

Midwives' and maternity support workers' perceptions of the impact of the first year of the COVID-19 pandemic on respectful maternity care in a diverse region of the UK

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BMJ Open Midwives' and maternity support workers' perceptions of the impact of the first year of the COVID-19 pandemic on respectful maternity care in a diverse region of the UK: a qualitative study

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ABSTRACT

Objectives To explore midwives' and maternity support workers' perceptions of the impact of the COVID-19 pandemic on maternity services and understand factors influencing respectful maternity care.

Design A qualitative study. Eleven semistructured interviews were conducted (on Zoom) and thematically analysed. Inductive themes were developed and compared with components of respectful maternity care.

Setting Maternity services in a diverse region of the United Kingdom.

Participants Midwives and maternity support workers who worked during the first year of the COVID-19 pandemic.

Results The findings offer insights into the experiences and challenges faced by midwives and maternity support workers during the first year of the COVID-19 pandemic in the UK (March 2020–2021). Three core themes were interpreted that impacted respectful maternity care: (1) communication of care, (2) clinical care and (3) support for families. 1. Midwives and maternity support workers felt changing guidance impaired communication of accurate information. However, women attending appointments alone encouraged safeguarding disclosures. 2. Maternity staffing pressures worsened and delayed care provision. The health service's COVID-19 response was thought to have discouraged women's engagement with maternity care. 3. Social support for women was reduced and overstretched staff struggled to fill this role. The continuity of carer model of midwifery facilitated supportive care. COVID-19 restrictions separated families and were considered detrimental to parents' mental health and newborn bonding. Overall, comparison of interview quotes to components of respectful maternity care showed challenges during the early COVID-19 pandemic in upholding each of the 10 rights afforded to women and newborns.

Conclusions Respectful maternity care was impacted through changes in communication, delivery of clinical care and restrictions on social support for women and their infants in the first year of the COVID-19 pandemic. Future guidance for pandemic scenarios must make careful consideration of women's and newborns' rights to respectful maternity care.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This qualitative study adds to the evidence on how maternity staff in the UK are under growing pressures, including pressures to provide respectful maternity care despite additional challenges brought by the COVID-19 pandemic.
- ⇒ All participants were women and White European, so their views may not represent those of all maternity staff in the region.
- ⇒ Responses may have been subjected to social acceptability bias; however, participants were assured of anonymity.
- ⇒ Reliability of the analysis was strengthened by the use of researcher triangulation in coding and refinement of the themes presented.
- ⇒ Results were compared with the components of respectful maternity care to improve transferability.

INTRODUCTION

The coronavirus disease (COVID-19) pandemic has placed extreme pressure on the National Health Service (NHS) to accommodate those acutely ill with COVID-19 while battling staffing shortages due to the same disease.^{1 2} Maternity services are unique as, unlike the adaptations made for some services, the role of a midwife during labour cannot be conducted virtually or be postponed.³ The need to continue providing maternity care during COVID-19 had to be balanced with effective infection control measures to protect women and staff.⁴

With over 2500 midwife vacancies in the United Kingdom (UK) in the months prior to the COVID-19 pandemic, maternity services were already stretched.⁵ Self-isolation in the first weeks of the pandemic created a shortfall of midwives of more than double this number.⁶ As a result, maternity staff reported adverse mental health effects because of long

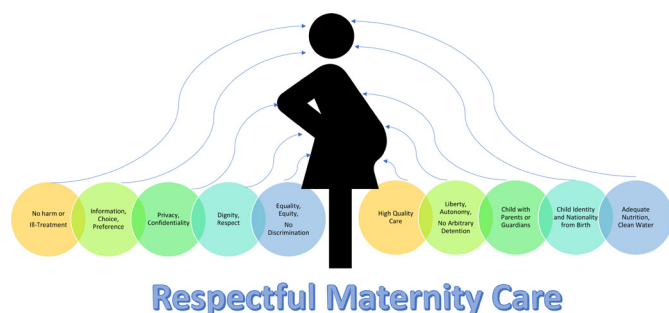


Figure 1 Components of the Respectful Maternity Care Charter description: a figure displaying the 10 components of the Respectful Maternity Care Charter as developed by the White Ribbon Alliance.¹⁰

working hours and having to continually adapt to rapidly evolving circumstances.⁷ As many as 90% of maternity staff globally reported feeling more stressed during the early COVID-19 pandemic.⁸

