



The impact of planning for COVID-19 on private practising midwives in Australia



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ABSTRACT

Problem: The COVID-19 pandemic response has required planning for the safe provision of care. In Australia, privately practising midwives are an important group to consider as they often struggle for acceptance by the health system.

Background: There are around 200 Endorsed Midwives eligible to practice privately in Australia (privately practising midwives) who provide the full continuum of midwifery care.

Aim: To explore the experience of PPMs in relation to the response to planning for the COVID-19 pandemic.

Methods: An online survey was distributed through social media and personal networks to privately practising midwives in Australia in April 2020.

Results: One hundred and three privately practising midwives responded to the survey. The majority (82%) felt very, or well informed, though nearly half indicated they would value specifically tailored information especially from professional bodies. One third (35%) felt prepared regarding PPE but many lacked masks, gowns and gloves, hand sanitiser and disinfectant. Sixty four percent acquired PPE through social media community sharing sites, online orders, hardware stores or made masks. Sixty-eight percent of those with collaborative arrangements with local hospitals reported a lack of support and were unable to support women who needed transfer to hospital. The majority (93%) reported an increase in the number of enquiries relating to homebirth.

Conclusion: Privately practising midwives were resourceful, sought out information and were prepared. Support from the hospital sector was not always present. Lessons need to be learned especially in terms of integration, support, education and being included as part of the broader health system.

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Statement of significance

The issue

Privately practising midwives are often not seen as a mainstream service and so are potentially missed in

planning when public health emergencies like the COVID-19 pandemic occur.

What is already known

Privately practising midwives continue to struggle for recognition and access to hospitals in Australia and it is unclear how they were affected by the COVID-19 pandemic.

What this paper adds

Despite the challenges privately practising midwives were resourceful in accessing personal protection equipment. All health care providers, including those in primary-level services, need to be involved in future pandemic planning,

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and collaboration and support through the health services needs to be provided across the health system. Aspects specific to homebirth must be considered in future clinical guidance and advice, to ensure that an integrated approach is undertaken.

1. Introduction

The novel Coronavirus (SARS-CoV-2) was first identified in December 2019 [1,2], and has spread rapidly around the globe, crippling health systems and significantly impacting front line health workers [3]. The World Health Organization (WHO) described COVID-19 as a public health emergency of international concern on 30 January 2020 and a pandemic on the 11 March 2020 [4]. In Australia, the Commonwealth Government's coronavirus emergency response plan was triggered in late February and a suite of approaches, including travel restrictions, quarantine measures and physical distancing were announced to both suppress the spread of the virus and allow health systems to prepare [5]. Maternity services in all countries have been impacted by the COVID-19 response including the implementation of telehealth, social distancing, use of personal protective equipment for clinical care and reduced visitors and support people [6]. In the middle of the focus on COVID-19, women and families are still having babies and having to navigate a complex health system [7].

The most common reason for hospital admission in Australia is pregnancy and childbirth. More than 300,000 babies are born in Australia each year and women attend more than two million pregnancy care visits annually [8]. Maternity services underwent rapid transformation in the delivery of pregnancy care to reduce the risk of transmission in both women and maternity care workers in response to the COVID 19 pandemic. On both social and mainstream media, women expressed increasing anxiety about these changes including concerns around their risk of contracting COVID-19, changes to intrapartum care, not having support people around them and potential separation from their baby [9,10]. In response to this, there seems to have been an increase in women interested in homebirth across the country, mirroring international observations [7,11,12]. The Australian College of Midwives

reported many additional calls relating to home births since March and private midwives in Australia have reported increased numbers of women requesting homebirth [10,13]. In Victoria, one publicly funded homebirth model has tripled the number of homebirths provided between March and May 2020 when compared to the same period in 2019 to meet the increasing demand [14].

