Improving provision and experiences of maternity care during the COVID-19 pandemic – lessons from the COVMAT study

Policy Brief 1

Key points:

- In response to the global COVID-19 pandemic in Australia, many changes were made to maternity and neonatal services, impacting all key stakeholders including consumers, families and providers of care.
- We conducted a national study using surveys and interviews with 5 key groups – women, their partners, midwives, doctors and midwifery students.
- Our study showed that the levels of service disruption were significant and impacted all involved, negatively and positively. Our findings provide insights into how the negative impacts might be minimised during future pandemics or health emergencies.
- Findings from our research showed that there were some factors that were protective or supportive during the pandemic, and these proactive and innovative approaches could be adopted in the future.
- The risks posed by not responding to the lessons learnt from the COVID-19 pandemic include increased costs to the health system due to long-term impacts on the health and well-being of all key stakeholders.
- Understanding the human experience of maternity services system changes in response to COVID-19 is vital. This can enable maternity care services to minimise the negative and optimise the positive impact of changes on those receiving and providing maternity care.

This policy brief summarises findings from the COVMAT study: An Australian cross-sectional study of over 4,500 maternity stakeholders – including women, partners, midwives, doctors, and midwifery students. The study provides a snapshot into maternity care during the pandemic and was conducted during the first wave of the COVID-19 pandemic from May to June 2020.

Impacts of COVID-19 on antenatal and birth care

In response to the COVID-19 pandemic declared by WHO on 11th March 2020, rapid and radical changes were made to the way maternity services were provided in Australia[1]. For example, public health measures were designed to reduce the number of people gathering together and this meant women had fewer antenatal appointments, were unable to bring partners or support people to antenatal appointments and face to face antenatal care was moved to telehealth[2]. Our findings showed that partners and support people felt excluded[3]. In labour and birth suites, only one nominated person was permitted to attend to support the woman, and, in some cases, women were in labour without support from a partner or family member[2].

Postnatal care was affected

As a result of the public health measures, postnatal wards in Australia implemented strict visiting restrictions, which meant support for women from fathers, other partners or family members were limited or even prohibited[2]. When babies were admitted to special care nurseries, only one nominated 'visitor' (usually the baby's mother) was allowed. This meant that fathers and non-gestational parents were unable to see their newborn for extended periods[3]. In the postnatal

period at home, adaptation to new parenting roles (such as lactation support) was impacted by reduced (or absence of) face to face support. Only those with complex care needs received direct care with many parents sharing that they felt abandoned and alone. Expectant and new parents' groups, which play an integral role in providing education, peer support, and connection were cancelled, and in some cases, online groups were started, although these were ad hoc and usually arranged by parents themselves[2].

Healthcare providers strived to provide quality care

Our study showed that midwives and doctors strived to deliver high quality and safe care in the context of rapidly changing policy. Staff reported struggling to access adequate personal protective equipment (PPE)[4-6]. In the early weeks, the supply of equipment to support clinical care using barrier precautions was irregular[4,5], prompting anxiety amongst staff in some units. Healthcare workers were concerned about the potential for occupational exposure to COVID-19 and worried for the safety of their families and loved ones because of their work in hospitals[1]. Midwives working in continuity models reported higher levels of satisfaction and felt able to support women and their families during the rapid change and uncertainty[5].

Education and learning opportunities were lost

Midwifery students form part of the maternity workforce in Australia. Most students had their clinical placements disrupted and for some even cancelled, preventing them from completing their continuity of care experiences which meant there were challenges in meeting requirements for their courses. Students' tuition moved to entirely online. Our study has shown that these rapid changes were disruptive to student learning and caused feelings of isolation, anxiety and threatened workforce supply[6].

Some positives emerged

Silver linings were described from each of the five stakeholder groups and point the way to areas for continued service innovation that will be helpful as we emerge from the current pandemic and seek to be prepared for future health crises[1-6]. Quiet maternity wards with minimal disruptions were particularly seen as a silver lining for women learning to breastfeed and care for their new babies[2,5]. Despite the challenges, most stakeholders were happy with the way services were provided in challenging circumstances (Fig.1)[1].