Respectful maternity care (RMC) is an essential part of maternity care provision worldwide.^{9 10} It is defined by the WHO as care, which ensures that a woman's 'dignity, privacy and confidentiality' is maintained alongside her rights to be free from mistreatment, to make decisions about her treatment and choose her birthing companion.⁹ These rights are necessary to achieve the Sustainable Development Goals, which seek equitable healthcare, as summarised by White Ribbon Alliance under the RMC Charter.^{10 11} The RMC Charter summarises the human rights afforded to women and newborns receiving maternity care in a healthcare facility.¹⁰ It compiles the rights set out across a multitude of international conventions and how these are applied to maternity care. Its components are set out in figure 1. The 10 key components cover a woman's rights to dignity, privacy, confidentiality, freedom from mistreatment and to make her own choices, including choice of birth partner. It also includes the rights of a newborn to be with their parents or guardians, and to have an identity from birth.¹⁰

Changes to maternity services and care access due to COVID-19 are known to have had negative consequences for women and families.^{12 13} Both the International Confederation of Midwives and UK charity Birthrights voiced concerns that some changes had been disproportionate and did not uphold women's rights.^{14 15} Therefore, they warned against banning birth companions and impinging access to perinatal care.^{14 15} Despite this, birth companions were restricted access during the early COVID-19 pandemic.⁴ This is an example of the conflicting and challenging decisions made in response to the rapidly emerging public health crisis of COVID-19, in light of uncertain risk from the virus to women, babies and staff members.

Considering these conflicting influences and pressures at the time, this study aimed to explore midwives' and maternity support workers' perceptions of the impact of COVID-19 on maternity services in the first year of the

pandemic, and the factors which influenced respectful maternity care provision.

METHODS

Aim

To explore midwives' and maternity support workers' perceptions of the impact of COVID-19 on maternity care provision in a diverse region of the UK, in relation to respectful maternity care.

Design

This qualitative study sought to explore the midwives' and maternity support workers' perspectives of providing respectful maternity care in a novel pandemic scenario with limited existing literature. A pragmatic approach was adopted for the study design.¹⁶ Semistructured one-to-one interviews were used, with interview guides developed to include questions on all components of respectful maternity care.¹⁰ All interviews were conducted remotely due to COVID-19 restrictions. The Standards for Reporting Qualitative Research and the Consolidated criteria for Reporting Qualitative research have been followed in the reporting of this study (see online supplemental files 1 and 2).^{17 18}

Participants

Participants were midwives and maternity support workers who worked during the first year of the COVID-19 pandemic in maternity services in a diverse region of the UK.

Sampling and recruitment

Purposive recruitment was conducted to include midwives and maternity support workers who worked clinically during the first year of the COVID-19 pandemic (March 2020–March 2021). Participants were recruited via professional contacts and advertising on local professional social media groups. Subsequent recruitment was conducted via snowballing, including some participants who further shared this advertising. Fifteen potential recruits were contacted with further study information: 11 were willing to participate, 3 were unavailable during the study period and 1 did not respond. Participants were recruited from multiple services in the region including tertiary referral centres, continuity of carer services, and district general hospitals. All of these settings were teaching facilities.

Patient and public involvement

Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

Data collection

Semistructured interviews were chosen as the data collection tool to explore individual perceptions and allow participants to speak candidly. A semistructured interview guide (online supplemental file 3) was developed, including questions on components of respectful

maternity care as described by the WHO such as ‘have women’s choices been affected by their care during the pandemic? ...How?’, as well as more general questions such as ‘what does the phrase ‘respectful maternity care’ mean to you?’.⁹ The interview guide was updated in an iterative process during the interview period to explore all the inductive themes developing from participant interviews.

Semistructured interviews were conducted between March and May 2021. Participant demographics were collected at the time of interview.

Data analysis

An inductive analytical approach following Braun and Clarke’s method of reflexive thematic analysis¹⁹ was used to derive interpretations from the data. Interviews were transcribed verbatim and transcripts were anonymised prior to analysis. Reflexive thematic analysis was facilitated by NVivo V.12 software and occurred contemporaneously to data collection, so that comparison between the transcripts and codes could be used to assess adequacy of the data.^{20 21} This pragmatic approach was taken to determine the point at which the data were adequately rich and complex to address the research question.²¹ This was reached at 11 interviews and so, with in situ consideration of the adequacy of data and resources available, data collection was ceased at this point.²¹ Two transcripts thought by the primary researcher to be data rich were subsequently analysed and coded by a second researcher. The two coders then corroborated their findings to reach agreement on themes. The primary researcher then recoded the remaining transcripts. The themes and quotations were then discussed and refined by all authors providing further researcher triangulation, and the final themes agreed.²² Finally, the final themes were compared with components of respectful maternity care.

RESULTS

The data set consisted of 11 interviews with an average length of 44 min (range 32–57 min). Participants were nine midwives and two maternity support workers from four healthcare trusts, all of whom were White European women with a median age of 40 (range 25–62 years). All participants had trained in the UK, 10 of whom trained in the region. The distribution of demographic variables is displayed in [table 1](#).

