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'Forgotten as first line providers': The experiences of midwives during the COVID-19 pandemic in British Columbia, Canada

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ARTICLE INFO

Article history:

Received 18 October 2021

Revised 17 July 2022

Accepted 20 July 2022

Keywords:

Midwives

COVID-19 pandemic

British Columbia

Canada

Qualitative methods

Maternity care

ABSTRACT

Objective: To explore midwives' experiences working on the frontlines of the COVID-19 pandemic in British Columbia, Canada.

Design: Qualitative study involving three semi-structured focus groups and four in-depth interviews with midwives.

Setting: The COVID-19 pandemic in British Columbia, Canada from 2020-2021.

Participants: 13 midwives working during the first year of the COVID-19 pandemic in British Columbia.

Findings: Qualitative analysis surfaced four key themes. First, midwives faced a substantial lack of support during the pandemic. Second, insufficient support was compounded by a lack of recognition. Third, participants felt a strong duty to continue providing high-quality care despite COVID-19 related restrictions and challenges. Lastly, lack of support, increased workloads, and moral distress exacerbated burnout among midwives and raised concerns around the sustainability of their profession.

Key conclusions and implications for practice: Lack of effective support for midwives during the initial months of the COVID-19 pandemic exacerbated staffing shortages that existed prior to the pandemic, creating detrimental gaps in essential care for pregnant people, especially with increasing demands for homebirths. Measures to support midwives should combat inequities in the healthcare system, mitigating the risks of disease exposure, burnout, and professional and financial impacts that may have long-lasting implications on the profession. Given the crucial role of midwives in women- and people-centred care and advocacy, protecting midwives and the communities they serve should be prioritized and integrated into pandemic preparedness and response planning to preserve women's health and rights around the world.

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Introduction

The rapid spread of the SARS-CoV-2 (COVID-19) pandemic has significantly impacted health systems in Canada and around the world. Given uncertainty around COVID-19 transmission and its effect on pregnant people and infants, maternity care practices were adapted to protect this vulnerable group (Davis-Floyd and Gutschow, 2021; Renfrew et al., 2020; Rudrum, 2021). With hospital births perceived as putting pregnant people at risk of contracting COVID-19, research in several countries identified an increase

in the number of people pursuing home births and midwifery services during the pandemic (Davis-Floyd and Gutschow, 2021; Green et al., 2021; Homer et al., 2021; Montebiano, 2021; Rudrum, 2021; van Manen et al., 2021). As such, many regions in Canada reported an increased need for midwifery services, despite already struggling to meet the demand prior to the pandemic (Rudrum, 2021).

British Columbia (BC) has the highest rate of midwife-assisted births in Canada, with midwives delivering 15% of all infants and involved in the care of 22% of pregnant people. Midwives in BC provide continuity of care as a publicly funded primary care option, with the opportunity for hospital or home birth (Stoll and Gallagher, 2019). Additionally, midwives practice

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women-and people-centred care, which prioritizes pregnant people's autonomy, dignity, and informed choice (Vedam et al., 2019). In 2019, there were approximately 300 registered midwives in BC, all of which were women (Canadian Institute for Health Information, 2019).

Midwives in BC entered the pandemic during contract renegotiations after the Midwives Association of BC (MABC) rejected the 2019 midwifery contract proposed by the government. Midwives called for their new contract to reflect fair wages and benefits, with a stronger commitment from the government to supporting their well-being (Midwives Association of British Columbia, 2020a). These demands stemmed from concerns around the sustainability of the midwifery profession after a 2019 study reported that 34.7% of 158 surveyed Western Canadian midwives considered leaving the profession due to burnout (Stoll and Gallagher, 2019). Negotiations had not yet been resolved at the time this study was conducted, putting midwives in a precarious position.

Despite lacking a formal contract, midwives continued providing crucial care during the pandemic, including early labour, postpartum, and newborn care in client homes. The MABC notes that these services reduced pregnant peoples' risk of exposure to COVID-19 by keeping healthy individuals out of the hospital, provided essential emotional support and clinical expertise to clients struggling with the uncertainty of pregnancy during a pandemic, and reduced the burden that labour and deliveries placed on hospital resources that were already stretched thin (Midwives Association of British Columbia, 2020b).

