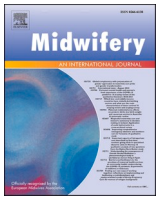
Midwifery 147 (2025) 104428

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw



Midwives' views and experiences of maternity care during COVID-19 in Ireland: A qualitative descriptive study

Paula Barry [a], Sunita Panda [b], Deirdre O'Malley [c], Nora Vallejo [a], Hazel Cazzini [d], Valerie Smith [e,*]

[a] The Coombe Hospital, Dolphins Barn, Dublin, Ireland
[b] School of Nursing and Midwifery, Trinity College Dublin, 24 D'Olier Street, Dublin, Ireland
[c] School of Health and Science, Dundalk Institute of Technology, Dundalk, County Louth, Ireland
[d] The Centre for Midwifery Education, Dolphins Barn, Dublin, Ireland
[e] School of Nursing, Midwifery and Health Systems, University College Dublin, Belfield, Ireland

ARTICLE INFO

Keywords:
COVID-19
Maternity care
Midwives' experiences
Qualitative enquiry
Qualitative descriptive study

ABSTRACT

Objective: To explore and describe midwives' views and experiences of maternity care during the COVID-19 pandemic in Ireland.
Design: A qualitative descriptive study involving semi-structured interviews to gather data was undertaken. Interviews, which were held between September 2022 and January 2023, were digitally recorded and transcribed verbatim. Thematic analysis was used to analyse the data.
Setting & participants: The study setting was a large urban maternity unit (> 8000 births per year) in the Republic of Ireland. Midwives of any grade, who were involved in providing maternity care to women and their families in any area of the hospital during the pandemic were eligible for inclusion. Midwives were invited to take part via the hospital intranet and advertisements that were posted on notice boards throughout the study site.
Findings: Thirteen midwives took part in the study. Four major themes reflective of midwives' views and experiences were identified. These were: '*Ever-evolving goalposts*', '*Feeling vulnerable*', '*Changing relationships*' and '*Challenges to the Philosophy of Midwifery*'.
Key conclusions and implications for practice: This study highlights the need to consider the impact of COVID-19 on midwives and maternity services now and in the future. As a priority, embedding strategies to support midwives to regain and sustain psychological and physical well-being, are required. Attending to these factors may aid in sustainable retention of the midwifery workforce, and, ultimately, act as protective factors for crises that could emerge, potentially, in the future.

Introduction

Although no longer a public health emergency of international concern, for almost three years the COVID-19 pandemic caused major disruptions across all sectors of society, especially health. By February 2025, according to World Health Organisation (WHO) statistics, just over 777.5 million cases of COVID-19 have been confirmed with an associated 6.9 million deaths (World Health Organisation, 2023). The global response to the pandemic involving widespread travel restrictions, national lockdowns, altered societal functioning, and the wide-scale introduction of vaccines to protect populations against coronavirus, was unprecedented. Healthcare sectors and healthcare provision underwent tumultuous changes, especially in the immediate weeks following the outbreak of COVID-19. In maternity care, for example, antenatal and postnatal care provision in many countries moved to telehealth or less frequent in-person appointments, partners were prohibited or restricted from attending labour and birth, and the use of personal protective equipment, where available, dominated maternity care providers' work and daily lives (Flaherty et al., 2022). For women experiencing pregnancy and birth during the pandemic, the impact of altered care structures and processes affected women and their families in multiple ways; largely negatively, although some positives were noted (Panda *et al.* 2021; Flaherty et al. 2022). Pre-pandemic rates of perinatal depression globally, for example, were reported at 11.9 %

* Corresponding author.
E-mail address: valerie.smith@ucd.ie (V. Smith).

https://doi.org/10.1016/j.midw.2025.104428
Received 3 March 2025; Accepted 15 April 2025
Available online 24 April 2025

(Woody et al. 2017). Following the outbreak of COVID-19, based on a rapid review of 46 studies, prevalence rates of perinatal depression and anxiety were cited at 25.6 % and 30.5 %, respectively (Tomfohr-Madsen *et al.* 2021), a more than doubling of pre-COVID rates. Moreover, anxiety and depression in new mothers who gave birth during COVID-19 were reported as high as 61.9 % (Stampini et al. 2021), with rates of clinically relevant depression, up to 12 weeks postpartum, at 43 % (Fallon *et al.* 2021).