Findings

Three themes were developed from the data to describe the impact of the first year of the COVID-19 pandemic on respectful maternity care provision in the region: communication of care, clinical care and support for families. These themes are described below. [Figure 2](#) displays these themes and corresponding subthemes.

Table 1 Distribution of demographic variables within the sample

Demographic variable	N=11 (%)
Gender	
Female	11 (100)
Male	0 (0)
Other	0 (0)
Age	
21–30	4 (36)
31–40	2 (18)
≥41	5 (45)
Job role	
Continuity of carer midwife*	2 (18)
Hospital-based midwife	7 (64)
Hospital-based maternity support worker	2 (18)
Additional responsibilities	
Research and/or teaching	3 (27)
Management	3 (27)
None stated	5 (45)
Years worked in the region’s maternity services	
0–2	3 (27)
3–10	4 (36)
11–20	2 (18)
≥21	2 (18)

*The continuity of carer model aims for consistency in the midwife/healthcare providers caring for a woman and her baby through pregnancy, labour and the postnatal period.³⁸

Communication of care

Provision of accurate information

Challenges in information provision during the COVID-19 pandemic were reported by all participants, impacting their ability to provide respectful maternity care. This impacted accurate history taking and clinical assessments, as well as being able to communicate the correct information to the women.

Participants stressed the difficulty of providing accurate information to their women. This is because staff themselves were unsure of the latest guidance:

We need to communicate the measures; we need to keep people informed because we haven’t got a clue and we can’t do it if we don’t know what we’re doing (p4).

Social media was thought to have been a source of misinformation for women and a factor in their decision-making, for example, on whether to receive the COVID-19 vaccine:

there’s so much junk on in social media and they’ll Google things and... it’ll be like ‘oh well, such and

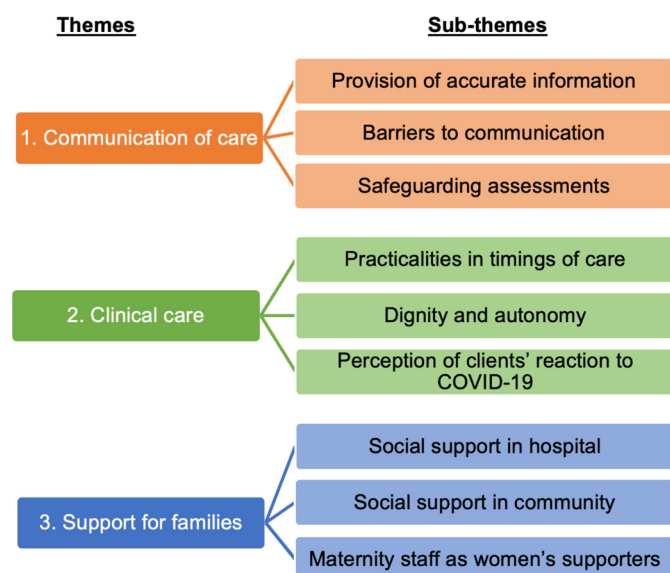


Figure 2 Inductive themes and corresponding sub-themes description: a figure displaying the categorisation of themes and sub-themes inducted from the data.

such said that COVID causes this so I'm not having it', as regards to the vaccine (p9).

Participants felt that better preparation antenatally for the hospital experience and how this has changed during the pandemic might have minimised some of the distress to women by reducing the mismatch between expectations and actual experience:

we just need to... communicate to these ladies all the time. That needs to start antenatally, what to expect during labour, during the visits, postnatally. If we give them all this information, they might not be so angry at us when it comes to it (p4).

Barriers to communication

The physical barrier of personal protective equipment (PPE) has provided a further barrier to communication, with one participant describing face masks as an emotional barrier to establishing a relationship with women:

I think sometimes it's easy to hide behind the mask. Sometimes, emotionally, you still have to make a connection. [...] It's... it's not, not to be afraid to be human, I think, sometimes (p9).

Participants noted that interacting with maternity services can be a frightening experience for women where there is a language barrier. This was worsened by COVID-19 requirements, which were not always intuitive:

Your English-speaking, born-in-this-country person wouldn't understand what was going on. But she... she was really like, 'I don't know what's happening to him' and she was frightened. Having a baby in a country where you don't speak the language in itself must be a nightmare. Having a baby in a pandemic in a country where you don't speak the language it's

just, it's unthinkable. It really is, I really feel for these women (p2).

It was reported that interpreter services were not always used due to time constraints. Those in the continuity of carer model saw themselves as better at accessing interpreter services as their role was more centred around building a relationship with women, *whereas in the hospital it's a little bit harder* (p2). One hospital-based participant felt discouraged in interpreter use due to costs:

with the masks, if we feel they don't understand us we get either the translation service which we can phone – but that's really expensive so management aren't keen on it (p4).