While the majority of women in Australia give birth in hospital, 0.3% of Australian babies are born at home [8]. The majority of these homebirths are provided by privately practising midwives (PPMs). PPMs are registered as midwives with the Nursing and Midwifery Board of Australia with *Endorsement* for Scheduled Medicines and are all self-employed. They provide care predominantly in the home and some also have visiting rights to admit women to hospital if needed. PPMs provide primary health care much like other private providers including general practitioners (GP) outside of the hospital system. Consequently, PPMs are often not seen as a mainstream service and so are potentially missed in planning when public health emergencies like the COVID-19 pandemic occur. In a similar way, GPs have also expressed concerns about patient access to care, their personal safety and individual wellbeing [15].

It is not known how COVID-19 has impacted PPMs in Australia, a small but important group in terms of demand for services, ability to provide such services, access to personal protective equipment (PPE), training in PPE and infection control, as well as ongoing practical and psychological support from the health system. The specific changes PPMs have made to their practice in response to the pandemic are also unknown. The aim of this study was to explore the experience of PPMs in relation to the COVID-19 pandemic. The findings will provide critical insights to guide maternity service preparedness for future pandemics or emergency situations and shine a unique light on a specific cadre of maternity staff.

2. Methods

A cross-sectional national online survey was conducted in the early days of the COVID-19 response in Australia. Prior to commencement, the study was approved by the Human Research Ethics Committee of Alfred Health in Melbourne (Project 198/20).

Table 1

Location of residence, practice scope and annual caseload.

	n (%)
Australian state of practice	n = 103
New South Wales	23 (22%)
Queensland	22 (21%)
Victoria	9 (9%)
Western Australia	9 (9%)
Australian Capital Territory	4 (4%)
South Australia	4 (4%)
Northern Territory	–
Tasmania	–
Not reported	32 (31%)
Place of practice	n = 103
Antenatal, labour and birth and postpartum care – home only	26 (25%)
Antenatal, labour and birth and postpartum care – home and hospital	28 (27%)
Antenatal, labour and birth and postpartum care – hospital only	2 (2%)
Antenatal care and education only OR Postnatal care and Lactation Consultant care only	4 (4%)
Other	11 (10%)
Not reported	33 (32%)
Annual caseload	n = 52
Range	1–60
<10	18
10–20	16
>20	18
Median annual births per midwife	12

Midwives currently providing any type of private midwifery services for antenatal, labour and birth and/or postnatal services in Australia were eligible to participate. The number of PPMs providing services, especially during labour and birth, is largely unknown. The most recent data is from 2015, which showed that there were 241 midwives who attended homebirths as a primary midwife, a decline from 287 the year before but several of these would be midwives working in the public sector [16]. We estimated that at least 100 PPMs would participate in the study based on interest and concerns in relation to COVID-19 expressed on social media.

A bespoke survey was developed for this study. The questions related to preparedness to manage potential COVID-19 clients, availability of personal protection equipment (PPE) and access to information about caring for women with COVID-19. The survey asked if the PPMs received information and support and whether they had experienced increased demand for services and in what magnitude. The survey used Survey Gizmo, an online survey platform, which is password protected.

The study was advertised on social media (Facebook, Twitter, homebirth, midwifery sites) and through personal networks in early April 2020. One reminder post was distributed – on 19 April 2020. The advertisement provided a link to the online surveys. When the person clicked on the link they were taken to the opening page of the online survey. There were a series of questions to answer to confirm their consent before they could start the survey. The survey took 10–15 min to complete.

Quantitative data was analysed using descriptive statistics. Content analysis was used to explore the open-ended questions and comments. All aspects of the survey were optional. Not all respondents answered every question, which means the amount of missing data varies.

3. Findings

In total, 103 PPMs responded to the survey, each question had between 61 and 81 responses. The location and type of practice of each of the PPMs is summarised in Table 1. PPMs practised in New South Wales (32%), Queensland (31%), Victoria and Western Australia (13% respectively), South Australia (6%) and the Australian Capital Territory (5%). There were no respondents from the Northern Territory or Tasmania.

