care within the north west regions of Melbourne since the beginning of the pandemic. Eligibility was geographically defied by the scope of the funding body, the North Western Melbourne Primary Health Network [NWMPHN]: Hume, Moreland, Darebin, Yarra, Melbourne, Maribyrnong, Hobson’s Bay, Brimbank, Moonee Valley, Melton, Wyndham, Moorabool, and the Macedon Ranges. The catchment area was appropriate to meet the needs of the study as a whole, facilitating connection with a variety of women and health and social care professionals, including midwives. These jurisdictions provide maternity services for a large and diverse range of families, and include some of the highest settlement rates of refugees and asylum seekers in Victoria [37,38].

### 4.2. Participant demographics

A total of eight midwives from public, private, and community-based settings were recruited and interviewed for this study. Years of clinical midwifery experience ranged from one to twenty-five. Scope of practice was diverse. One participant provided antenatal and postnatal care only. Two worked within postnatal and birthing wards only. Five worked across the continuum of pregnancy, labour, birth, and early parenting care for up to six weeks post-partum. Three of these five participants also provided home birth services. Participant diversity ensured a range of experience and insight was represented within the data, which was appropriate given the broad scope of the research question. In view of the local study setting and to safeguard participant identities, pseudonyms have been assigned to each midwife, and no further details regarding their demographics are provided within this article. Maternity services and employees may be easily identified by local readers if numerous or unique details are named.

### 4.3. Sampling

Purposive and snowball sampling techniques were used to facilitate the strategic recruitment of eligible participants able to provide meaningful data [39]. Flyers were developed for online distribution and included a hyperlink to the Participant Information Sheet. Recruitment mediums included organisational email, WhatsApp, Twitter, and Facebook accounts. This strategy aimed to reach a broad audience within known professional networks and to comply with the state government’s stay-at-home restrictions in force at the time [40]. Participants were able to recommend other midwives and forward the digital invitation on. The number of midwives interested in participating aligned with project expectations and timelines. Although, a commitment was made ahead of time that no one who expressed interest in participating in the study would be turned away, as it was important for midwives to share their experiences if they wished. When recruitment closed, the hyperlink was adapted and directed interested persons to a webpage, which included the contact details for the study team.

### 4.4. Data collection

Data were collected via in-depth semi-structured interviews using telephone or video software, during the Victorian lockdown, between September and October of 2020. The eight interviews each lasted between forty to eighty minutes, were audio recorded with consent, then transcribed for analysis purposes. Questioning was open-ended, and used hermeneutical phrasing to encourage reflection, such as ‘tell me about your experience of...’. Analysis began alongside data collection;

an iterative approach to questioning facilitated the contemporaneous incorporation of important learnings into the interviews as the study progressed.

#### 4.5. Saturation

Interviews continued until saturation was reached. Saturation was identified when lines of enquiry became repetitive during interviews, and participant narratives overlapped significantly, sharing numerous characteristics [41]. Final data were rich and nuanced [41]. Although it is generally accepted in qualitative research that achieving saturation is key to producing rigorous results, it is also important to note that saturation is sometimes contested within interpretive phenomenological literature [30]. Given the understanding that lived experience is subjective, the methodology does not seek to provide a finite understanding of a phenomena, and exploration is theoretically infinite [30]. Utilising saturation as a measure of quality was also beneficial in providing a degree of pragmatic constraint to contain the volume of data collected within the limits of feasibility required to meet project deadlines and scope.

#### 4.6. Interpretive phenomenological analysis

Interpretive phenomenological analysis is different to a thematic analysis; the analysis seeks to reveal, understand, and communicate the essence of a lived experience [32]. Within this study, transcripts were initially read numerous times whilst listening to audio recordings, and pertinent connections or reflections documented. Stories were then crafted from verbatim data, which is a unique element of the methodology [42]. For each interview, essential elements of a participant’s narrative were woven together, interview questions deleted, and unintelligible aspects improved [42]. The final product was a story intended to expose the bones of an interview; an important step toward making interpretive analytical assertions [42]. Stories were returned to participants for review, a process known as member checking [43]. Although some phenomenologists question the worth of this practice, others assert the importance of taking this step in partnership with participants [42, 43].

Within this study, confirming narratives presented within the stories provided a meaningful opportunity for participants to corroborate the researcher’s preliminary analytical assertions, and reflect upon phenomenological understandings revealed by the narratives [42]. Six midwives reviewed their stories, providing endorsement and positive feedback. After reading her story, one midwife replied, “Yes. *This is exactly what being a midwife in a pandemic feels like. I love it*”. Two midwives revised several minor details that were not relevant to story themes, such as the specifics of their position description. These changes sought to correct information shared during the interview, rather than the researcher’s interpretations of data. Otherwise, no changes to the stories were made. Two midwives declined to review, citing high workload and stress.

Interpretation of the data continued by means of a manual coding technique, meaning that the stories were coded by hand [44]. Three cycles of coding were required to ensure an appropriate level of interpretation was applied, and descriptive elements of the analysis were minimised or removed [44]. Codes were then grouped into themes or understandings, to map the data as a whole. Regular project meetings between the study team facilitated rigorous discussion and theme development throughout the analysis, alongside fortnightly scholarly supervision for the first author. Heidegger’s hermeneutic circle provided ongoing structural guidance for the research process, such as re-reading and re-writing to increase interpretation and understanding, and refine key messages [30]. Ongoing reflection and repetition were essential to understanding and writing phenomenologically [30,32].

#### 4.7. Ethical considerations

This study received approval by the Royal Children’s Hospital [RCH] Human Research Ethics Committee and the Australian Catholic University [ACU] Human Research Ethics Committee, including peer review of the study protocol. Every effort was made to ensure the safety of participants and their data. Key issues identified include, but are not limited to: Data handling, protection of participant identities, and supporting participants who become distressed during interviews. Data was electronically stored in re-identifiable format using Research Electronic Data Capture [REDCap] as a secure database [45]. Access was granted to study staff only. Strategies for managing distress included demonstrating empathy, offering to stop the interview, and referral to community links or counselling. As a registered midwife, I have extensive experience and training in incidental counselling techniques and crisis management, which enabled a confident and appropriate response when required.

### 5. Findings

Study findings include nine themes, or understandings (Table 1). The unknown cost of change and adaptation; waves of the virus; balancing risk; telehealth; personal protective equipment; stripping away support; the privilege of abiding by the restrictions; separation, distress, uncertainty; and, professional strength. This section uses a literary narrative style to depict the lived experiences of midwives providing care during the pandemic [31]. In some places, details have been removed from the stories to preserve anonymity and the first author uses her own lived experience as a midwife to extend interpretations of the data, which is congruent with interpretive phenomenology [28–30].