The pandemic also impacted maternity care professionals, especially in the early days when confusion, fear, and rapidly altering care structures and processes abounded (Flaherty *et al.* 2022). The physical and psychological impact that the pandemic has had on maternity providers is continuing to unfold. A global survey of the experiences of 1191 maternal and neonatal care providers, from 77 different countries, found that 58 % of participants reported higher stress levels during COVID-19 (Kolié et al. 2022). This was consistent across studies with a variety of contributing factors identified including changes in staffing systems, staff absence, and subsequent shortages due to staff self-isolating from exposure to the virus or confirmed infection, lack of information on changing policies and procedures, fear of transmitting the virus to family members, or inadequate training and preparation for redeployment and infection prevention and control (Bailey and Nightingale, 2020; Hunter et al. 2020; Kolié et al. 2022; O'Farrell et al. 2023). Strikingly, a UK-based survey administered to nurses and midwives over three-time points from April to August 2020 observed probable post-traumatic stress disorder in 44.6 % (n = 909/2040), 37.1 % (n = 1350/3638), and 29.3 % (n = 634/2162) of participants at each time-point respectively (Couper et al. 2022). Furthermore, midwives practicing during the pandemic experienced moral distress arising from difficulties in helping women and their partners manage anxieties and fears when they themselves were operating in an environment of uncertainty and rapidly changing information (Wilson et al., 2021). Uncovering and understanding these unintended and nuanced consequences, which have the potential to impact midwives' health and well-being and quality maternity care longer-term, is critical to support the midwifery workforce beyond the pandemic and into the future.

In Ireland, as with other countries, midwives, as well as pregnant or postpartum women and their families, had to adapt almost overnight in efforts to curb the spread of COVID-19. To explore and understand the impact of COVID-19 on maternity care within a national context we conducted a three-part study that i) explored women's experiences of maternity care during COVID-19 (Panda et al. 2021), ii) compared pregnancy, birth, and postpartum clinical outcomes before and during the pandemic (Smith et al. 2021), and iii) explored midwives' views and experiences of maternity care during COVID-19, the focus of the current paper. Gaining insight and understanding will help provide a national narrative of the impact of the pandemic on midwives' personal and professional lives and may help to identify practice innovations that could be beneficial in the future and sustainable long-term. The findings may also help to identify the supportive needs of midwives beyond the pandemic and will expand the global body of evidence on the topic. Lastly, the findings of the study will contribute to future qualitative evidence syntheses of maternity care providers' views and experiences of care during COVID-19 or inform other related evidence synthesis reports or policy documents.

Methods

Study design

To explore and gain an in-depth understanding of midwives' views and experiences, we undertook a qualitative descriptive study. The approach was chosen as it facilitated data gathering on experiential feelings, views, and perspectives, while simultaneously allowing for further probing to elicit information. Drawing on naturalistic inquiry, the chosen approach would 'give voice' to midwives' accounts of maternity care during COVID-19 (Sandelowski 2000). Although a substantive body of literature on healthcare providers' views, attitudes, and experiences of COVID-19 has emerged, exploring the phenomenon of interest exclusively from midwives' perspectives in the Irish context is novel and minimally understood. Of the one report that was identified this inquiry focused on midwives' experiences of providing perinatal bereavement care during COVID-19 (Power et al. 2022). For these reasons, the basis for the study was not underpinned by a theoretical framework specifically, rather we wished to draw on midwives' perspectives as offered by the participants of the study to gain an overall understanding of maternity care in Ireland during COVID-19. The study is reported using the COnsolidated criteria for REporting Qualitative research (COREQ) checklist (Tong et al. 2007) (Supplementary File 1).

Study setting

The study setting was a large tertiary maternity care hospital in the Republic of Ireland with an annual birth rate of approx. 8500 births. Midwives working in the hospital were both nurse and midwife trained, or midwife trained only. The hospital offers care to women through public and private pathways and is a training hospital for doctors and midwives. Changes to infrastructural and care services began following the confirmation of COVID-positives cases in Ireland and further escalated following the first national lockdown on 27 March 2020. Examples of these changes included the redeployment of midwives to other areas of the hospital, the establishment of screening stations at the hospital entrance, a suspension of some services including waterbirth, community services, and some clinics (e.g., breastfeeding clinics, birth reflection clinics), a reconfiguration of physical space, with the establishment of 'red zones' to accommodate women who were suspected or confirmed positive for COVID-19, a reduction in the number of routine antenatal surveillance visits for healthy pregnant women, a strict no visiting policy other than for partners who could attend when women were in established labour, and a change to telehealth for some consultations (e.g., postpartum breastfeeding support). In addition, partners were prohibited from attending ultrasounds and some partners were delayed access to the labour ward while their partner's COVID status was being determined, missing the birth of their baby as a result.