All PPMs were in private practice and practised in varying capacities across the pregnancy, labour and birth and postpartum continuum (see Table 1). The highest proportion of midwives practised the full spectrum of care including antenatal, birth and postpartum care at home and in the hospital (40%), and the lowest proportion of respondents provided antenatal and/or postnatal care (4%).

3.1. Increased demand from women wanting homebirth

Ninety-three percent of PPMs reported an increase in the number of enquiries relating to homebirth which ranged from 17% receiving an extra 1–4 calls to 28% receiving over 20 extra calls over the past month. The PPMs reported that women gave reasons such as concerns about the hospitals limiting support people during labour, other restrictive practices in hospitals and increased exposure to COVID-19. Many of these enquiries were made close to the women's due date even as late as 39 weeks of pregnancy. PPMs explained women's reasons with these examples:

"Fear of going to hospital due to COVID. Fear of being unsupported in hospital due to support people restrictions."

"Last week I had more enquires than I've had in about 6 months!"

"I have had more requests from women who are concerned about the increasingly restrictive practices in hospitals which has made them turn to homebirth as a personally safer option."

3.2. Obtaining information on COVID-19

PPMs were asked where they received information about COVID-19 and were provided a series of options. The most common sources of information for PPMs were state and federal health departments, professional colleges (Australian College of Midwives (ACM), Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) and the World Health Organization (WHO). PPMs also sought information from the New Zealand Department of Health and New Zealand College of Midwives, along with contacting other PPMs for information.

Of the 62 responses, the majority of PPMs (82%, n = 51) felt they were very well informed or well informed about the implications for practice and the care of women. However, almost half (19/44) of the comments by PPMs stated that they would feel more informed if there was information specifically tailored to the unique practise of caring for women planning a homebirth including telehealth. Responses on what would have been helpful included:

"Information which is more relevant to visits at home as a midwife"

"Guidance from the ACM on appropriate response to COVID-19 specifically for midwives in private practice"

"I heard about Telehealth Medicare changes from social media and haven't had any information from Medicare directly"

This information would have been welcomed from the ACM, RANZCOG and governing bodies (state and territory health departments, Medicare), whom some PPMs felt were "slow" to give advice relevant to their practice.

"I think ACM and RANZCOG were slow to give advice regarding pregnancy, however I know that the knowledge base has been rapidly expanding and local context is important to acknowledge"

PPMs acknowledged that, given the rapid evolution of the situation, the information and advice changed daily making it challenging to ensure their practice was safe and up to date.

"As the situation is changing regularly it is hard to keep up with what is going on."

"Information that is not changing every day. But that's how a pandemic is I'm realising"

3.3. Feeling and being prepared for COVID-19

When it came to being prepared with personal protective equipment (PPE), one third of PPMs (21/61; 34%) felt they were prepared. PPMs were required to purchase PPE themselves and many reported that they were affected by the common lack of PPE including masks, gowns and gloves as well as hand sanitiser and disinfectant. Some PPMs (9/30; 30%) had a stock of PPE which they were now able to use. PPMs also commented that it would have been helpful to have had access to PPE, for example from their affiliated hospital, however this was not possible despite them making requests as explained here:

"Have requested small supply from local hospital for new home birth bookings – denied."

"Access to gowns from local hospitals would be very helpful."

"Easier access to PPE. Assistance from local hospital had been denied."

Two thirds of PPMs (39/61; 64%) were able to acquire some form of PPE through social media community sharing sites, online orders and Homebirth Australia which have been supplying masks. Around 65% (27/48) of PPMs reported making adaptations to PPE as part of their preparation. They reported sourcing PPE from non-hospital suppliers (hardware stores, for example) and are also wearing homemade cloth masks which can be washed between uses. Homemade hand sanitiser was also being made or sourced.