#### 5.1. The unknown cost of change and adaptation

Throughout the pandemic and in the midst of the 112-day lockdown in Victoria, all aspects of our lives were upended and transformed as we adapted to the restrictions. Unprecedented, novel, rapid. How many times have we read these words? Perhaps they feel dated now? At the time these data were captured they were scarily accurate. As I interviewed the midwives for this study, a deep fatigue filtered through the air we breathed in our sequestered homes. Palpable despite being physically separated by a telephone or video call. No matter the midwife’s practice setting, heartache permeated each discussion as we considered the unknown cost of change to midwifery and impacts on the women and families we cared for. At a pragmatic level, minimising risk and transmission of the virus was an absolute priority; it was the outcome that was sometimes difficult to navigate. The metaphorical elephant in

**Table 1**  
Understanding midwives’ lived experiences throughout the pandemic.

Theme	Description
1. The unknown cost of change and adaptation.	Midwives grapple with fast-paced change and uncertainty.
2. Waves of the virus.	Midwives reflect on the way our response to the virus has changed over time.
3. Balancing risk.	Midwives observe the dynamic ways that risk is now perceived, because of the pandemic.
4. Telehealth.	Midwives share experiences of screening for family violence and working with interpreters over the telephone.
5. Personal protective equipment.	Midwives observe the impact of PPE on woman-centred care.
6. Stripping away support.	Midwives feel complicit in causing harm when separating women from their families.
7. The privilege of abiding by the restrictions.	Midwives discuss the inequitable impacts of COVID-19 restrictions for some women.
8. Separation, distress, uncertainty.	Midwives are concerned about longer-term mental health implications for women and babies.
9. Professional strength.	Being with-woman in a pandemic.



the room was the human cost of isolation. It could feel taboo as a health-care provider to name it. Were we all doing the right thing?

*“I can’t help but think there are other ways to approach this.” (Hazel)*

The difference in policy and procedure between facilities could be stark. The novel nature of this virus meant that the available evidence was sometimes scant or non-existent. It felt normal for midwives to be frustrated, confused, or sceptical. With a question mark hanging over the long-term implications of decisions made in the present, it was hard to fully commit to the more challenging changes that transformed the level of involvement with families and support people. The effects of restricting support people and visitors were complex, although the effort by employers and the Victorian government to protect staff was noted and appreciated. Midwives bore witness to the pronounced and distressing consequences of these changes. During these interviews, midwives expressed a convoluted sense of uncertainty and sadness for women, families, and themselves.

*“We are all sort of, flying blindly in this as we find out more and more.” (Hazel)*

*“We are setting up issues for women that will have an impact in the long run, rather than just making sure COVID is not spread. I think there are some important issues that are being overlooked in our immediate response. We’re sending families home supporting the historically negative perspective that women are the sole caregivers of children, and that women are the only bearers of that knowledge.” (Grace)*

We looked to the situation overseas and saw many health systems overwhelmed. Our Victorian hospitals were anticipating increased admissions for COVID-19, and some organisations were able to second or redeploy healthcare workers to their service. This frantic reshuffling of staff effectively reduced the number of professionals available in parts of the community. Whilst midwives in the community pushed themselves to care for each family in their caseload, dedication alone was not a remedy for inadequate staffing.

*“We have a massive caseload and to be honest we’re still finding ways to manage that because it is overwhelming.” (Lillian)*

When midwives spoke during these interviews, I intuited that some strove to overcome systemic issues, in the kind or quality of care they were able to provide in light of the challenges of the pandemic. Certain midwives perhaps powered around the wards; or left their work telephone on to respond to text messages from anxious mums, despite being off duty. Foregoing meal and toilet breaks, rest, and sleep might have meant one or two more women received better care that day. Within private practice, COVID safety recommendations were not always incorporated, illustrating this tendency to compensate in a pronounced and observable way. These midwives were able to make their own decisions, and so for some, face-to-face care continued with few changes.

*“I tried telehealth, but it didn’t work. The relationship with your midwife is one of the things that keeps homebirth safe. So, if I haven’t got the opportunity to develop that relationship during our appointments then I probably shouldn’t be doing my job.” (Mavis)*

In view of the unknown cost of change, this autonomy in practice could be both a privilege and a burden. Families using that service feel seen, heard, reassured.

*“I think most families are incredibly grateful that they still get to see a practitioner face-to-face. I’ve had lots of enquiries from women who are more than 30 weeks pregnant and haven’t actually had a face to face with a practitioner yet, apart from having some blood drawn or having an ultrasound. Even women who are booked with maternity group practices [continuity of midwifery model of care], haven’t had face to face appointments. No one has taken their blood pressure except maybe their*

*GP at their first visit. No one has palpated their baby. No one has measured a fundus. No one has seen their face when they talked about difficulties. No one has seen how the woman connects with her partner. I think that’s really distressing for lots of people. I’ve had at least two male partners of women at booking visits in the last couple of months share their feelings with me. We have all been sitting there together filling in forms, reviewing blood work, and talking about what they want in the first forty minutes or so, then this big sigh of relief comes out. One father said, ‘oh my god it’s such a relief to have someone actually listen to us and to know that we’ve organised care away from all that craziness’. So that kind of thing is extremely rewarding, to know that I can offer that to people.” (Mavis)*

What of the personal and professional cost to that midwife? The resources to care for more families do not exist, she is one person with finite energy and capacity to work. Will her practice be legally supported in the event of an unexpected outcome? The midwife lives with this risk, for herself and for the families.

Midwives who provided homebirth services experienced an unprecedented surge in booking enquiries. These midwives felt that many families were considering homebirth to avoid birthing in the hospital during the pandemic. Sometimes this was about being scared of the virus, but primarily seemed to be about staying connected with partners, family, and support people to feel safe.

*“Homebirth itself is getting some really good press at the moment, because so many women are choosing to step away from hospital care.” (Mavis)*  
*“But if you think that the biggest thing on their mind is ‘how long can you stay for? What are the visiting hours?’. It’s the first thing anyone asks, which clearly reflects that we need to improve our practice so that women aren’t so nervous and scared to be in a hospital setting.” (Thelma)*

Within the hospital, workloads surged in the absence of those family members and support people, who would usually have been present during appointments, labour, and birth. Present to receive good or bad news about the baby. Present and able to assist. Fetch that indispensable glass of icy water topped with bendy straw, hold a nervous hand, wipe a sweaty brow, or whisper words of reassurance. Women were alone so much of the time, with midwives scrambling to fill the void.

*“From a midwifery perspective, we don’t have more time to help the women. We still have the same patient load. The patient load wasn’t reduced so that we could accommodate the fact that women would need more support.” (Grace)*

The experience of professional disempowerment beat listlessly through these conversations. In the midst of the lockdown in Victoria, waterbirth was temporarily banned in most hospitals. This was a penultimate moment that wreaked discord and devastation for many midwives, as the decision became symbolic. Was the specially honed skill-base of our profession invisible, or unwanted? Where was the evidence-base? Where was the consultation? Where was the midwifery voice in these decisions? Midwives wanted to be asked. Midwives saw themselves as being uniquely positioned, able to bring important insights to the evolving multitude of policy and practice changes.