Study participants

Midwives, of any grade, who were involved in providing maternity care to women and their families in any area of the hospital during the pandemic were eligible to take part in the study. Purposive sampling, to ensure the selection of midwives that could provide rich information on views and experiences of care during COVID-19, was used to select the study participants. Recruitment commenced in August 2022 by advertising the study via the hospital intranet and placing posters in all clinical areas including antenatal outpatient clinics, ultrasound clinics, antenatal wards, the labour ward, and postnatal wards. Participation was voluntary whereby midwives interested in taking part in the study contacted a dedicated member of the research team directly, and participant information leaflets were forwarded via email.

Data collection and analysis

Participants interested in taking part in the study were subsequently contacted by a member of the research team to clarify any queries related to the study, obtain written consent, and schedule a date and time for an interview. To enhance data collection quality and rigor, two members of the research team (SP and HC), both female and educated to PhD and MSc levels respectively, with previous experience in qualitative interviews conducted all interviews. These researchers, at the time of the study, were working in midwifery education and had no working or other direct relationship with the study participants. Prior to commencing an interview, participants were informed of the

researchers' role in the study and of the study's purpose. One-to-one, semi-structured interviews were used for data collection. The interviews were held between 23 September 2022 and 24 January 2023. The mode of the interview, that is via telephone, face-to-face, or online using Zoom was at the discretion of a participant's preference. An interview guide (Table 1) developed from the literature was used to guide the interview conversation. Probes or prompts were used where appropriate to facilitate the flow of discussion. Participants' demographic data were collected at the start of each interview. All interviews were audio-recorded and transcribed verbatim by a professional transcriber who had signed a confidentiality agreement with the University in advance.

Data were analysed using Braun and Clarke's (2021) thematic analysis framework. This method involves six steps: i) becoming familiar with the data, ii) generating codes, iii) generating themes, iv) reviewing themes, v) defining and naming themes, and vi) locating exemplars. Microsoft Word was used to manage and analyse the data. Following data familiarity, coded text from each transcript, with the descriptive codes and associated text, was copied onto a clean Word document by one member of the research team. These codes were discussed with a second member of the research team prior to identifying the themes. These themes were further reviewed alongside the coded text and the themes were finalised and named, with exemplar quotes supporting the themes located. Theme generation and naming the themes was iterative, involving discussion and agreement by two members of the research team.

Table 1
Interview guide.

Introduction	Welcome and introduction. Thank the participant for taking the time to take part in the study. Provide reassurance that the interview can be stopped at any time/restarted/rescheduled; ensure the participant is comfortable to begin. Remind the participant of the purpose of the interview and the procedure, i.e., uninterrupted storytelling followed by some questions. Ensure that the participant understands the process and re-affirm consent. Reminder about recording and explain about transcribing. Collect demographics
Beginning of the interview	Start the interview with a general question about COVID-19 (how s/he is found the situation in general)
Experience of maternity care during COVID-19	Can you tell me about your experiences of working during COVID-19; how (if) COVID-19 impacted your experiences of providing care; in what way; what worked well, and what did not work so well? Can you talk to me about the impact of the pandemic on your personal and professional life; what were your feelings around this? Were there any infrastructural limitations, policies/guidelines that facilitated or limited your role as a frontline healthcare provider? Can you tell me about any support structures available to you at work during the pandemic Can you tell me about (if any) coping strategies you used to cope with challenges imposed by the pandemic Have you any suggestions for dealing with similar crises in the future? How did you view the experience overall; what could have been done to have improved it (focusing specifically on COVID-19-related impacts)
Concluding the interview	Make sure all aspects of the participant's experience have been covered. Ask if there is anything else s/he would like to add Thank the participant for her/his time and contribution to the study