The majority of PPMs (75%) felt they were well informed about breastfeeding and COVID-19, however they were concerned about in-person contact as they had limited access to PPE. One PPM wrote that she was doing:

“Mainly online/phone to answer questions, history etc then in person as needed on a case by case basis . . . Face to face only 15-30 mins max as needed”

Many comments related to the importance of continuing to breastfeed and PPMs stated they were following the guidelines as they emerged:

“I'm comfortable with the guidelines that if the woman practices hand hygiene and wears a mask while feeding if she is unwell. If other guidelines are developed, I will follow them, but the information seems to be quite consistent.”

Very few PPMs (15%) reported being involved in simulations or drills in the event a woman in their care required admission to their local health service. There were conflicting answers regarding waterbirth with some PPMs reporting that the recommendation was not to provide waterbirth at home, while others stated they were not directed to cease practices such as waterbirth at home (86%).

3.4. Altering practise to accommodate COVID-19 precautions

Ninety-five percent (56/60) of PPMs reported changing the way they consulted with women including limiting consultation times to 15 min and spacing their appointments so women were not spending time in a waiting room. They are also sanitising equipment after each client and changing their clothes when they come home following a consultation or a birth. Telephone/video consultations are common and PPMs report screening women prior to attending a home visit. For example:

“I am limiting antenatal appointments. No face to face appointments before 24 weeks. Bookings done via video conference.”

“We are now screening all women prior to appointments and then having minimal contact by phoning before the appointment.”

Face to face birth classes had been cancelled and many PPMs had developed written information to distribute to the women and their families about minimising the risk of bringing infection into the home, social distancing and preparing for birth. Some PPMs reported that they were following the development of guidelines for in-hospital care and implementing similar precautions in the community:

“. . . by seeing changes in hospital has made it clearer what changes we should make in community.”

Included in these changes in practice, some PPMs were limiting the number of people during face-to-face consultations but not during birth, and self-isolating to minimise the risk of contracting COVID-19:

“Less people present for appointments, but not limiting supports at birth.”

“Other than the visits to clients I am self isolating.”

There were many comments relating to advising women that, should they need transfer to hospital, it is unlikely that PPM will be able to accompany them. PPMs explained that they were:

“Using more telehealth. Cancelling face to face childbirth classes. Writing a plan and making available for clients”

“Informing all women that if the need for transfer arises during labour, I will not be able to come with them to the birth unit of the local hospital as I will be seen as a support person, not a health professional.”

Tele or video conferencing was also mentioned in regard to the provision of postnatal support for women at home.

“Some telehealth where appropriate - mainly postnatal consults”

3.5. Support and information from the collaborating health service

Sixty-eight percent of PPMs who have a collaborative arrangement with local hospitals reported a lack of support from that service. They reported to have been “shut out of births” of women who have needed transfer from home to hospital and others have requested assistance from the local hospital and been declined. One PPM wrote:

“. . . I have been told very clearly that if I need to transfer I am NOT allowed in the birth suite or postnatal ward.”

Two (2%) PPMs stated that their local health service decided to exempt them from the “one-person rule” and allow them to stay with a woman who had transferred from home.

4. Discussion

The aim of this study was to explore the experience of PPMs in Australia in relation to preparing for the COVID-19 pandemic. One hundred and three PPMs from all of the States and Territories in Australia with known PPMs responded. Issues relating to clinical guidance specific to the home setting, access to PPE and infection control advice and support from health services were identified. These findings provide critical insights to guide maternity service preparedness for future pandemics or emergency situations and shine a unique light on a specific cadre of maternity staff that is often forgotten by mainstream health services.