*“I would like to know... at least if I had someone who I know truly understood my perspective and who could speak for me, great, as long as I knew there was a voice in that space. But I’m not even sure that that voice exists. I don’t know if these policies are written by someone that gets midwifery from my perspective at all.” (Grace)*

During the second wave in Victoria, we were collectively cut off from the rest of Australia. It could feel like we were alone in the epicentre. Midwives providing care struggled to reconcile the unknown cost of change, with the need to save lives from a deadly virus that was becoming embedded in our community.

## 5.2. Waves of the virus: first and second lockdown experiences

Reflecting on the experience of the first lockdown, it seems now that we were all so naïve in our rush to resume normal living. Little did we know, this first lockdown was a taste of things to come; the scary, tedious, protracted, uncertain, and isolated experience of the second wave. At the beginning, there was no tangible sense of how long this virus would be with us.

*“All of these things were changing. I felt that our ability to provide family-centred care was being diluted. But in hindsight, it was nothing compared to what was coming.” (Hazel)*

At the start of that first lockdown, change was constant, frantic. A revolving door of new policies and procedures within hospitals and in the community, that had to be adapted on a day-to-day basis. Advice regarding appropriate PPE progressed as the accompanying evidence-base evolved, and in some settings was being rationed in preparation for the worst-case scenario. Imagine starting a shift and being given two masks for the day. At the time it was staggering to comprehend. What would happen to healthcare workers if we ran out? Whatever happened to changing PPE in between patient encounters? For midwives, this was a new way of thinking and living at work.

*“There was an interesting experience I had with a woman who was query-COVID. This was very early days in context of the new protocols addressing COVID. In that, we knew it was serious, but there weren't really concrete policies in place anywhere yet. At that point the policy was kind of ‘we'll just wear a normal mask, but we're not really concerned’. Her notes were still being taken in and out of her room. She was escorted for a chest Xray through common spaces, with the PSA [Patient Services Assistant] wheeling her in a chair. There were really no concerns. Then, as it looked more and more likely that she was going to be COVID-positive, it was interesting to see how we were trying to catch up with that information. Looking back and seeing ‘oh my gosh, there were so many moments where we really could have spread this’. Then the rush when she did become confirmed COVID positive, of trying to go back and repair all the possible damage that had been done.” (Grace)*

It felt at times that we were scrambling, stuck in a reactive state, lacking in strategy.

## 5.3. Balancing risk

Living with COVID-19 has transformed the way that risk is measured and perceived, particularly when case numbers and rates of community transmission are high.

*“I think that the priority of what's considered safe and how you balance risk against benefit has changed. Obviously because leaving the house is now risky when previously that wasn't. So that's changed. I think we're prioritising.” (Lillian)*

Reduction of viral transmission rates in the workplace required midwives to adapt; use telehealth, wear PPE, socially distance, avoid unnecessary touch or face-to-face encounters, and physically exclude family members or support people. When evaluating the biomedical, social, and emotional risks associated with this virus, the midwives I spoke to perceived and considered the compounding risks for the families who were being forcibly separated.

*“From the start I've felt that the social consequences of the virus and this pandemic are going to outweigh any kind of physical illness.” (Edith)*  
*“Clinical decisions are being made that are based on risk mitigation or the worst-case scenario. I feel like humanity is being sacrificed.” (Hazel)*

Their concern was not directed at downplaying the potential harm of an uncontrolled and deadly virus allowed to rage unchecked. Nonetheless, it was ethically distressing to feel complicit in the dismantling of

humanity in midwifery care, at an unknown cost to women, babies, and families.

## 5.4. Telehealth: the burgeoning distance that appeared between us

Telehealth was implemented early on during the first wave, for all midwives interviewed. Although, the practice environment appeared to determine the way in which telehealth was inevitably used. Many midwives were already accustomed to consulting over the telephone. Pragmatically, this was not a challenge. For the midwives I spoke with who worked in models of care without any continuity, a wave of sadness and frustration had swept into the widening abyss that sat between themselves and their clients in the absence of face-to-face care. Visits were shortened, telephone-based clinic lists were lengthened. It seemed illogical; women were alone, craving information to address this protracted state of uncertainty. These midwives, with less time than ever, briskly articulated their curated lists of critical information through a face shield and a mask, down the phone-line.

*“There's a lot of information that's not getting covered. A lot. We're dealing with the fundamental basics of an antenatal clinic appointment like, ‘how have you been feeling, has your baby been moving, these are your pathology results, these are the results that we have to organise before you return for your next visit, this was your fetal heart rate’. We're talking bullet point; this is what we can get through. Any of the other questions around pregnancy care and wellbeing, or any other questions they might have about what to expect in the care from this health institution, anything, or broader topics of health and wellbeing, are absolutely not being addressed.” (Grace)*

Three-way telephone calls between woman, midwife, and interpreter could introduce yet another layer of disconnect and distance to the visit. A midwife waits on hold, feeling the minutes tick by. Now she is running late. The telephone line crackles, and she is finally connected. Although the conversation will take longer as they communicate across multiple languages, there is no extra time afforded to this visit. This woman is likely to receive less information and have limited opportunities to ask questions or clarify information, compared to someone who can speak English. The gravity of this weighs heavy on the midwife's conscience.

*“During the pandemic, especially where English isn't the first language, there's a lot of things that are being missed and a lot of things that aren't understood. Although we do our best, you also have to understand and remember that clinic times have been reduced. We're supposed to keep them to ten minutes if possible, 20 minutes at a maximum. For anyone that understands all of the things that we have to address in an antenatal appointment, it's basically impossible.” (Grace)*

The art of midwifery may be captured in tiny moments when we are face-to-face with women. Shared smiles, eye contact, with knowing hands resting on a pregnant belly. Being together and being in tune with the gravity of what it means to have a baby. Can this connection be made over the telephone?

*“There's nothing like being together and in person.” (Hazel)*

One midwife I interviewed who worked in private practice, chose to have the initial meet and greet with clients over zoom, and all subsequent visits face to face. This midwife felt that telephone-based antenatal care jeopardised her ability to build a meaningful relationship with her clients, which in turn would make her care less safe.

*“I do meet and greets via Zoom now, whereas I used to do that first visit face to face. I am still doing face to face appointments for all the other visits. I think it's too important to develop a close relationship with a woman before a homebirth to put in another level of distancing. I tried out the telehealth, but it really, really didn't work.” (Mavis)*

Midwives repeatedly voiced concerns around screening for family

violence over the telephone, a mandatory practice in Victoria. The midwife is seated at a desk, with the telephone pressed to an ear that is straining, alert for any background noise that might indicate the woman on the line is not alone. The midwife asks if she feels safe at home and hopes that her best effort has been enough. That the woman has not been placed in harm's way because an undetected, unsafe person was privy to the call. Some midwives spent days and nights off-duty thinking about what had happened, what would happen, and if the women were ok.