Instead, two participants reported attempting to communicate via gestures. One described how colleagues used a raised voice:

a lot of the time—I'm glad this is confidential—a lot of the time in the hospital they kind of fudge appointments and they will just go [shouting and speaking slowly], 'ARE YOU ALRIGHT? IS YOUR BABY MOVING?!' (p2).

In some settings, partners were reportedly used as interpreters, despite the knowledge that this is not recommended practice as family members may have their own biases. One participant feared that this practice could allow an abusive partner to manipulate a consultation:

what if this isn't an actually trusted individual, what if this... this isn't a person that they trust. They could be saying anything (p2).

Safeguarding assessments

There was a discordance in whether domestic violence had increased during COVID-19. Three participants who cared for women over a longer period of time thought that domestic abuse had increased, whereas two participants in shorter stay settings did not think domestic violence disclosures had increased. One of these participants suggested this perception was due to a lack of time for staff to gain women's trust:

often people are here for a very short period of time. To disclose any domestic violence, it's about... it's usually about how they feel, about someone that they feel they can trust, and sometimes that doesn't... the quick change of staff on a department like mine, it's... You don't necessarily build up that trusting relationship quick enough that they will confide in you, essentially (p3).

Virtual communication, while advantageous in improving access for women and being time-efficient for staff, was a concern with regards to picking up on safeguarding concerns as some environmental cues were lost:

You can see if there's an ashtray in the kitchen. You can see if there's some joints in there. You can get a

gauge of... people's finances, what resources they've got, whether it's a suitable environment. You can get a gauge of partners, things like that (p5).

Virtual communication and the wearing of PPE also impeded non-verbal communication. Particularly when enquiring about socially taboo matters, participants described how they compensated for the lack of facial expression by looking at other body language:

some of the more personal questions such as drug abuse, social service involvement in the past with other children... You have to be more aware of the whole body language, not just the face. I mean around the eyes, you know (p9).

Furthermore, participants were concerned for women's privacy during virtual consults, as staff could not tell who else was listening to their discussions. When consulting remotely, one participant described their fear that staff could not tell if a domestic abuser was controlling the conversation:

With safeguarding as well, it's just a telephone call. Who's sat next to that woman? Are you on speaker-phone? (p5).

However, it was thought that women seeing their healthcare professional alone, when in person, had made it easier to ask routine enquiry questions privately and sensitively:

we ask about domestic violence, any other concerns, coercions, anything at every appointment. That's a positive thing, it's been a lot easier to ask those safeguarding questions because we have access to the women on their own. They've been coming to appointments by themselves (p5).

Participants reported prior difficulties asking about domestic abuse when visitors or partners accompanied women. Several participants wanted limitations on ward visiting hours to continue after the pandemic to allow them to ask about domestic violence at an appropriate time:

we are hoping that when we do reintroduce visiting, it's going to be restricted visiting hours so that then we have got that time to ask people in a confidential way, not as a tick box exercise and you can pick your moment to ask them (p5).

Clinical care

Practicalities in timings of care

Staff reported having less time to spend with women during the COVID-19 pandemic:

Half the staff are off shielding and so it's still a lot of work, if not more, for less staff to take on. So, if you want to have been able to provide... excellent patient care, I'm going to say, we're a little more stretched to do that (p8).

so the demand for clinical work increased with that lack of support to be able to provide that additional support for, um, for patients (p3).

This high workload and staffing issues caused delays which were felt to negatively impact patient care:

I had a lady ring the bell. She was diabetic and she said she hadn't had her metformin. I went to see the midwife. She said, 'oh yeah I'll take it, I'll take it up to her' and another hour passed, and she rang again. But she'd been vomiting everywhere, and her blood sugar was really high so, so I think if she'd got that tablet earlier, I think it would have been better for her (p10).

Even with the best intentions, sometimes staff did not have the time to help women with basic hygiene:

I don't think that is respectful; if I just had a baby and I want to have a wash, that is a pretty basic need, but because of staffing, physically, you don't get to give that care. I used to think it's the care I wanna give, it's caring, it's compassionate. But actually, I think it's the bare minimum (p7).

This had a heavy mental burden on the staff; several participants described leaving work upset by the difficulties they had in providing care. Staffing pressures were thought to have had a significant impact on the quality of care during the pandemic:

our staffing was so cr*p we were really almost working at absolute minimum care, certainly on the postnatal wards [...] sounds awful and it is, and it was, you know, you'd come home from the shift crying. Because you sit on the loo, when you get to go to the loo, and you think 'F—! I haven't seen, God, I haven't seen one of my women' and you'd literally be going in, flicking back the sheet, checking they weren't bleeding, and almost like knocking the cot to check the baby was still alright. I mean it's proper dangerous (p5).