While healthcare workers such as midwives play a vital role in pandemic preparedness and response, studies have shown that providing frontline health services during crises can have a detrimental impact on healthcare workers, including exposure to disease. In BC, 7.3% of the 90,000 COVID-19 infections that occurred between January 2020 and March 2021 were among healthcare workers (BC Centre for Disease Control, 2021). Women health workers in particular may endure disease exposure and illness, burnout, poor mental health conditions, and financial shocks (Morgan et al., 2022). Given that midwives faced an increased demand for their services during the pandemic and that the majority of the global midwifery profession is made up of women, it is important to understand the unique difficulties and risks they confront as part of crisis response. However, research exploring the effects of health crises on midwives is limited (Eagen-Torkko et al., 2021; Erland and Dahl, 2017). This study sought to explore the experiences of midwives working on the frontlines of the COVID-19 pandemic in BC, Canada, to gain insight into the challenges they faced and identify strategies for better supporting their well-being, as well as the health of their patients more generally.

Gender-based analysis

Researchers used a gender-based analysis lens to explore the ways in which gender norms and roles impacted midwives during the COVID-19 pandemic. Gender norms refer to the often unspoken rules that govern the attributes and roles that are valued and considered acceptable for men, women, and gender-diverse individuals (Morgan et al., 2016). Gender-based analysis seeks to make these norms explicit and identify gender bias within policies, processes and structures. Gender roles include tasks and behaviour deemed appropriate and expected of a particular gender both at work and at home.

Gender-based analysis recognizes norms and roles impact all aspects of work and personal life, including health systems, examining the mechanisms through which gender power relations manifest as inequities. For example, male-dominated professions typically offer more prestige, career advancement opportunities, and

stable positions and salaries, while female-dominated professions, such as nursing and midwifery, are at a higher likelihood of job insecurity, devaluation, marginalization, and even abuse (Hay et al., 2019). Here a gender lens was applied to ask how gender norms and roles structured midwives experiences at the health system, household/community and individual level. The analysis explores how factors such as widespread social norms and beliefs, common practices, expected gender roles, unequal access to resources, and imbalances in decision-making and autonomy effected midwives experiences during the first year of COVID-19.

Methods

This qualitative analysis explored the experiences of midwives during the first year of the COVID-19 pandemic as part of a larger study researching the impact of the pandemic on women healthcare workers in BC. Three focus groups and four semi-structured interviews were conducted with midwives between December 2020 and February 2021, with a total of 13 participating midwives. Participants were recruited purposefully through advertisements emailed to all midwifery practices listed on the MABC online directory. Inclusion criteria for participants was being 19 years of age or older and having worked in BC as a midwife during the COVID-19 pandemic. Participants meeting the inclusion criteria were scheduled to participate in a focus group or semi-structured interview, depending on their personal preference and availability. All participants identified as women, consistent with the gender nature of the sector which is almost completely women dominated. Midwives participated from all health authorities in the province.

The limited sample size reflects the challenge of reaching healthcare workers during a public health crisis and is consistent with qualitative studies conducted in similar circumstances (see, for example, Erland and Dahl, 2017). Instead of focusing on reaching data saturation, researchers facilitated interviews and focus groups until all individuals that volunteered to participate were included. Considering sample size and methods, the aim is not to provide representative findings, but to analyze a range of illustrative experiences. Such in-depth qualitative research is apt at including meaningful inquiry reflective of the experiences of those most affected in academic and policy discussions (Sallee and Flood, 2012).

Focus groups and interviews were held virtually through Zoom and audio recorded. Focus groups were moderated by researchers who all identified as women. All participants received a gift card as an honorarium for participation. Each session lasted approximately one hour and was semi-structured, with a mix of discussion and questions based on guides developed by the researchers. These guides were organized around the key themes reflective of a gender-based analysis lens, including questions around the impacts of COVID-19 on personal and professional life, access to resources and decision-making, and resilience strategies.