*“Through the pandemic it's really scary because we usually see people. To be blunt, we usually see people and I can, even if for just my own sanity, visually say that they're okay, not close to death. But when we're doing everything by phone it's just so dangerous. The woman could be on speaker, their partner could be there right next to them. I think it's innately unsafe.” (Lillian)*

Perhaps for midwives, in some ways this pandemic has magnified the workforce dilemmas that preceded it. The juxtaposition of experience between midwives with and without continuity was often remarkable and challenging to synthesise during the interviews. The presence of continuity, and a greater degree of autonomy and control, enabled some midwives to continue working in relative partnership with women and families.

*“We can Zoom during their visits, so their grandmothers or other people can see their pregnant bellies and listen to the baby.” (Charlotte)*  
*“I've tried to compensate by ensuring we are doing Facetiming with partners and family, doulas and student midwives. I suggest that we record the fetal heart rate for those who are not able to be at the appointment in person.” (Hazel)*

Continuity provided a protective shield. A fuller cup. There were tiny measures, time and effort, that compensated in other ways for the restrictions to care.

### 5.5. Personal protective equipment: a blessing and a barrier

Access to adequate personal protective equipment was an essential component of feeling safe at work. Despite wanting to wear it and to feel protected from the virus, every additional layer increased the growing sense of distance between midwife, woman, and family.

*“We wear eye protection and a mask, or a face shield and a mask at all times and whilst PPE is necessary, it makes it so much harder to connect.” (Hazel)*

Overnight, midwives rustled in and out of postnatal rooms in their plastic gowns, disturbing women already woken so frequently by their new babies. In birthing, the midwives outside of continuity of care models, worked to build trust and rapport with women and families met that day. A shift spent raising their voice to be heard through an N95 mask, which muffled every word. Paradoxically, voices needed to be raised to sooth, reassure, and explain. Without being able to rely on facial expression, a soft voice, or body language, it was difficult to enter a birthing room in a non-intrusive way. Those first few moments with a labouring woman are important. With midwives ensconced in PPE, this quiet encounter could feel awkward, distant, intrusive.

*“It's this really impersonal experience and must be kind of intimidating to women. So, you're doing handover and there's this woman who is in such an exposed, vulnerable position, labouring, maybe half naked on a fit ball in the middle of the room and this weird creature comes through to get handover, it can't be a positive moment.” (Grace)*

Perhaps as social beings, many humans inherently need to see each other's faces to feel connected? For these midwives, being connected with women was an important feature of quality and safety in care. PPE was critical, valued, wanted. The connection that was missing as a result was still a devastating loss.

*“In context of working in birthing, look, I understand why from an institutional and healthcare perspective, we need to have PPE and be protected. It's serious and it's real and I understand the need. I'm not saying that I don't appreciate the efforts that have been taken to protect the staff. But it is amazing the impact that it has on women centred care in a birth space. For a lot of women, not being able to see a person's mouth while they're speaking, and not being able to really see a person's eyes. I mean, I think we start to realise how powerful that communication tool is. How important it is, being able to have your whole face visible to women. And how much we communicate with our eyes. And with small, almost unspoken words.” (Grace)*

Again, these interviews revealed to me that midwives who worked in models with continuity did not appear to experience the same level of disconnect.

*“At least when there is continuity of care, even in the presence of PPE... you have the advantage of that connection. You have formed a relationship as the foundation of care. I can't imagine what it would have been like if women didn't have that. If they were just surrounded by masked strangers.” (Hazel)*

Relationships were a protective factor in preserving emotionally connected care.

### 5.6. Stripping away support

Midwives are uniquely placed as care providers. The partnership between midwives, women, and families lies at the heart of meaningful care. Before the pandemic, involving support people in all aspects of care was a fundamental measure of best practice.

*“The support for families has been stripped away. It's not by choice, it's forced.” (Esther)*

Midwives felt confused, compromised, and complicit as they sent new fathers or parents' home just two hours after the birth of their child. In the instance of a clinical emergency, the time it took to save lives and tend to woman or baby might rob that family of any opportunity to bond. The immeasurable value in those first moments of new life were seemingly invisible, unappreciated, or unseen by the health professionals, administrators, and bureaucrats in charge of policy and practice change. At the time these interviews were conducted, the evidence-base informing this particular policy was apparently sparse. Midwives understood the stripping away of support to be based on a general understanding of infection control procedure, and transmission of COVID-19. The absence of a demonstrable evidence-base to support this particular policy imposed another layer of ethical distress for the midwives required to abide by it. On a day-to-day basis, the emotional harm caused to many families was palpable. Was this really the right thing to do?

*“I just feel awful, and I can see their faces, and I can see everyone's face in that situation is just gutted. And angry and resentful towards us as the people who have to be the bearers of that bad news.” (Grace)*

The perception of the harm this caused for many people was almost alienating. Midwives who practiced in hospitals were placed in a uniquely harrowing position; responsible for enforcing restrictions they understood to be emotionally harmful and potentially traumatic; whilst having no discernible sense of voice or influence.

*“Because of the way that sometimes midwives are perceived by those above them, they don't really care about what we think. They're like 'oh yeah you'll be fine, just go and change a nappy or something'. They don't understand the full extent of the job that we do. It's not just catching babies and changing nappies, it's a whole heap of other things and there's so many emotions involved. It is at times really frustrating, and there have been more shifts that I've left angry and annoyed than I have not. But*



again, it's getting to that point where we're all just so defeated by it, that it's just acceptance really". (Esther)

The general level of intervention during labour and birth that is normal in Australian hospitals may be life changing for women, but is not considered grounds for special treatment in a pandemic. A woman may experience a long and arduous induction of labour that results in a caesarean section and a post-partum haemorrhage. She may feel exhausted and not be able to reach her baby, food, or water from the postnatal bed. She may not speak any English. Her milk might not feel like it is coming. But her partner or her family cannot stay. She must buzz the midwife, wait for the midwife. A chorus of buzzers echo around the ward, and midwives scramble to respond.

*"Labour and birth have not gone to plan. In their heads major surgery is an extenuating circumstance to the rules. There are all these things have been said in the media and at the hospital, that if you've got an extenuating circumstance, we can allow partners to stay. Well, they therefore see that surgery, that big, massive, life changing operation as an extenuating circumstance. By all accounts in maternity, it's not."* (Esther)

Midwives in private practice were confronted with restrictions on their attendance in hospital similar to family members and support people, although this did vary according to the institution. The inconsistent approach between organisations could feel nonsensical and stirred underlying feelings of professional invisibility; the need to transfer a planned homebirth to hospital is not uncommon. During the pandemic, the energy that had gone in to building a strong relationship for the labour and birth might be dashed in a moment.

*"I have had a hospital transfer during the pandemic. The healthcare facility told me I couldn't go. I wasn't allowed to go with them. I put her in the ambulance, stayed at the house, and cleaned up. Packed up my stuff and went home. It was awful. It was really awful."* (Mavis)

The ambulance arrives, the midwife calmly settles the woman and her support person into the back. She gives the attending paramedics a comprehensive verbal handover and relinquishes her notes. Her clients leave and she tidies their house feeling sick with guilt. Now, she has to wait. Maybe tomorrow she will find out what has happened.