Maternity staff reported difficulties meeting women's needs under such pressures:

it's a lot more difficult to provide the care that you'd be happy to go home after saying 'that went well, and I've given that person absolutely everything they need' because we physically don't have the capability to do that at the moment (p8).

When women had long waits for appointments, there were concerns that they had been unnecessarily exposed to COVID-19. These delays and cancellations worsened anxiety for women:

You need to communicate, even when there's not a pandemic, but it's more important in the pandemic, because if you're scared of catching something that could be life threatening for you and your baby, you need to know why you're sitting there for two hours (p9).

Delays were worse for women who were COVID-positive; sometimes they were seen 'last' (p11) to prevent the spread of infection between bays. Furthermore, for some, only one assigned member of staff could answer their call bell and had to first don PPE. There were additional delays in donning and doffing of PPE.

it takes like it's longer because only the person looking after them can go into them like they have one person assigned to them each shift and before they go in, they have to put all the gowns on, and the masks and the gloves and everything so it does take quite a long time (p10).

One participant gave an example of where it would be dangerous to delay answering a call bell:

every single one of those call bells could be somebody having a PPH. It could be somebody saying, 'I can't wake my baby up (p5).

Despite this, participants did note some practical benefits of the pandemic. While some participants were opposed to virtual appointments due to safeguarding concerns, others thought they could be continued for consultations which did not require a physical examination:

I think there is definitely role for telephone calls for this, and some more than others. So, for instance, if a woman was being counselled about the risks and benefits of a vaginal birth after Caesarean section. But there are some things, if a woman reports palpitations and chest pain, that kind of needs a one to one (p9).

One participant thought that virtual appointments improved access for women by removing transport difficulties and took up less time for maternity staff:

it can be a long appointment and then you have all the secondary points with that: parking is a nightmare, the charges for parking... It kind of fit in with our routine a bit more because we'd say, 'we'll call you at 11 o'clock and we'll speak to you then' and they were aware and waiting, whereas [at in-hospital appointments] sometimes it's like trying to find... looking for a needle in a haystack

Dignity and autonomy

Working during COVID-19, especially during the initial months, was described as a frightening and busy time for maternity staff. In some instances, this environment was described as detrimental to the provision of dignity and autonomy for women.

Participants described fear of contracting the virus at work and the potential risk to their families:

It was scary, you know, like I know quite a lot of people have contracted it now from the, from work (p8). I was very scared. I was very scared about bringing it home, I'm still very scared about bringing it home (p2).

This fear was felt by participants who had been greatly 'affected' (p4) by the pandemic themselves, especially those with colleagues who had died of COVID-19:

I think what's affected me more than anything through all of this is our girls dying, the staff dying. Personally, that's affected me, and I find that really hard... (p4).

This fear sometimes negatively impacted respectful care delivery for the women, particularly those who were found to be COVID positive. One participant described how some staff *don't want to treat COVID patients* (p5) and so did not answer call bells or avoided going into those rooms.

'[staff] put the woman's food tray on the bin just inside the door and said, 'your meals there' and shut the door! These women could be post C-section so then they are expected to get out of bed, still catheterised, go and get their food and take it back in (p5).

This participant described a scene where staff had not wanted to go into a COVID-positive area after some of its occupants were discharged:

The two remaining women in there were in a vile environment. Their... their vista was looking at a bed with a bloody sheet left on there. You know, when they went to use the sink to wash their hands, there was dirty linen down there (p5).

One participant described how some women had also received remarks from healthcare professionals about their decision to have a child during the pandemic:

I've heard of a couple of women receiving quite a lot of negativity, even from health professionals, about trying for a child during a pandemic. 'Why would you do that? Why would you? Why would you try for a child during a pandemic? Why would you do that?' (p2).

One participant described incidents of discrimination and racial stereotyping by staff towards those who are COVID positive from Asian communities:

we have a lot of Asian women. I mean, 'Asian', ridiculous term anyway, Asia's a big place, but so, Pakistani women. People will be like 'oh yeah, but they've all been living in the same house. They've all been seeing each other. There's no way they haven't been seeing extended family and everything so no wonder they've got COVID'. What's that about? Well and anyway, so what if they have? They're here, they're our patient, they've got COVID. It's not a name game (p5).

However, some reported positive impacts were reported as a result of the pandemic response. A lack of visitors allowed women's rights to dignity and privacy¹⁰ to be upheld more easily. For example, visitors were thought to be intrusive at times:

sometimes the women won't even have underwear on yet [...] and the relatives are pulling the curtain round trying to jump into the bed space (p7).