Rigor

A series of activities were undertaken to enhance research rigor. During data collection, the interviewers made notes following each interview to maintain an audit trail. This activity also helped in guiding later interviews by allowing for additional probes and prompts to garner further in-depth information on topics arising in earlier interviews (Lincoln and Guba, 1985). Credibility was enhanced through member-checking, whereby all participants were offered a copy of their interview transcript to confirm accuracy and resonance with their views and experiences (Holloway and Wheeler, 1996). Three participants opted to receive a copy of their transcript and all three confirmed the accuracy of the transcribed data. During data analysis, dependability was enhanced whereby two members of the research team independently coded three transcripts and met to compare the interpretation of these data, including an assessment of assigned codes for relative congruency (Cronin et al. 2015). Following this, credibility was enhanced through prolonged engagement with the data by one member of the research team who coded all the remaining transcripts. Before agreeing on the final themes, the same two members of the research team further reviewed and discussed the identified themes and sub-themes alongside associated codes to ensure the participant's own words were comprehensively reflected in the findings. An audit trail of codes and theme identification was maintained to ensure confirmability (Streubert and Carpenter, 2011) (Table 3).

Ethical approval

Ethical approval to conduct the study was granted by the Research Ethics Committee of the study site (reference: Study No 30–2020). Written and verbal information about the study was provided to those who expressed an interest in taking part in the study. Written informed consent was taken prior to each interview.

Findings

Participant characteristics

Thirteen midwives expressed an interest in taking part in the study and all 13 were interviewed. Seven interviews occurred via telephone and six via Zoom. None of the midwives opted for an in-person interview. The duration of the individual interviews ranged from 33 to 44 min, with an average duration of 39 min. Recurring narratives were evident by interview 10. The remaining three acted as confirmatory interviews, whereby no significant new information was identified during these interviews, thus providing reassurances for data sufficiency. The participants held various roles as midwives, including specialist roles ($n = 6$), staff midwives ($n = 4$), and midwife managers ($n = 3$). The duration since qualifying as a midwife ranged from three to 29 years. Regardless of their specific roles, over half of the midwives ($n = 8$) were redeployed to work as a member of the COVID team during the pandemic. Table 2 presents the participant characteristics.

Thematic analysis

Four overarching themes were identified during the analysis of the data. These were *'Ever-evolving goalposts', 'Feeling vulnerable', 'Changing relationships',* and *'Challenges to the Philosophy of Midwifery',* within which there were seven sub-themes. Table 3 presents these themes and sub-themes along with codes (shortened for illustrative purposes) that contributed to the themes.

Theme 1: ever-evolving goalposts

This theme illustrates the fast pace with which information, clinical guidance, and policies changed during the COVID-19 pandemic and how

Table 2
Participant characteristics.

Role	Years qualified	Study ID	Area of practice during the pandemic
Midwife with a specialist role	29	MW1	COVID Unit
Midwife with a specialist role	5	MW2	COVID Unit and specialist department
Midwife with a specialist role	12	MW3	Community
Midwife with a specialist role	23	MW10	Specialist department
Midwife with a specialist role	22	MW11	COVID Unit and specialist department
Midwife with a specialist role	5	MW13	COVID unit
Staff Midwife	9	MW9	COVID Unit
Staff midwife	6	MW4	COVID Unit
Staff midwife	20	MW5	Labour ward and COVID Unit
Staff midwife	3	MW6	Labour ward
Midwife manager	24	MW7	Postnatal ward
Midwife manager	25	MW8	COVID Unit and all clinical areas
Midwife manager	18	MW12	Labour ward

Table 3
Themes, sub-themes, and associated codes.

Theme	Sub-theme	Associated codes (examples)
Ever-evolving goalposts	Communication issues	COVID response team, COVID response team communication/lack of communication, methods of communication, different communication for different healthcare professionals, personal communication, rumour, changing policies (local), changing policies (national), nightly news, media, social media
	Redeployment	General redeployment, triage desk, COVID assessment unit, uncertainty red/green zones, short staffed, sick leave, immunosuppressed (staff/family members), in it together
Feeling vulnerable	Personal Protective Equipment	No PPE, mind PPE, all day PPE, no masks (the beginning), fear for self, social distancing, lack of obstetric support, midwifery scope of practice
	Fear of contaminating home	Isolated (friends/family), fear for family, fear of bringing virus home, regime leaving work, regime once home, personal safety, anxiety, stress
Changing relationships		Positive public support, public support turns, isolated women/partners, extended restrictions, lack of trust in women, lack of trust in colleagues
Challenges to the Philosophy of Midwifery	Balancing COVID and quality care	The best we could, social distancing, telemedicine, phone triage, face-to-face, video and pictures, unsupported women, women worried (self and baby)
	Medicalisation	Induction of labour (early), medicalise everyone, didn't agree with blanket policies, increased interventions,
	COVID fall-out	Couldn't do it again, burnout, good colleagues gone, overworked midwives

it impacted midwives. Two sub-themes were identified in this theme. These were '*Communication issues'* and '*Redeployment'*.