### 5.7. The privilege of abiding by the restrictions

The restrictions did not allow for consideration of culture, language, or family dynamics. The inherent assumption was family homogeneity; mother, father, baby. The exclusion of support people was inequitable for many women, and midwives were unable to advocate for women outside of extraordinarily exceptional circumstances.

*"We've assumed there's only one person, where's there's only one other partner, who really would need to be present at the birth of their child."* (Grace)

*"We are having a one size fits all approach applied to all women."* (Hazel)

A woman who can't speak or read any English trails after any visibly pregnant woman she can see near the entrance of a busy hospital, hoping they will lead her to the right place for her appointment that she has been told to attend alone. She doesn't want to do the wrong thing. A single mother with four other children is in early labour. She calls the friend who was going to look after the kids while she has this baby, but the friend doesn't answer. She is nervous and worried the baby will come before she gets help for her other kids. Another woman tries to fall asleep in her car, parked on a quiet street. There is no fuel in the tank. She is still waiting to hear about housing from the social worker. Tonight, her baby isn't moving as much as usual, but she has no credit on her telephone to call the hospital. They will call her for the next telephone appointment in two days. She keeps the volume turned up loud so

as not to miss the call.

*I think that is about people deteriorating because of all the factors around destitution, but also about the increase in the quantity of people needing assistance because of that. You know, loss of income, loss of Medicare [the right to access government funded healthcare]."* (Lillian)

Many, many women need more flexibility than others to engage with care. There is a sense that if midwives had a stronger voice in responding to this pandemic, these existing inequities would be being addressed rather than degenerating. The inability of organisations to take an individualised approach to care has meant at times in the pandemic, midwives felt they were providing a crisis health response, rather than holistic primary care.

*"It just kind of snowballs when you realise this family has the swiss cheese model. We've just caught them right at the bottom there, before something really quite awful could've potentially occurred."* (Lillian)

For some midwives, the sense of complicity in causing distress has eroded their resilience. For all midwives that I spoke to, vicarious trauma had worn away at wellbeing. Joy was stripped from many workdays.

### 5.8. Separation, distress, uncertainty

Whether contemplating possible mental health outcomes, breast-feeding rates, or neonatal readmissions for weight loss and jaundice; the midwives I interviewed for this study intuited the correlation between a woman's experience of pregnancy, labour, and birth, and her subsequent journey as a mother. In a contradiction of terms, the unclear and unknown implications of the pandemic were certain.

*"I think that the mental health detriment of this is underseen at this point"*. (Esther)

*"If I were to forecast, I feel that there will be a surge in perinatal mental health issues due to isolation and an increase in demands on services and supports. Women aren't able to share their pregnancy journey with their families and communities. I think this will, for some, impact the transition to motherhood."* (Hazel)

*"It's the sadness and the loneliness of the women that we look after, from not having that normal support that they expected."* (Thelma)

*"There's so much anxiety, stress and unhappiness surrounding labour, birth, and postnatal care at the moment. Even antenatal care. I think it is really stressful for families being separated. I think it's a really awful thing."* (Esther)

*"It was so traumatic and although they were together, I feel that the damage had been done. This experience has left her with a deep-seated trauma."* (Hazel)

Midwives have observed the distress of childbearing women at this time, are concerned for the mental health and wellbeing of mothers and babies, and worried about the long-term outlook.

### 5.9. The strength of our profession

The birthing room is quiet and dark. The woman kneels on a pillow on the floor with her head resting on the bed. She rolls her head back and forth, grunting. Her midwife sits beside her, murmuring reassurance and pressing a heat pack in to the small of her back. A small gush of pink liquor flows on to a pad that sits between the woman's legs. The midwife smiles invisibly, beneath the skin-tight N95 mask that chafes abrasively against her cheeks. The air suddenly fills with the smell of faeces, and the midwife's invisible smile broadens. She says, "your baby is getting closer, you're going to meet him soon". The baby's father looks on, alarm etched across his face as he observes the speck of faeces that has dropped from his wife on to the soaked pad below her. He has never witnessed birth before. The midwife quietly replaces the soiled pad,

changes her gloves, and resumes her quiet murmurs of encouragement. Yes, this midwife is ensconced in PPE, her throat sticking with thirst and bladder bursting. Yet here is this midwife, connected and in-tune with woman, in a birth, in a lockdown, in a pandemic.

Midwives work in an environment that is visceral, embodied, messy, mammalian. The primal aspects of midwifery inherently contradict many of the safety precautions we live with as we navigate life with the virus. Social distancing did little to decrease risk in a birthing environment. The dichotomy of birth, infection control, and viral transmission triggered midwives' feelings of invisibility and misrepresentation during the pandemic. No longer able to share a hug at the end of a difficult night shift, midwives trudge out to their cars tired and alone.

*“On the day that RANZCOG [Royal Australian and New Zealand College of Obstetricians and Gynaecologists] made the recommendation that labouring in birth pools was to be ceased, that day I had an entire glove full of liquor. Like I had all the PPE on, but it didn't matter. Just a full glove of liquor. It felt like, I really don't know how this is really going to change much in terms of bodily fluids being transmitted. In a labour and birth, bodily fluids are present.” (Grace)*

The tension of living through a pandemic has emphasised pre-existing vulnerabilities and strengths of the midwifery workforce. Any intention to leave clinical practice is entwined with feelings of midwifery being invisible or de-valued. Midwives want to provide midwifery care. Midwives crave the power of having their voice represented in meaningful conversations. Like an N95 mask, this relentless pandemic has attempted to stifle the innate strength and resilience of the profession and disregard our voice. No one asked us.

## 6. Discussion

Findings from this research present new evidence regarding the experiences of midwives providing care in the north west suburbs of Melbourne, Victoria during the pandemic. This is one of the first papers that specifically voices the experiences of midwives in this context. Given the interesting timeframe that data were collected, this study also reveals unique insight into emotions associated with stringent and lengthy lockdowns, such as fatigue and surrender. Findings highlight the importance of meaningful consultation and collaboration when enacting changes to policy and practice, as well as identifying protective factors to professional wellbeing such as continuity of care and the relationship between midwife, woman, and family.

Conflicting ideologies are an important source of emotion work for midwives [24]. It is well-understood that philosophical discord between medical dominance and the midwife-woman relationship has the power to compromise kind or quality of care, and cultivate emotional difficulties [24]. Professional satisfaction is improved and burnout reduced when midwives work in a way that promotes continuity, due in part to the inherent fulfilment of providing relationship-based care for women and families [19]. To contextualise the results of this study, it is necessary to consider the state of midwifery in Australia prior to COVID-19. The overlaying of a pandemic upon midwives has amplified pre-established issues. This is a workforce embedded in a paradoxical state. Specialist skill, passion, and the ideals that underpin woman and family centred care are juxtaposed against considerable rates of burnout, trauma, and attrition [17,23,24].