Perception of clients' reaction to COVID-19

All participants believed that COVID-19 had caused additional distress to women. Participants acknowledged that women were at risk of contracting COVID-19 when interacting with maternity services. The risk of contracting COVID-19 was thought to have been *really hard and tiring* (p10) for women, who were also more afraid due to not being able to have partners present. These factors were thought to be the driving force for more women not attending their appointments or requesting early discharge from hospital.

I just think women may not access the services as much as they would've done before because they can't have people in with them, so they're scared, they feel vulnerable (p6).

Participants believed that women thought the NHS was overwhelmed to the extent that it did not prioritise their wishes. One participant stated, *it's kind of like it [maternity care during COVID-19] can become us and them* (p9). This prevented cooperation between staff and women:

Instead of working together, I think the women are afraid that we're representing the NHS. The NHS as an entity, 'all the NHS is struggling, everybody there is riddled with COVID' (p9).

Furthermore, maternity staff recognised that they had to balance high-quality, respectful maternity care with preventing COVID-19 transmission, but felt that sometimes this was not recognised by women in their care:

They're just kind of in their bubble and they say, this is what I want, this is how I want to be treated and not thinking about the bigger picture and going... well actually there's the midwives, you know we don't want to get COVID, we need to protect us, we've got families (p1).

Support for families

Social support in hospital

Social support for women while in hospital was reduced during the COVID-19 pandemic.

The biggest thing that's affected their experience has been uncertainty, lack of support from family and friends, and lack of support from midwives because of staffing (p7).

Partners were not able to be present for many of the scans, appointments, and often for large parts of labour. As a result, women were without their usual support networks, even sometimes when receiving bad news:

there are partners sitting in the car park, there's women coming in who have been told that they've got, you know, it's not a viable pregnancy, being told they've got foetal anomalies and they haven't got anybody with them (p5).

Participants questioned why this restriction was necessary, especially in comparison to other services. When asked what they would have changed about the pandemic, most participants wished women could have had a partner present for more of their journey and noted the utility of lateral flow testing, introduced later on in the pandemic, to facilitate this.

Concerns were raised about possibly increasing the incidence of postnatal depression due to reduced social support.

We've had quite a few tearful ones. They've all hated it, they've all said 'ohh it's a horrible time'. All of them end up crying at some point, like 'cause they really want the partners (p4).

Nonetheless, there were some benefits as participants felt women sought more companionship from those in neighbouring beds, providing them with peer support that might not ordinarily be accessed:

they, you know, can be on their own and actually they communicate, and they make their friends within the bay, and I think that's really good and supportive for them, you know, not having their partners [...] that doesn't always happen when the partners are here and it's normal, normal day-to-day, so that's really good (p3).

Social support in community

Participants felt that national COVID-19 restrictions had reduced the support available to women in the community and described the significant role of socialising with other pregnant women or those with newborns in protecting women's mental health.

things like antenatal classes and stuff that women always used to go to, kind of NCT and all of those sorts of things, always used to be face-to-face and you always used to kind of meet the group [...] All of those things, all of those kinds of socialising things that are a massive mental health support. You know, if you can text another mum at 3 o'clock in the morning and go, 'uh is yours still feeding?', 'Yes mine is'. That's a massive solidarity thing. All of that's gone and I think that that is huge (p2).

While some antenatal classes had been taking place via Zoom, it was widely acknowledged by participants that virtual interactions were not a satisfactory replacement for forming face to face relationships:

you can never detract from the enjoyment of having that face to face in any aspect of your life, we're social people, so you can never detract from that (p1).

Participants did note that isolation has not been entirely negative; some families were expected to have enjoyed spending more time bonding with their baby:

That time with baby has been really special and for their partner and them to spend that time with baby alone has been quite special for them (p11).

Impact on newborn care

In compliance with infection control regulations to prevent transmission of COVID-19, a woman and her newborn may have been separated for periods of time. For example, when the newborn needed to be in the neonatal unit, but the woman was COVID positive. This was thought to be highly distressing for both mother and infant:

Horrendous. You know, um... and especially when women can't visit their babies on the neonatal unit when we know that baby is going to have a poor outcome and potentially, you know, not survive... and I know we've got to protect them. I don't know. Just some really horrendous things (p5).

Women and newborns were also sometimes separated for at-home postnatal checks, for example, when a household member was COVID positive to prevent transmission, which one participant described as *horrible to do* (p6). This means that maternity staff did not observe the interaction between woman and newborn, or even see the woman face to face at all. Partners were also restricted from visiting the newborn. This stretched into longer periods for the most unwell patients who had to stay in hospital:

it's going to affect fathers or whoever their partner is. Like I say, we've got lots of incidences where we've got women in and they're going to end up being in five days and their partner can't see them. Now that's a huge chunk of life and it's, and it's really traumatising for a lot of the partners (p5).