Audio recordings from the seven focus groups and interviews were transcribed by an external transcription service. Thematic analysis using a framework approach was utilized to systematically analyze the data (Gale et al., 2013). After familiarization with the transcripts, the research team created a coding framework based on *a priori* and emerging themes from the literature and data. The *a priori* themes were informed by a scoping review conducted by the researchers that analyzed women healthcare workers' experiences during crises (Morgan et al., 2022). Emerging themes were identified through joint review (by all authors) of initial transcripts. Two researchers then applied the coding framework to all transcripts to explore connections and comparisons between participants and themes in the data. Data was inputted into charts based on the coding framework, in which additional themes and relationships were grouped.

This study received ethical approval from the Office of Research Ethics at Simon Fraser University. Researchers received verbal consent from all study participants, who were made aware that participation was voluntary and could be withdrawn at any time. Participant anonymity was preserved throughout the analysis and in the presentation of these findings. All participants received a summary brief with an overview of the research findings and were given the opportunity to share feedback.

Results

Qualitative analysis surfaced four key themes. First, midwives faced a substantial lack of support during the pandemic. Second, insufficient support was compounded by a lack of recognition. Third, participants felt a strong duty to continue providing high-quality care despite COVID-19 related restrictions and challenges. Lastly, lack of support, increased workloads, and moral distress exacerbated burnout among midwives and raised concerns around the sustainability of their profession.

Lack of support

Midwives described sudden and drastic increases in their workloads in response to the evolving needs of their clients during the pandemic, particularly given a higher demand for home births. Despite serving more clients, midwives expressed feeling “*forgotten as first line providers*,” with their efforts largely unrecognized, unsupported, and undervalued by health leadership. Their exclusion from aid supplied to other essential healthcare workers during the pandemic, such as personal protective equipment (PPE), financial accommodations, and other forms of social protection, revealed a systemic lack of consideration for the services they offered.

A common frustration raised by participants was that midwives did not receive government-funded PPE that was provided to other frontline healthcare workers until months into the pandemic. This caused feelings of vulnerability, fear, and stress around contracting and transmitting COVID-19 to clients and family members. Midwives discussed the risks inherent in their profession due to home visits, check-ups, and births that put them in close contact with their clients’ home environments and bodily fluids, underscoring the importance of access to adequate PPE.

“You need to understand that we birth. We get covered in fluid. We get spat on. We get vomited on. We have amniotic fluid on us, poop, everything. We are out in the community. You maybe don’t know we’re here, but this is what we’re doing. We need PPE.”

(Interview 2)

When PPE was distributed, many midwives were only given access for use in home births, despite needing it for other types of clinical appointments. Some midwives recounted being required to pick PPE up at the hospital every time there was a birth, which was challenging given the unpredictable nature of labour and “*reflected a lack of understanding of what we do and who we are*.” (Interview 2)

Midwives felt discouraged that they did not receive the same financial assistance as other frontline workers. For example, temporary pandemic pay was awarded to many healthcare and social services workers in BC, including nurses and physicians, but not midwives (BC Gov News, 2020). Midwives also explained that physicians received subsidies from the government to implement COVID-19 related safety measures in their clinics. However, midwives were not given these financial supports, placing a considerable burden on their practices and forcing them to rely on personal funds.

“We’re getting these emails that are talking about ‘Physician and nurse compensation for your heroic efforts’... Meanwhile, everyone’s struggling. All the clinic owners are struggling. There’s so much burnout... Most of us recognize we’re frontline healthcare workers in a pandemic, but [there is] this complete invisibility of the work that we do.”

(Focus Group 3)

Several participants had to take time off from work due to suspected or confirmed COVID-19 diagnoses and described the financial consequences of not having sick leave, sick pay, or disability benefits. Financial ramifications of taking time off were exacerbated during the pandemic because of inequities in the midwives’ ability to access benefits when they contracted COVID-19. In August of 2020, WorkSafe BC, the organization providing benefits to injured workers in BC, labelled COVID-19 as an occupational risk illness for nurses, enabling quick access to coverage after exposure (BC Nurses’ Union, 2020). However, midwives recounted putting in substantial effort to prove they had contracted COVID-19 at work before they were able to access benefits, even after working with COVID-19 infected patients. One participant quit midwifery to return to nursing because of the injustice she felt when denied coverage for an occupational exposure, despite paying into sick benefits.