A study by Fenwick et al. found high rates of personal and work related burnout in 990 Australian midwives; 64.9% reported moderate to severe levels of personal burnout, and 43.8% of work-related burnout [21]. Trauma and vicarious trauma are strongly correlated with burnout [25]. Established causes include disrespectful interactions between women and staff, professional disrespect, traumatic birth events, feelings of complicity in poor practice, and workplace issues such as inadequate staffing that compound stress in an emergency situation [23]. Harvie et al. surveyed 1037 Australian midwives and found that 42.8%

had thought about leaving the profession within the preceding six months [17]. Qualitative themes included thoughts of ‘going nowhere’ professionally due to the lack of continuity of care options and inflexibility of mainstream care; and, being at ‘breaking point’ due to overwhelming dissatisfaction with an excessively stressful work environment [17]. Data such as these highlight some of the challenges faced by midwives prior to the pandemic and its associated phenomenon of large-scale illness, death, lockdown, and changing care.

Recently, a paper addressing the pandemic experiences of Australian midwives nation-wide reported findings that closely align with L2WM: Midwives [8]. Bradfield et al. found the impact of change for midwives to be significant [8]. Primary concerns emphasised by participants related to the negative effects observed for women and families being separated [8]. Bradfield et al. also found that the protective effects of continuity of care continued throughout the pandemic [8]. Their recommendations included systemic expeditious change, and that national workforce strategies ought to prioritise woman and family centred models of care to promote wellbeing for midwives, as well as for women [8]. It is important to note that data for this research were collected nationally, and that the unique pandemic experiences of Victorian midwives have not been specifically investigated. L2WM:Midwives is one of the first known studies responsive to this knowledge gap.

The findings from L2WM:Midwives corroborate emerging knowledge and provide increased evidence supporting the recommendations made by Bradfield et al. [8]. Midwives who had access to continuity of care felt better equipped to navigate change. Maintaining an ongoing caring relationship with woman and family encouraged professional resilience. Telehealth was incorporated with greater confidence, including working with interpreting services over the telephone. Barriers to rapport posed by restrictive PPE were more easily navigated. These midwives embodied a comparative sense of autonomy and control within their practice, and also had increased access to professional support when they needed it, including regular supervision that was built-in to the role for some. Unfortunately, the majority of midwives do not yet have access to continuity of care in our maternity system [19, 22].

Many of the stories shared in these findings elucidate a sense of professional invisibility, the silenced voices of midwives during the pandemic. The sorrow and loss of woman and family-centred care inextricably linked to feelings of anger and defeat, owing to the overt absence of meaningful consultation. This was epitomised by the response of some midwives to the temporary prohibition of waterbirth during the Stage 4 lockdown. Midwives saw themselves as uniquely placed, available to share specialist knowledge and to advocate for women. Midwives who were interviewed for this study felt morally compromised by the exclusion of family members and support people, because of the emotional impacts they observed. While health risks relative to COVID-19 were respectfully understood and acknowledged, these midwives felt simultaneously complicit in causing harm.

For all participating midwives, the inherent inequity of a ‘one size fits all’ approach to enforcing the coronavirus restrictions caused significant distress. These midwives were present at the coalface, observing the unintended disparate effects of separation for women and families. Stories depict harrowing accounts of emotional harm to those with the greatest need for equitable support. Systemic understandings of what entailed an ‘extenuating circumstance’ to restrictions did not align with the understandings of midwives.

Midwives felt that the emotional harm caused by separating women and families was so significant, that in some cases it outweighed harm of the virus. Within this study, midwives questioned whether there may have been another way to safely approach change, that better reflected the priorities of the midwifery workforce and of women. This point presents a pertinent learning to inform systems, leaders, and policy-makers responsible for responding to the pandemic in the longer term. Expending time and resources to consult, confer, and collaborate prior to enacting change may be an important and worthwhile investment in

workforce wellbeing and staffing retention [8,26]. This could be achieved in the workplace via ongoing staff forums or meetings, opportunities to give feedback on policies before they ‘go live’, and more broadly via increased opportunities for collaboration between healthcare organisations, our peak professional body [the Australian College of Midwives], governments, and unions.

Inadequate resources and staffing in hospital settings during the pandemic compounded stress, increased unsustainable workloads, and amplified feelings of resignation and surrender. The emotional distress caused by these workplace factors has direct implications for professional sustainability. This aligns with previous research, which has suggested that our health system could be strengthened by providing better support and improving staffing ratios during times of duress and demand, such as a pandemic [26]. Increasing access to continuity of care; restructuring of maternity services to allow for team-based care and increased capacity of caseload midwifery care; and increased midwifery staff numbers in all areas, may also provide a strong foundation and a maternity workforce well positioned to effectively respond to the needs of women and families, in a sustainable and effective way, during times of crisis in the future.

## 7. Strengths and limitations

A key strength of this research is the methodological framework used to inform the enquiry. Interpretive phenomenology is philosophically driven, requires a reflexive and rigorous approach to conducting research, and is associated with an increased depth of understanding. Additionally, this paper is one of the first to specifically address the pandemic experiences of midwives in Victoria, which remain unique in comparison to other Australian states and territories, due to the ‘second wave’ and second lockdown. Timing of data collection is both a strength and limitation. The emotions associated with lockdown are important to capture, but are limited in considering the range of experiences associated with the pandemic long-term, as society adapts to living with the virus. Findings may provide transferrable insights for midwives, leaders, policymakers, and systems in global regions that have also undergone extended lockdowns. Limitations include the restricted eligibility criteria for participants. Although, given the high number of births and service acuity, alongside the diverse cultural and sociodemographic scope of the north west regions of Melbourne, this limitation is somewhat mitigated.

## 8. Implications for practice

Key findings describe the negative emotional impacts for midwives following a perceived lack of representation during the pandemic, at a decision-making level. As the pandemic response continues long-term, appropriate representation of midwives is critical to ensuring the unique values and perspectives of the profession are seen to be included, when contemplating or instigating change. Midwives want to feel that their voices are heard. This finding suggests a need to refine the way that information is communicated to clinical staff, ensuring clarity and accessibility for those working at the coalface. Midwives are a critical workforce at risk of increased burnout and attrition due to their pandemic experiences. Pre-existing workforce issues could potentially worsen over the coming months and years, warranting improved access to professional supports. This paper highlights the importance of continuity of care as a professionally protective factor that encourages resilience and wellbeing. Therefore, increased opportunities to work in models that provide continuity may enhance professional satisfaction and longevity for midwives.

Midwives in this study also raised important concerns that screening for family violence over the telephone could place women at risk of harm. Historically, antenatal care has usually been provided face to face, and policy has emphasised screening for safety early in pregnancy [46]. It is unlikely that identifying and responding to family violence via

telehealth has been a substantive feature of health care education to date. Following the widespread uptake of telehealth in Victorian maternity services, generating evidence to inform this redesign of antenatal care ought to be prioritised. Telehealth is a new area of practice, and further research is urgently required to understand the needs of midwives and women in this space [47].