Sub-theme 1.1: communication issues

Amid the reorganization and transformation of maternity services that occurred during the initial wave of COVID-19, midwives described a '*chaotic*' (MW4) professional life. Daily, midwives experienced a working environment where corridors were blocked off and sections of wards were adapted to red or green zones to separate women who tested positive or were suspected positive/exposed to COVID-19 from women who were not. Frequently care pathways for women with or suspected COVID-19 changed, on the same day on some occasions. During these tumultuous and rapid changes, the communication between midwifery management, the COVID response team, and midwifery staff was described as suboptimal and *'poor'* (MW3). They reported that there was no focal point or one point of access to the most recent guidance, rather uncovering the information was generally by '*word of mouth'* (MW10) and this was regularly conflicting.

> *'I think the communication was really poor, it wasn't, like you didn't know… Because everyone was going by different policies'* (MW3)

Not only was this confusing for midwives but many midwives felt it was confusing for women accessing the services, especially when midwives themselves were uncertain about the information available. Having been off duty for some days, midwives described contacting colleagues the night before returning to work to gain updates on policy and guideline information and changes to this. WhatsApp groups tended to be their source of up-to-date information:

> *'If someone was on shift and then they'd be texting into the group, being like, the red zone's just been moved over to us'* (MW1)

Sub-theme 1.2: redeployment

Midwives were redeployed from community services to acute services, from antenatal and postnatal wards to the COVID assessment unit, and from green zones to red zones regularly. Many described a collegial approach to redeployment, recognising that some colleagues or their family members were considered to be immunosuppressed and thus more susceptible to the virus. Midwives worked overtime to cover staff shortages which were a frequent occurrence, mainly due to illness or being in close contact with a person who was COVID-19 positive. Some midwives described a heightened sense of professional responsibility in helping their colleagues to provide maternity care especially when staff shortages existed.

> *'I felt so guilty being at home and being well and not having COVID and knowing how short staffed the hospital was*' (MW4)

Contrastingly, for some midwives, redeployment was a source of fear and concern. For example, some midwives who were dual-qualified, that is registered as a midwife and as a nurse, described experiencing concern about being redeployed to the general hospitals. This concern appeared more pronounced for those who had intensive care nursing experience and was fuelled by media reports and rumour. Information from the media on COVID-19 was described by the midwives as constantly evolving, and many who rarely engaged in mainstream media described watching the news nightly to hear the numbers of positive cases and deaths nationally and internationally. The dramatically evolving and rapidly changing figures were a source of worry and fear for midwives, especially for midwives who had family overseas.

> '*I remember every day switching on the television and see how bad things were actually going at home'* (MW13)

Theme 2: feeling vulnerable

This theme illustrates the feelings of vulnerability, worry and fear

that many midwives experienced when working during COVID-19. Two sub-themes identified in this theme were *'Personal protective equipment'* and *'Fear of contaminating home'*

Sub-theme 2.1: personal protective equipment

The lack of access to personal protective equipment (PPE) at the beginning of the pandemic and the inconsistent advice on when to wear PPE and when not to wear PPE was described by many midwives as a source of constant worry and stress. Midwives described how they tried to '*mind the PPE'* (MW9), by conserving its use, where possible, which served only to heighten their sense of vulnerability. In this sense, in preserving PPE as well as reducing the risk of exposure or contamination, some midwives had to remain the entire day in one room or in a small localised clinical area. Rather than being able to leave the area for a break, food and drinks were brought to these midwives. These midwives described how food got cold, and they became dehydrated due to perspiring in the PPE during twelve-hour shifts.

> *'…like we weren't allowed to leave the room for hours sometimes… you know if you were in and out of the room then you were going to spread the virus more'* (MW6)

Feelings of isolation were also associated with this. Although for some, they described feeling safer wearing full PPE and not moving around the hospital. Midwives also revealed vulnerabilities in describing how they experienced concern about access to obstetricians when caring for COVID positive women. These midwives talked about how senior clinicians appeared hesitant to enter these isolation spaces to review women when midwives had concerns and requested a review. This presented a challenge for midwives' scope of practice, as under normal circumstances, women would be reviewed immediately when a midwife expressed concern.