Participants stressed the negative impact this would have on the mental health of the partner and bonding with the newborn:

I think we're going to see a generation of gentlemen or birth partners or fathers that are going to struggle to bond. We're gonna see more... because it's not, postnatal depression doesn't just affect the mums, it can affect the dads and I think we're going to see more of that (p9).

Concerns were also noted that the newborns would have had less opportunity to *interact with their contemporaries* (p2), one participant noting this may impact their development:

I do think the babies are suffering—well not suffering because they don't know any better—but possibly in the long term, because they haven't got that stimulation (p4).

One participant reported some new mums had regretted their decision to have a baby at this time due to the difficulties brought by the pandemic:

But it's sad to think that, you know, you've got this baby of you, this lovely little baby, who is essentially healthy and well, you know, and you're regretting having your baby because of what's going on in the world that we can't control here (p8).

However, beneficially, participants felt that COVID-19 restrictions gave additional privacy on the wards and at home which may have facilitated the rise in breastfeeding rates during the pandemic:

our breastfeeding rates have improved since the pandemic because people aren't coming to the wards and so you can have that baby skin to skin. So that's been quite good, and it can obviously follow on at home because you shouldn't be having anybody at home (p6).

Maternity staff as women's supporters

In the absence of visitors, partners and community support, participants felt that midwifery staff *suddenly are that support mechanism* (p8). Participants acknowledged that while better than nothing, they are not a replacement for the support of a partner:

It's not... by any stretch of the imagination, I am not their husband, I'm not trying to be that, but I think it's better than being alone (p2).

The continuity of carer model was perceived to provide protection to maternity staff's role as women's supporters during the pandemic. Where resources permitted, this service allowed them to attend appointments with the women, even during visiting restrictions. The ongoing relationship its staff had built with the women in their care meant that they were a *'familiar face'* (p2):

The trust is going to develop, and they are able to open up a little bit more and it's about... the biggest thing is communicating and communicating on that right level. Once you get that relationship right and you develop that trust, then it's going to open a whole... more doors then and hopefully improve the care and deliver what they need (p1).

However, it was acknowledged that the continuity of carer model requires adequate staffing to operate successfully, although some teams were disbanded at the beginning of the pandemic. One participant reported that staff have worked considerable overtime out of duty to the women in their care:

So when we've got a team fully back up and running, it will be a lot easier then and I won't feel like I'm doing extra to help out with the team and not letting women down. 'Cos that is what we, we don't want to let the women down and that's why we do extra. Well,

I do. I'm an idiot really, but it's just I don't wanna let them down (p6).

Comparison with components of respectful maternity care

These inductive themes were compared with components of respectful maternity care described by the White Ribbon Alliance.¹⁰ COVID-19 was found to impact all components of respectful maternity care featured in the RMC charter, as demonstrated in online supplemental file 4 with key example quotations.

DISCUSSION

This study explored the perceptions of nine midwives and two maternity support workers on the impact of the COVID-19 pandemic on respectful maternity care in a diverse region of the UK. The main impacts of the early COVID-19 pandemic on respectful maternity care were found in the areas of communication of care, clinical care and support for families. Challenges were found in all components of respectful maternity care and in upholding each of the 10 human rights afforded to women and newborns under the Respectful Maternity Care Charter.¹⁰ However, a few benefits to respectful maternity care were also noted. Positive findings include the relative ease of making routine enquiries about domestic violence when women attended maternity services alone, and the positive role of midwives, especially under the continuity of carer model, in providing much needed emotional support to women despite the pandemic pressures.

This study benefits from a qualitative methodology which allowed maternity staff to share their perspectives on challenges and successes in maternity care provision during the early COVID-19 pandemic. Data adequacy was reached in this study and analysis was strengthened by the use of researcher triangulation in coding and refinement of the themes presented.

A limitation of this study is that all participants were White European women; therefore, it is likely that the findings do not reflect all the perspectives of the midwifery workforce in this diverse region. The use of purposive sampling through professional contacts may have introduced recruitment bias to the study sample. A further limitation is that participants were discussing the quality of their service, and the professionalism and attitudes of themselves and their colleagues. As a result, responses may have been subjected to social acceptability bias.²³ To mitigate this, participants were assured of anonymity and interviews were conducted individually.