“My greatest stress about catching COVID is financial because my husband is unemployed and if I get COVID and have to be off, even for two weeks, even if I have a mild form, that will affect us. And if I have to be off for a month, we won’t be able to pay our mortgage.”

(Focus Group 2)

Lack of recognition

Midwives expressed that the pandemic had further exacerbated and exposed existing inequities by highlighting the lack of recognition afforded to the midwifery profession when compared to other providers. Multiple midwives felt that this lack of respect was likely in response to the feminization of their profession, largely characterized by women midwives caring for women clients. Midwives stated that maternity care and women’s health issues are severely undervalued, which one midwife labelled as “*the most disgusting example of misogyny*.” Many midwives desired for their value as healthcare workers to be recognized by other health professions and leadership.

“I feel marginalised as a midwife and as a midwife leader in this, and I never felt marginalised as a person of colour growing up because of the privilege that I had ... COVID has amplified that... It shows that there’s no system for midwives, because it’s created for physicians and nurses. We’re just too small. And they’re not going to start new systems for us, and they won’t let us join existing systems.”

(Focus Group 1)

Midwives explained that their expertise around maternal care also went unrecognized. They discussed rarely being asked for input by organizational management or leadership when it came to developing protocols to address COVID-19 within maternity services, leading to a lack of consideration around their own needs and those of their clients. They described inadequate representation in health leadership and significant barriers to participating in decision-making.

“Initially, I don’t think they were letting us into the operating room as midwives... Just another way that they kind of told us that the work we do is undervalued. That there really wasn’t a role for us in the OR, which just goes to show, I think, on

a more systematic level, how much people don't care about women's emotional health and the experience that birth is."

(Interview 4)

Duty to provide high-quality care

Despite experiencing fear of COVID-19 transmission and stress from intensified workloads, midwives expressed a strong moral obligation to continue providing high-quality care. Midwives felt conflicted adhering to protocols that reduced their own risk of contracting COVID-19 but limited their ability to provide emotional support and high-quality care to patients. They conveyed that the inability to comfort patients through physical touch, the requirement for shortened or virtual appointments, and the exclusion of family members from appointments or births disrupted their ability to develop the deeper relationships with clients that they felt made up *"the essence of midwifery care."* In some situations, this sense of moral obligation ultimately led midwives to break COVID-19 regulations and compromise their own health for the benefit of their clients. Many midwives discussed the impossibility of remaining socially distanced from clients during births.

"In labour, rubbing somebody's back or just feeling her arm and smoothing her hair out of her face, that's what I do. Those little things make the care 'care,' not just a person standing in a room. And so, when you're asked to just be this distant person in the room... I think midwives pretty much fail at that. We just can't really do that. And so, that's just the risk, right? You take that risk."

(Interview 1)

Midwives demonstrated an ambition to take on additional work responsibilities and lend their skills to assisting clients and colleagues. For example, midwives became involved in COVID-19 testing, with no additional compensation for this expanded scope of work. One midwife also served on a specialist team providing surgical assists to C-sections for clients suspected of having COVID-19.

The intense pressures of the pandemic were characterized as adding *"fuel to the fire,"* compelling midwives to become involved in advocacy efforts when new protocols compromised midwifery values around informed choice. Midwives advocated against bans on home births and labour support people that infringed on client autonomy. Some midwives were hopeful that advocacy efforts paired with increased awareness of their valuable work would lead to stronger support and decision-making opportunities for midwives in the future.

"[Leadership] basically advised that we stop doing home births. That was a big stretch for us because we were getting more people asking for home births... We had to do some shuffling and changing to become more involved in the discussion. And to let them know that because of our philosophy of informed choice discussions, it's not really our choice to stop doing home births... It felt like a huge paradigm shift for them to understand the way we worked a little bit more and for us to get a seat at the table."

(Interview 3)

Impacts on the midwifery profession

The pandemic had a substantial impact on midwives' careers and the profession at large. Midwives reported a significant amount of burnout, largely the result of the inadequate support they were afforded compared to other frontline healthcare professions in conjunction with the moral distress of having to compromise on client care.

"People's experience of midwifery care has really changed. That is a place where we find high work satisfaction- Is connection with clients and it's one of the key factors that motivates people... [There is] not the same level of job satisfaction in terms of relationship with our clients and now they have burnt out healthcare providers."