In this survey, Australian PPMs reported an increase in enquiries for homebirth services in the early months of 2020 with some receiving more than 20 extra calls over the prior month. This was also reported in the media [10,12,14]. The Australian College of Midwives has also recently surveyed women about the experience being pregnant and giving birth in the early period of the COVID-19 response in Australia and found that 26% of women reconsidered their planned place of birth [7]. The main reasons were a fear of contracting COVID-19 in the hospital; they were told that they could not take support people to appointments, their option of homebirth in a publically-funded model was not available, they were worried their birth choices will be impacted and they were concerned about access to water immersion or Entonox for pain relief in labour. More than 2700 women responded to the online survey and 6% were either transferring or looking for a PPM to transfer care to and 3% were planning a freebirth, (that is, to give birth at home without midwifery and/or medical assistance). Planning to freebirth due to the COVID-19 restrictions is of significant concern and highlights the importance of options for women including access to PPMs.

Privately practising midwives need tailored, timely information to inform their care but the resources available were not specific to private practice or were confusing. Anecdotally, many midwives across Australia were finding access to tailored, non-overwhelming

information a challenge. Guidance from RANZCOG was quick to be produced [17] which respondents in this study found useful. It is important that information is developed that is more specifically tailored to meet the needs of midwives caring for women at home. This would occur if health facilities engaged pro-actively with community health workers (including PPMs) in their pandemic response planning.

In Australia, PPMs are mostly based in the community and attend the majority of homebirths. Some also provide care in one specified area such as antenatal and/or postnatal care, as was demonstrated in the survey. There are around 600 midwives recorded by the NMBA in 2020 as having *Endorsement*, which is essential before they can work as a PPM. However, it is unclear how many of these are practising privately [18] and the anecdotal estimates are that this is less than 200. Privately practising midwives are often forgotten in maternity service plans and guidance although collaborative arrangements were meant to address this. It appears this was also the case during the current the COVID-19 pandemic with nearly half of the PPMs responding that they would feel more informed if the information was specifically tailored to the unique practice of caring for women planning a homebirth, including telehealth. Delays in the dissemination of advice was also recognized. This experience mirrors that of other primary care providers including GPs who also experienced challenges during the planning phase [15].

It is evident that PPMs who responded were resourceful and sought out information from a range of sources to inform their care. It is clear that the plethora of policies and guidelines in the early weeks of the COVID-19 response was confusing and complex to navigate. Considerations around infection control, including attendance at labour and birth, analgesia such as inhalation analgesia, mode of birth and ability to support breastfeeding, particularly for women who test positive for COVID-19, have been the subject of much debate. In particular there were conflicting answers given regarding waterbirth, with some PPMs reporting that there were recommendations that suggested not to provide waterbirth at home. The confusion over waterbirth has been reported in other countries. In the United Kingdom (UK) more and more hospitals were banning waterbirth completely for all women, leading the Royal College of Midwives to issue a Clinical Briefing on waterbirth and COVID-19 [19]. In the UK, around 26% of maternity services had stopped all waterbirths, and not just for those with suspected or proven COVID-19. The Royal College of Midwives recommended that “the current evidence does not suggest that there should be a blanket cessation on the use of water in labour or waterbirth for all women” [19] although it is unclear what impact this recommendation has had in the UK. Clear, consistent evidence-based advice is clearly needed for waterbirth and other issues related to infection prevention and control. The challenges and uncertainties regarding practice changes highlight the importance of engaging primary health services, such as those PPMs provide early, and with up to date and relevant information to guide practice.

Privately practising midwives raised the lack of access to PPE and resources such as hand sanitizer and disinfectants. Some midwives who had clinical privileging rights with hospitals requested supplies but were denied. This led many PPMs (64%) to going online and accessing supplies through social media, online orders, hardware stores and organisations such as Homebirth Australia, who sourced supplies. Previous clients of PPMs and local community suppliers also donated, sewed cloth masks and supported some of the PPMs. Some midwives even made their own hand sanitizer. These experiences are similar to many health care providers across the world who have been calling for better access to PPE [20] including in community-based maternity settings [6].