It is also noted that this study explored the perceptions of midwifery staff at the start of the COVID-19 pandemic, and how it evolved during its first year. There is potential for recall bias, in participant, responses as these data were collected retrospectively. The study timeframe may limit the application of this study's findings to the present circumstances as: the situation is no longer emergent; some infection control measures have been rationalised

as more evidence about COVID-19 became available; and fears may have been lessened by the availability of a vaccine. However, it does still provide useful insight into the perceptions and impact of a rapid change to maternity service provision.

Communication of care

Our findings concur with recent evidence that women experienced emotional distress due to the limited information available to them about the impact of COVID-19 on their maternity care.²⁴ Lack of communication and misinformation, as reported by our participants, is a barrier to respectful maternity care provision.¹⁰ To mitigate this, effective communication in emergencies should be established by frequently updating staff and harnessing social media to provide accurate information to the public, wherever possible.²⁵

A 2016 study shared this study's findings that professional interpreter services are underused in maternity services.²⁶ The COVID-19 pandemic has furthered the barriers to care for those with limited English proficiency, as reported by our participants.²⁷ Professional interpretation services must be used where required to facilitate equitable care and patient safety.^{10 28}

The perception of participants in this study that domestic violence disclosures increased during the early COVID-19 pandemic is reflected in the national increase in calls to Refuge.²⁹ Participants' view that the absence of a partner at appointments facilitates routine enquiry about domestic violence is in accordance with previous concerns from midwives about the presence of partners at appointments.³⁰ As a result of these findings, we recommend that some continued visiting restrictions should be considered to facilitate an appropriately timed routine enquiry about domestic violence.

Clinical care

Participants echoed the voices of pregnant women that during the pandemic, they needed more time and support from their midwives.³¹ This was difficult due to staffing pressures, already present prior to the pandemic,⁵ which worsened due to additional tasks and a reduced workforce.¹ Although the literature shows that most front-line staff prioritised service users' needs above their own health anxiety during the pandemic,⁷ an over-worked and distressed workforce is less able to provide high-quality healthcare, creating a downwards spiral.³² These findings show there is an urgent need for staffing shortages to be addressed from a governmental level to increase capacity for respectful care, maintain minimum safety standards, and protect the mental well-being of maternity staff and women.

Although not common in this study's findings, incidents of stereotyping and discrimination against women of Asian ethnicity and those who were COVID-positive suggest a concerning presence of stigmatisation in the region's maternity services. This is against a woman's rights to equitable care and freedom from ill-treatment,

and additionally may demonstrate intersectionality of racial prejudice and health stigma.¹⁰ Women from Black or other Minority Ethnic groups represented 55% of all pregnant women admitted to hospital with COVID-19 infection, despite representing only 13% of the UK population.³³ Discrimination voiced by participants highlights the importance of the Royal College of Midwifery's recommendation for training to empower individual staff members to take responsibility in identifying and tackling these issues.³⁴

Support for families

Participants felt strongly that a lack of partner support had been distressing for women. Having a birth partner of choice is included as a key recommendation for RMC and is a protective factor for safer birth.^{10 35} As a result, maternity staff worked to increase their role as a woman's supporter. In breach of the right of every child to be with their parents or guardians,¹⁰ women and newborns were also separated in some instances. Participants thought this was highly distressing, and evidence now shows that this practice is not beneficial since the risk of COVID-19 transmission is outweighed by the survival advantage of skin-to-skin contact and exclusive breast feeding.³⁶ Partners, too, were thought to have found being separated from their newborn to be psychologically distressing and have prevented bonding.¹³ Currently, pandemic management has changed to ensure that women can have their birth partner present and every effort should be made to facilitate this in any future crisis situation.³⁷

The continuity of carer model was thought to facilitate a high standard of care, despite the pressures of the COVID-19 pandemic, since it provided women with one healthcare professional whom they saw for the majority of their journey, including intrapartum. This model has been found to be preferred by women and to facilitate care, which respects individuals' decisions.³⁸ A woman experiencing social isolation may be at increased risk of postnatal depression³⁹ and research shows increased incidence during COVID-19.^{40 41} This made the role of continuity of carer more important during the pandemic, to provide women with the support of a 'familiar face'.⁴² Participants shared this perspective, reporting the service had continued in the pandemic only due to the goodwill of staff who did not want to let down the women with whom they had built a relationship. This study reinforces the key role of midwives and maternity care workers in patient support, and how provider continuity should be promoted when designing and delivering maternity care services.

CONCLUSIONS

This study gives novel insight into midwives' and maternity support workers' perceptions of the impact of the early COVID-19 pandemic on respectful maternity care provision in a diverse region of the UK. Challenges were

identified in all components of respectful maternity care and in upholding each of the 10 rights afforded to women and newborns under the Respectful Maternity Care Charter. Ongoing management of COVID-19, and planning for future events must be made in careful consideration of the impact on the rights of a woman and newborn to respectful maternity care.

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