The rapid pace of change during the pandemic has been challenging. Although the speed of Victoria’s response to COVID-19 demonstrates that when circumstances require, systemic transformation is possible. This is a critical learning. As healthcare systems continue to respond to the pandemic in the longer-term, this newfound adaptability presents a unique opportunity to strengthen evidence-based service delivery and improve outcomes for midwives, as well as women.

## 9. Conclusion

The experience and expertise of midwives are a critical resource, inadequately harnessed throughout the pandemic. Midwives are more likely to enjoy their work, provide high-quality care, and remain in the profession when they are involved in important conversations, feel their values are represented in the care they provide, and are able to work in ways that support continuity. This study provides important recommendations to inform our response to the pandemic long-term, and to future epidemics, pandemics, or other large-scale events.

### Author statement

This research article contains our original work, has not received prior publication, and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted. The authors agree to abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

### Ethical statement

Ethics approval was obtained from the RCH Human Research Ethics Committee and the ACU Human Research Ethics Committee.  
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### Conflict of interest

None declared.

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### CRediT authorship contribution statement

**Fran Hearn:** Writing - original draft, Methodology, Conceptualization, Formal analysis, Investigation, Visualization. **Laura Biggs:** Writing - review & editing, Methodology, Conceptualization, Formal analysis, Investigation, Supervision, Project administration. **Heather Wallace:** Writing - review & editing, Formal analysis, Investigation, Supervision. **Elisha Riggs:** Writing - review & editing, Methodology, Conceptualization, Formal analysis, Investigation, Supervision, Funding acquisition.