Effective PPE must be available for midwives based in the community for antenatal appointments and for assisting births [6]. Studies of infection control and personal protective equipment (PPE) in home healthcare have focused on hospital-in-the-home, where healthcare workers are caring for unwell people and often doing regular invasive procedures [21,22] rather than in the context of pregnancy care. Maintaining infection control in the home environments can be more difficult and this is even more so during a pandemic when PPE is a heightened issue [23]. For midwives this may be weighing scales and bags for example that will be taken from house to house [22,24].

It is hard to enforce social distancing in someone else’s house and there may be less recommendations about how many people are allowed in someone’s home when the midwife is present. However, PPMs did report limiting the number of people present during antenatal consultations and screening of clients prior to visiting to rule out potential exposure. The healthcare workers clothing may also become a source of contamination [25]. Many health workers in maternity settings have little knowledge of decision-making in relation to the choice and use of facemasks [26], not to mention the impact of facemasks on development of rapport. Privately practising midwives are less likely to have to engage with the infection control practices required in the context of a pandemic response.

Unfortunately, PPMs did not always receive adequate support from the hospital sector and this needs attention in future planning. Sixty-eight percent of PPMs who have a collaborative arrangement with a local hospital reported a lack of support from that service. In this survey very few reported being able to access simulation training run by the services and they reported being “shut out of births” of women who have needed transfer from home to hospital. These registered health professionals were seen as ‘support people’. Others requested assistance from the local hospital and this was declined. It is concerning that these PPMs were denied support and respect and this points to ongoing issues with acceptance of midwives practising autonomously in Australia. This may be because hospitals themselves were coping with enormous change and disruption in their own services and were unable to consider community-based providers such as PPMs.

This study has a number of limitations. We had 103 responses to the online survey but it is difficult to know the total number of PPMs at the current time point to calculate a response rate. In 2015 (the most recent data available) there were 241 midwives who attended homebirths as a primary midwife [16], though this includes both PPMs and midwives employed in publicly funded homebirth programs. In the past five years, there have been considerable reductions in the number of PPMs due to challenges with insurance and meeting regulation requirements. We estimate that there are probably less than 200 PPMs in Australia and probably many less providing full spectrum of care services (antenatal, labour and birth and postnatal). Therefore, the response from more than 100 PPMs is encouraging and probably reflective of the broader experience. Additionally, not every question was answered which likely reflects the different areas of practice for the PPMs. With a longer lead in time, we may have been able to refine the survey to reduce these missing data. However, the COVID-19 response was rapid, and it was important to gather timely information in the pandemic.

5. Conclusions

This study shows that PPMs were fully aware of the need to protect themselves and their clients in the COVID-19 response and took the necessary actions in terms of information and PPE. It was challenging however and many did not receive adequate support through the public health system. This highlights that some PPMs

may not be well integrated into the public health system and this means they are not acknowledged as another group of primary health providers to be supported and engaged with.

PPMs are privately and federally funded through Australia's universal health insurance scheme (Medicare) but there are really no mechanisms in place to support them in a time of pandemic preparedness. This is unlikely to be the last pandemic and lessons need to be learned for the future, especially in terms of integration, support, education and inclusion as part of the broader health system. Midwives such as PPMs also need to develop their own preparedness plans including ways to come together to support one another, provide training and advice.

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Ethical statement

This study was approved by the Office of Ethics & Research Governance at Alfred Health, Melbourne, Victoria Australia – Project ID number: Project 198/20.

Conflicts of interest

The corresponding author, Caroline Homer, is the Editor-in-Chief of *Women and Birth*. This paper was therefore managed completely by the Deputy Editor, Linda Sweet, to avoid any conflicts of interest. The usual processes of blind peer review were undertaken.

One of our co-authors, Hannah Dahlen, is a private practising midwife which may be considered as a conflict of interest.

Author contributions

CH conceived the study and wrote the first protocol. HD, MDT and VS developed the data collection tools and assisted with collecting. VS led the analysis of the data. CH wrote the initial draft of the manuscript and all authors contributed to numerous drafts. All authors approved the final version.

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