(Focus Group 3)

Midwives also described the detrimental consequences of the pandemic on midwifery training and clinics. Midwifery students and recent graduates discussed the disillusionment of graduating during a pandemic when clients were extraordinarily stressed, and midwives were unable to offer the quality of care that they valued. Many midwifery practices were incapable to mentor students during the pandemic because of heightened workloads, fears of COVID-19 transmission, and financial stressors. This was alarming to participants given the critical importance of training new midwives to carry on the profession. Additionally, midwives recalled midwifery clinics that closed during the pandemic due to challenges with PPE and a lack of financial assistance from the government.

"This year there's been a lot of stress in terms of the threat of what if one of our clients tests positive and then it makes the news, or the midwives are so stressed and then they burn out and they leave... If my [clinic] that I've worked almost a decade to build is, in one year, demolished because of this and the lack of supports in place, it would be a real shame"

(Focus Group 1)

Multiple participants noted that they, as well as colleagues, had to take time off from work, considered quitting, or left their jobs because of burnout, mental health issues, COVID-19 infection, and/or the absence of crucial support. This exacerbated existing staffing shortages, and the deficit in midwife replacements hindered their ability to meet the demand for midwifery services and resulted in turning clients away.

"We lost two very experienced incredible midwives in the last year and a half... It's almost like when you're in a midlife crisis, midwives are going through that. They're trying to figure out how to make this sustainable or to find a Plan B. There's this crossroad right now. I'm hearing everyone talk about a Plan B, myself included."

(Focus Group 1)

Participants mentioned fears around the long-term implications of the pandemic on their profession, given the high numbers of midwives leaving their roles. They underscored the dire need for midwifery to become sustainable by increasing equality and access to support, as well as recognition for their essential contributions. Without these major shifts, midwives would continue burning out and leaving the profession, making it impossible for the shortage in professionals to meet the growing demand for midwifery care. Ultimately, midwives expressed alarm that the shortage of midwives would significantly limit women-centred care and birth choices.

"Women deserve options in care and if we don't support a midwifery profession that's sustainable, child-bearing people will have less choice, and that will cause a worse care to exist. Because when we don't have the balance of different care providers coming from different perspectives, women are offered less choices."

(Focus Group 2)

Discussion

The midwives who participated in this research described how the care they provided during the COVID-19 pandemic went largely

unsupported and unrecognized, with inadequate access to PPE and important benefits. However, midwives felt a strong duty to offer high-quality care for their clients, resulting in moral distress when COVID-related restrictions hindered their connections with clients. Midwives highlighted impacts on the profession at large, with midwives leaving the field and practices closing, raising concerns around the future of women-and people-centred care.

Literature around disease outbreaks has identified a supply of adequate PPE as a significant source of anxiety among healthcare workers (Chigwedere et al., 2021; Fernandez et al., 2020). Our study indicated that this stress was shared by midwives, who viewed PPE as protection against COVID-19. As such, midwives characterized their initial exclusion from the government's PPE distribution for frontline workers as disrespectful, demonstrating a lack of recognition of their role within maternity care and a misunderstanding of the risks inherent in their profession. A qualitative analysis in Belgium surfaced similar experiences among midwives working during the pandemic, in which the absence of midwives from the priority providers receiving PPE was "at the core of the feeling of insecurity and distrust of the public authorities" and "raised questions about the... status and recognition of midwives in the medical establishment altogether" (Huysmans et al., 2021). This points to the importance of providing midwives with PPE, both to reduce their risk of contracting COVID-19 and as a means of promoting recognition for these frontline workers.

While the inability to access PPE caused stress, midwives felt conflicted when PPE and other COVID-related restrictions limited their ability to offer the same quality of care as before the pandemic and influenced their rapport with clients. Similarly, qualitative studies of midwives working during COVID-19 in Australia, as well as during the 2014 Ebola epidemic in Sierra Leone, noted that midwives suffered significant moral distress when disease control measures compromised patient care. Many were willing to "bend the rules" to care for clients in ways that they considered non-negotiable, despite risks to their own safety (Bradfield et al., 2021; Erland and Dahl, 2017). Eagen-Torkko et al. (2021) argues that following and enforcing disease control procedures requires midwives to hold an authoritative role over their clients, contradicting midwifery's deep-rooted values of shared decision-making. In our study, this moral distress and inability to develop close relationships with clients was a substantial contributor to burnout, resulting in midwives leaving the profession. These findings are supported by a survey conducted by the MABC in 2020, which revealed that the number of midwives in BC experiencing moderate to high occupational burnout increased from 45% in 2017 to 77% during the pandemic. 20% of midwives reported actively taking steps to leave the profession during COVID-19 (Midwives Association of British Columbia, 2020b).