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## References

- [1] World Health Organisation, Timeline: WHO's COVID-19 Response, World Health Organisation, Geneva, 2021 [Cited 2021 March 13]. Available from: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline/#1>.
- [2] Department of Health, Coronavirus: Current Situation and Case Numbers, Australian Government, Department of Health, Canberra, 2021 [Cited 2021 March 13]. Available from: <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers>.
- [3] Department of Health and Human Services, Victorian Coronavirus (COVID-19) Data, State Government of Victoria, Department of Health and Human Services, Melbourne, 2021 [Cited 2021 March 12]. Available from: <https://www.dhhs.vic.gov.au/coronavirus>.
- [4] Department of Health, COVID-19: A Chronology of State and Territory Government Announcements (Up Until 30 June 2020), Australian Government, Department of Health, Canberra, 2020 [Cited 2021 Mar 13]. Available from: [https://www.aph.gov.au/About/Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements#\\_Toc52275800](https://www.aph.gov.au/About/Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements#_Toc52275800).
- [5] Department of Health and Human Services, Essential Workers and Essential Providers List, State Government of Victoria, Department of Health and Human Services, Melbourne, 2021 [Cited 2021 March 13]. Available from: [https://www.dhhs.vic.gov.au/sites/default/files/documents/202102/Essential%20Workers%20and%20Essential%20Providers%20List\\_2.pdf](https://www.dhhs.vic.gov.au/sites/default/files/documents/202102/Essential%20Workers%20and%20Essential%20Providers%20List_2.pdf).
- [6] J.P. Vogel, B. Tendal, M. Giles, C. Whitehead, W. Burton, S. Chakraborty, et al., Clinical care of pregnant and postpartum women with COVID-19: living recommendations from the National COVID-19 Clinical Evidence Taskforce, *Aust New Zeal J Obstet Gynaecol* 60 (6) (2020) 840–851, <https://doi.org/10.1111/ajo.13270>.
- [7] Department of Health and Human Services, Clinical Guidance and Resources – Coronavirus (COVID-19), State Government of Victoria, Department of Health and Human Services, Melbourne, 2021 [Cited 2021 March 23]. Available from: <https://www.dhhs.vic.gov.au/clinical-guidance-and-resources-covid-19>.
- [8] Z. Bradfield, Y. Hauck, C.S.E. Homer, L. Sweet, A.N. Wilson, R.A. Szabo, et al., Midwives' experiences of providing maternity care during the COVID-19 pandemic in Australia, *Women Birth* (2021) e1–e10, <https://doi.org/10.1016/j.wombi.2021.02.007>. Epub 2021 March 15.
- [9] C.S.E. Homer, M. Davies-Tuck, H.G. Dahlen, V.L. Scarf, The impact of planning for COVID-19 on private practising midwives in Australia, *Women Birth* 34 (1) (2021) e32–e37, <https://doi.org/10.1016/j.wombi.2020.09.013>.
- [10] L. Sweet, Z. Bradfield, V. Vasilevski, K. Wynter, Y. Hauck, L. Kuliukas, et al., Becoming a mother in the 'new' social world in Australia during the first wave of the COVID-19 pandemic, *Midwifery* (2021), 102996, <https://doi.org/10.1016/j.midw.2021.102996>. Epub 2021 March 21.
- [11] L. Ostacoli, S. Cosma, F. Bevilacqua, B. Berchiulla, M. Bovetti, A.R. Carosso, et al., Psychosocial factors associated with postpartum psychological distress during the COVID-19 pandemic: a cross-sectional study, *BMC Pregnancy Childbirth* 20 (1) (2020) e1–e9, <https://doi.org/10.1186/s12884-020-03399-5>.
- [12] K. McCaffery, R. Dodd, E. Cvejic, J. Ayre, C. Batcup, J. Isautier, et al., Health literacy and disparities in COVID-19-related knowledge, attitudes, beliefs and behaviours in Australia, *Public Heal Res Pract* 30 (4) (2020) 303420212, <https://doi.org/10.17061/phrp303420212>.
- [13] M.J. Renfrew, H. Cheyne, J. Craig, E. Duff, F. Dykes, B. Hunter, et al., Sustaining quality midwifery care in a pandemic and beyond, *Midwifery* 88 (2020), 102759, <https://doi.org/10.1016/j.midw.2020.102759>.
- [14] D.F. Pacquiao, Social inequality and the COVID-19 pandemic, *J. Transcult. Nurs.* 32 (1) (2021) 86, <https://doi.org/10.1177/1043659620962557>.
- [15] L. Paakkari, O. Okan, COVID-19: health literacy is an underestimated problem, *Lancet Public Heal* 5 (5) (2020) 249–250, [https://doi.org/10.1016/S2468-2667\(20\)30086-4](https://doi.org/10.1016/S2468-2667(20)30086-4).
- [16] A. Eddy, Midwifery as primary healthcare, in: S. Fairman, S. Tracy, H. Dahlen, L. Dixon (Eds.), *Midwifery: Preparation for Practice*, 4th ed., Elsevier Australia, Sydney, 2019, pp. 79–88.
- [17] K. Harvie, M. Sidebotham, J. Fenwick, Australian midwives' intentions to leave the profession and the reasons why, *Women Birth* 32 (6) (2019) 584–593, <https://doi.org/10.1016/j.wombi.2019.01.001>.
- [18] B. Hunter, L. Warren, Midwives' experiences of workplace resilience, *Midwifery* 30 (8) (2014) 926–934, <https://doi.org/10.1016/j.midw.2003.12.004>.
- [19] K. Dawson, M. Newton, D. Forster, H. McLachlan, Comparing caseload and non-caseload midwives' burnout levels and professional attitudes: a national, cross-sectional survey of Australian midwives working in the public maternity system, *Midwifery* 63 (2018) 60–67, <https://doi.org/10.1016/j.midw.2018.04.026>.
- [20] E. Callander, M. Sidebotham, D. Lindsay, J. Gamble, The future of the Australian midwifery workforce – impacts of ageing and workforce exit on the number of registered midwives, *Women Birth* 34 (1) (2021) 56–60, <https://doi.org/10.1016/j.wombi.2020.02.023>.
- [21] J. Fenwick, A. Lubomski, D.K. Creedy, M. Sidebotham, Personal, professional and workplace factors that contribute to burnout in Australian midwives, *J. Adv. Nurs.* 74 (4) (2018) 852–863, <https://doi.org/10.1111/jan.13491>.
- [22] C. Catling, C. Rossiter, Midwifery workplace culture in Australia: a national survey of midwives, *Women Birth* 33 (5) (2020) 464–472, <https://doi.org/10.1016/j.wombi.2019.09.008>.
- [23] J. Toohill, J. Fenwick, M. Sidebotham, J. Gamble, D.K. Creedy, Trauma and fear in Australian midwives, *Women Birth* 32 (1) (2019) 64–71, <https://doi.org/10.1016/j.wombi.2018.04.003>.
- [24] B. Hunter, Conflicting ideologies as a source of emotion work in midwifery, *Midwifery* 20 (3) (2004) 261–272, <https://doi.org/10.1016/j.midw.2014.03.010>.
- [25] R. Sidhu, B. Su, K. Shapiro, K. Stoll, Prevalence of and factors associated with burnout in midwifery: a scoping review, *Eur J Midwifery* 4 (February) (2020) e1–e15, <https://doi.org/10.18332/ejm/115983>.
- [26] S. Shorey, V. Chan, Lessons from past epidemics and pandemics and a way forward for pregnant women, midwives and nurses during COVID-19 and beyond: a meta-synthesis, *Midwifery* 90 (2020), 102821, <https://doi.org/10.1016/j.midw.2020.102821>.
- [27] M. Miles, K. Francis, Y. Chapman, B. Taylor, Hermeneutic phenomenology: a methodology of choice for midwives, *Int. J. Nurs. Pract.* 19 (4) (2013) 409–414, <https://doi.org/10.1080/10376178.2015.1067571>.
- [28] M. Heidegger, *Being and Time*, Blackwell, Oxford, 1962.
- [29] H.-G. Gadamer, *Truth and Method*, 2nd ed., London, Sheed and Ward, 1989.
- [30] M. van Manen, *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, State University of New York Press, Albany, 1990.
- [31] J. Cowan, E. Smythe, M. Hunter, Women's lived experiences of severe early onset preeclampsia, in: G. Thompsom, S. Downe, F. Dykes (Eds.), *Qualitative Research in Midwifery and Childbirth: Phenomenological Approaches*, Routledge, Hoboken, 2011, pp. 96–113.
- [32] E. Smythe, From beginning to end: how to do hermeneutic interpretive phenomenology, in: G. Thompsom, F. Dykes, S. Downe (Eds.), *Qualitative Research in Midwifery and Childbirth: Phenomenological Approaches*, 1st ed., Routledge, Hoboken, 2011, pp. 35–54.
- [33] C. Emden, M. Sandelowski, The good, the bad and the relative, part one: conceptions of goodness in qualitative research, *Int. J. Nurs. Pract.* 4 (4) (1998) 206–212, <https://doi.org/10.1046/j.1440-172x.1998.00105.x>.
- [34] L. Kay, S. Downe, G. Thomson, K. Finlayson, Engaging with birth stories in pregnancy: a hermeneutic phenomenological study of women's experiences across two generations, *BMC Pregnancy Childbirth* 17 (1) (2017) 1–12, <https://doi.org/10.1186/s12884-017-1476-4>.
- [35] L. de Witt, J. Ploeg, Critical appraisal of rigour in interpretive phenomenological nursing research, *J. Adv. Nurs.* 55 (2) (2006) 215–229, <https://doi.org/10.1111/j.1365-2648.2006.03898.x>.
- [36] M. Sandelowski, The problem of rigor in qualitative research, *ANS Adv. Nurs. Sci.* 8 (3) (1986) 27–37, <https://doi.org/10.1097/00012272-198604000-00005>.
- [37] North Western Melbourne Primary Health Network, Refugees and Asylum Seekers, North Western Melbourne Primary Health Network, Melbourne, 2021 [Cited 2021 August 5]. Available from: <https://nwmphn.org.au/our-work/priority-populations/refugees-and-asylum-seekers/>.
- [38] North Western Melbourne Primary Health Network, Children and families area profile, North Western Melbourne Primary Health Network, Melbourne, 2017 [Cited 2021 August 5]. Available from: <https://nwmphn.org.au/about/our-community/community-and-population-health-profiles/>.
- [39] P. Liamputtong, *Qualitative Research Methods*, 5th ed., Oxford University Press, Melbourne, 2020.
- [40] C. Benedict, A.L. Hahn, M.A. Diefenbach, J.S. Ford, Recruitment via social media: advantages and potential biases, *Digit. Health* 5 (2019) 1–11, <https://doi.org/10.1177/2055207619867223>.
- [41] J. Morse, The significance of saturation, *Qual. Health Res.* 5 (2) (1995) 147–149, <https://doi.org/10.1177/1049732315576699>.
- [42] K. Caelli, Engaging with phenomenology: is it more of a challenge than it needs to be? *Qual. Health Res.* 11 (2) (2001) 273–281, <https://doi.org/10.1177/104973201129118993>.
- [43] T. McConnell-Henry, Y. Chapman, K. Francis, Member checking and Heideggerian phenomenology: a redundant component, *Nurse Res.* 18 (2) (2011) 28–37.
- [44] J. Saldaña, *The Coding Manual for Qualitative Researchers*, Sage, London, 2009.
- [45] P.A. Harris, R. Taylor, B.L. Minor, V. Elliott, M. Fernandez, L. O'Neal, et al., The REDCap consortium: building an international community of software platform partners, *J. Biomed. Inform.* 95 (2019), 103208, <https://doi.org/10.1016/j.jbi.2019.103208>.
- [46] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 2: Collaboration to Support Good Mental Health and Wellbeing, Parl Paper No. 202, Session 2018–21 (Document 3 of 6), Victorian State Government, Melbourne, 2021 [Cited 2021 August 22]. Available from: [https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS\\_FinalReport\\_Vol2\\_Accessible.pdf](https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_Vol2_Accessible.pdf).
- [47] S.M. Jack, M.L. Munro-Kramer, J. Roberts Williams, D. Schminkey, E. Tomlinson, L. Jennings Mayo-Wilson, et al., Recognizing and responding to intimate partner violence using telehealth: practical guidance for nurses and midwives, *J. Clin. Nurs.* 30 (3–4) (2021) 588–602, <https://doi.org/10.1111/jocn.15554>.