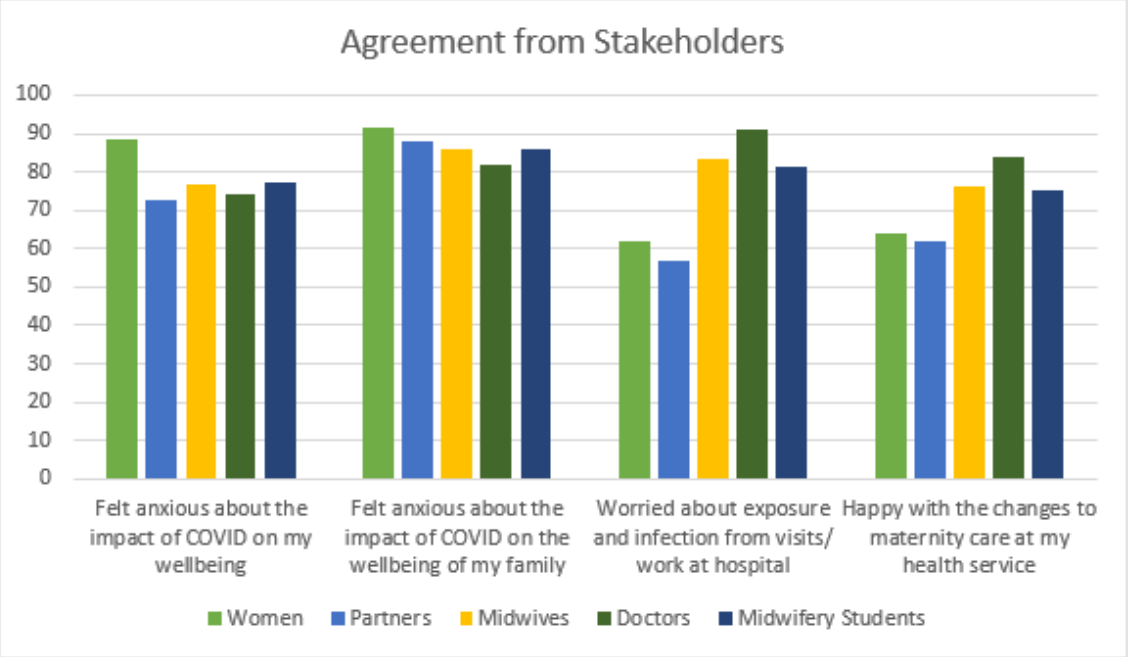

Figure 1. Agreement from five key stakeholder cohorts[1]

Our research findings indicate a number of considerations for policy and practice in the future.

For women

- Ensure that pregnant women have their support person of choice attend antenatal appointments and investigative procedures with them.
- Provide innovative ways to ensure women can access quality primary care from midwives and doctors outside of acute care settings.
- Flexible modes of antenatal education should be provided to women when face to face care is not possible.
- Ensure pregnant women have choice and control over who is able to support them and provide care during and after birth.
- Create alternative ways to provide support for new mothers to establish infant feeding and parenting skills when face-to-face care cannot be provided.
- Support the establishment of online parenting groups and forums where parents can access swift, accurate and evidence-based information.
- Ensure increased mental health and family violence support services to pregnant and postnatal women during public health crises.

For Partners

- Ensure women's partners/ support persons are enabled to participate in all interaction with maternity services (preferably face-to-face, but also by virtual means) if women indicate that this is their preference.
- Avoid significant restrictions in the length of time partners and key support persons of women can visit postnatal wards.
- Antenatal education programs (which may be online) should harness the potential of partners/ support persons to provide key support for women during pregnancy, birth and the postnatal period. With appropriate education and information, partners/ support persons can be an invaluable support resource for women especially when social and health professionals' networks are reduced.

For healthcare professionals

Midwives

- Increase the availability of continuity of care models which are a supportive strategy for midwives to provide woman-centred care during pandemic times.
- Improve access to technology-assisted healthcare. In periods of public health crisis where direct contact is not possible or desirable, midwives need to have appropriate devices to provide safe assessment and care.
- Consider adoption of clinical guidelines that were revised during the pandemic and were found to be beneficial by women with no apparent change in clinical outcomes e.g.., GTT Screening for GDM.

Doctors

- Enable the expansion of telehealth services to target flexible approaches to consultation and care for women
- Explore ways of improving and enhancing the connection, communication and capacity for load-sharing between primary and acute settings.

Midwifery Students

- Ensure that hospital instructions regarding pandemic management consider students to be health service staff to support clinical placement.
- Education stakeholders including universities, health services and health regulators should consider ways to

further collaborate and enhance agile responses to protect and support student learning during periods of health crises.

Health and maternity services

- Health services could consider maintaining some (but not all) of the visiting policy restrictions implemented in postnatal wards during the pandemic. Having fewer visitors allows for more time for mothers and support persons to rest, bond with their babies and receive uninterrupted breastfeeding guidance.
- It is recognised that this was a fast moving time and space in terms of government guidelines (for example regarding face-to-face maternity service provision) and that this created multiple challenges for health services trying to maintain services, while keeping women and babies safe. Consistency of guideline and policy across health services is critical especially to reduce confusion and fear. Parents scheduled for health consultations should be contacted prior to each consultation, to ensure that they are aware of the latest health service policies.
- Consider the inclusion of disaster preparedness education in professional competency training.
- Ensure alternative approaches for providing antenatal and breastfeeding education to women and their partners are available, when face-to-face services cannot be held.
- Consider ways to support and adapt the continuation of maternal and child health care in the postnatal period
- Increase funding to support community and primary health care models. Most pregnant women achieve better outcomes and with primary health care by a known midwife. During health crises, hospitals are known to be areas of higher clinical risk; care in the community enables safe care for a well population who have specific fears and anxieties.
- Future scaling up or down of responses should consider not only epidemiological modelling but also the impact on people and in particular, the psychosocial impact on new parents.

About Us

We are a national interprofessional collaboration of clinicians, academics, researchers, and professional leaders with a background in midwifery, obstetrics, public health, and psychology.

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