These long-term effects on the midwifery profession are crucial because research on midwives and the broader health workforce has linked burnout to higher rates of turnover, absenteeism, lower quality of care, missed care, and adverse effects on patient safety (Albendín-García et al., 2021; Eagen-Torkko et al., 2021; Hofmeyer et al., 2020). Additionally, the MABC states that the number of currently registered midwives in BC are not enough to keep up with the demands for midwifery, especially with increasing needs due to COVID-19 (Midwives Association of British

Columbia, 2020b). This raises concerns around the future of midwifery in BC and the loss of vital benefits that they confer to their clients and the healthcare system, including people-centred care and informed choice during pregnancy (Luo and Yin, 2020; Vedam et al., 2019). For example, a 2019 survey study of 2,051 women who received maternal care from obstetricians, family physicians, or midwives in BC found that clients of midwives reported significantly higher feelings of autonomy than patients of physicians or obstetricians. Midwifery clients felt more empowered and respected to make informed choices about their own care (Vedam et al., 2019). Recent articles have also highlighted the importance of midwives serving as advocates for safe and compassionate maternal care, especially during outbreaks when health systems are more likely to infringe on the rights of these vulnerable groups as part of disease prevention and control efforts (Davis-Floyd and Gutschow, 2021; Erland and Dahl, 2017; Luo and Yin, 2020). In our study, midwives discussed advocating against bans on homebirths and labour support people to preserve client birth choices. Violations of reproductive rights in healthcare are more difficult to identify and address when allies, like midwives, are not there to witness and deter them (Davis-Floyd and Gutschow, 2021).

In addition, midwives described how the pandemic exposed existing inequities, including gender disparities entrenched in the healthcare system. All currently registered midwives in BC are women, and 90% of the nursing and midwifery workforce worldwide is made up of women (Canadian Institute for Health Information, 2019; Lancet, 2020). Several midwives felt that the dearth in support and recognition they received compared to other frontline health workers was largely due to the feminization of their profession and a lack of value and understanding placed on maternal health in general. Monteblanco (2021) argues that lower status among midwives compared to physicians is largely attributed to the historical shift from birth being treated as a natural event cared for by midwives in the community to a medical pathology treated by physicians in male-led facilities. This left midwives at the bottom of the medical hierarchy (Monteblanco, 2021). This inequality is reflected in our study in which midwifery practices did not receive the same financial assistance or benefits as other healthcare workers.

Additionally, midwives reported barriers to leadership and decision-making opportunities around the COVID-19 response, which likely contributed to protocols that disregarded midwifery values and were not feasible in direct patient care. For example, policies restricting midwives' access to operating rooms and requiring them to drive to the hospital to sign out PPE for each birth revealed a misunderstanding of their essential role and the risks they had to manage. A qualitative analysis of midwives' experiences in Belgium found that midwives were excluded from the development of maternity care guidelines during COVID-19, leading to feelings of marginalization and processes that were not aligned with their values (Huysmans et al., 2021). However, midwives in our study discussed that the pressures of the pandemic and insufficient support they received motivated them to come together and advocate for their rights, increasing awareness and visibility of their role within pandemic response. Similarly, studies in the United States have discussed the implications of

Table 1
Participant Breakdown.

Data Collection Method	# of Data Collection Events	# of Participating Midwives
Focus Group Discussions	3	9
Semi-Structured Interview	4	4
Total	7	13

Table 2
Coding Framework.

FRAMEWORK	CODES
Health Systems Level	<ul style="list-style-type: none"> • Resources • Moral obligation & guilt • Participation in decision-making • Protocols and procedures • Coping strategies and support • Workload • Other
Community and Household Level	<ul style="list-style-type: none"> • Family and home situations • Caring for dependents • Social, professional, and economic impacts • Coping strategies and community support • Other
Individual Level	<ul style="list-style-type: none"> • Physical health • Mental health • Social, professional, and economic impacts • Coping strategies and support • Other

the increased demand for midwifery services and visibility around the profession during the pandemic, providing an opportunity for midwives, a previously disadvantaged and overlooked profession, to advocate for policy changes (Gutschow and Davis-Floyd, 2021; Monteblanco, 2021). Davis-Floyd and Gutschow (2021) state that “this pandemic offers both a disruptive moment and a long-overdue opportunity to fix systemic problems within maternity care in ways that can benefit providers, mothers, newborns, and families.”

Study limitations

A limitation of this study is that the experiences and views described by participants are not necessarily representative of those of the many midwives throughout BC, Canada, or other countries or healthcare professions. While effort was made to ensure diversity in respondents, there is an overall lack of diversity within the sample, with many of the respondents identifying as Caucasian. As a result, experiences of midwives who identify as Black, Indigenous, or a Person of Color, are underrepresented and key challenges of these groups were likely missed.

Implications for practice

The findings of this study point to necessary strategies to support midwives through reducing inequities in the healthcare system, mitigating the risks of disease exposure, burnout, and professional and financial ramifications that may have long-lasting implications on the profession. Midwives should receive access to financial aid afforded to other essential workers, such as pandemic pay and funding to implement COVID-19 safety measures. Opportunities for paid sick leave are also important given the risk of COVID-19 exposure and the financial consequences of being unable to work. Additionally, midwives should receive fair compensation for any expanded scope of work. Midwifery students and new graduates need further guidance and mentorship to navigate new responsibilities as they enter the workforce. Providing high-quality and accessible PPE is also of vital importance given the occupational risk of COVID-19, as well as the need to ensure that midwives feel valued. Mental health resources, such as psychological first aid and mindfulness-based techniques, should also be accessible to midwives to help cope with stress, mitigate burnout, and promote self-care and resilience (Albendín-García et al., 2021; Eagen-Torkko et al., 2021; Hofmeyer et al., 2020). Midwives should

be involved in decisions around PPE and maternity care protocols to ensure that their risks are considered. Midwives could be valuable partners in developing innovative strategies that promote COVID-19 prevention without compromising on woman-centred care and midwifery’s core values of shared decision-making and client autonomy (Eagen-Torkko et al., 2021).

Conclusion

This study imparts insight into the experiences of midwives during the first year of the COVID-19 pandemic in British Columbia, Canada. Midwifery care is associated with fewer unnecessary medical interventions, cost-savings to families and health-care systems, and autonomy and birth choices for pregnant people (Albendín-García et al., 2021; Monteblanco, 2021). However, the inability to effectively support midwives will further exacerbate staffing shortages that existed prior to the pandemic, creating detrimental gaps in essential care, especially with increasing demands for homebirths (Albendín-García et al., 2021). The findings of this study point to the importance of strengthening support for midwives to improve the sustainability of the profession and mitigate disease exposure and burnout. Given the vital role of midwives in women- and people- centred care and advocacy, protecting midwives and the communities they serve should be prioritized and integrated into pandemic preparedness and response planning to preserve women’s health and rights around the world.

CM analyzed the data and completed the first draft of the manuscript. AK, HLT, KH and NO assisted with data analysis and contributed to subsequent drafts. JS and RM oversaw the project, conducted data collection, and contributed to subsequent drafts.

Ethical approval

This study received ethical approval from Simon Fraser University.

Acknowledgments

The authors would like to acknowledge and thank the midwives that made this study possible by sharing their experiences and valuable recommendations.

Funding sources

This work was supported by the British Columbia Women's Health Foundation (BCWHF) and the [Canadian Institutes of Health Research](#) (grant number [OV7-170639](#)).

Declaration of Competing Interest

None declared.

Acknowledgments

The authors would like to acknowledge and thank the midwives that made this study possible by sharing their experiences and valuable recommendations. The authors would also like to thank the British Columbia Women's Health Foundation (BCWHF) and the [Canadian Institutes of Health Research](#) (grant number [OV7-170639](#)) for supporting this research.

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