> *'…really concerned about the woman's health, and I was like, I really need a doctor'* (MW1)

Sub-theme 2.2: fear of contaminating home

Many midwives used the language of worry, fear and stress in their narratives. Some described experiencing a constant state of worry: for the women they cared for, about their own exposure to COVID-19, about bringing COVID-19 home, and worry that loved ones would get sick.

> *'There was a fear element all the time'* (MW8)

Midwives described in detail the regimes they put in place to prevent bringing the virus home. Many showered before leaving work, although a lack of shower facilities onsite meant long queues. Midwives described how, on arriving home, they would remove their clothing at the door, put their clothes in the washing machine and immediately shower. They instructed family members to go outside or to another part of the house while this regime was undertaken. It was only after showering that they felt able to come into contact with, chat with, or hug their family members.

Theme 3: changing relationships

This theme reflects how some relationships with colleagues, with women, women's families, and the public changed because of COVID-19, and how this caused considerable upset for midwives. All 13 midwives who were interviewed spoke at length about the impact of the restrictions imposed on partners of women who were attending the maternity services. They described feeling a sense of sadness for women because they could not have their partner with them, in some cases, for ultrasound, for labour and birth and in the days immediately after birth. Having to communicate to partners that they were not allowed to attend the hospital was challenging.

> '*Being the person to say to the partners on the phone you are not coming in, I don't have your COVID status, you are not coming, that was horrendous'* (MW12)

Midwives felt empathy for women, especially for women who were undergoing an obstetric emergency and who had limited English and no support person. Midwives described trying to set up smartphones and tablets to record births for partners who were sitting in the car park as they were refused entry. Although the rationale for reducing the number of people in the room was to minimise the risk for everyone (women, babies, and healthcare professionals), many believed this blanket policy was wrong and had a lasting negative impact on them and the women they cared for.

> '*I do really feel bad, that, like, that's the best experience a woman has in her life. And because of COVID she's not able to share it with anyone'* (MW6)

For the most part frontline workers received positive commentary from the media during the pandemic. Some midwives talked about neighbours' kindness, for example, helping with childcare and cooking dinners, as a gesture of appreciation for being a frontline worker. However, the longer the maternity restrictions were sustained, and when they remained in place long after the introduction of the vaccination programme, midwives felt a change in how the maternity services were being portrayed in the media, including criticisms of the services and the ongoing visiting restrictions. Some midwives described feeling hurt when radio, television and online forums spoke in negative terms about the maternity services.

> *'And then there was a lot of negative publicity around the partners and that was the most hurtful thing'* (MW11)

In a heightened state of worry during pregnancy, midwives recounted how some women denied having symptoms of COVID-19 or being in close contact with a person who was COVID-19 positive at the triage desk when accessing the maternity hospital. Midwives recognised the worry and stress that women experienced during the pandemic, yet they also described an erosion of trust between the midwife and some women in their care.

> '*it was kind of disheartening because you spend your life looking after women. And doing your best for them, and that was what you were being given back, was people lying and putting you then at risk'* (MW2)

The collegial and '*everybody pulled together'* (MW9) atmosphere that was depicted by many midwives was contraindicated by some who felt that a small number of midwives took advantage of the situation. They expressed disbelief that some midwives could be out sick so frequently and genuinely be COVID-positive.

> '*certain members of staff were out 3 and 4 times, you know… and they were on full pay…so they took advantage of the situation, where others just keep going'* (MW5)

Contrastingly, some midwives in describing how they felt disconnected from friends and family who were not healthcare professionals as they were unable to relate to their experience of working on the frontline referred to an unintended consequence whereby relationships with professional midwifery colleagues were strengthened as a result. Although unable to take breaks together while at work, midwives experienced a strong sense of collegiality and being part of a team, within which firm long-term friendships were forged.

> *'yeah working together and getting through it together'* (MW5)

Theme 4: challenges to the philosophy of midwifery

This theme was identified from data that described the conflict midwives experienced in adhering to social distancing policies and new

care pathways and in relation to their philosophy of midwifery. Three sub-themes were identified in this theme. These were '*Balancing COVID-19 and quality care*', '*Medicalisation*' and '*COVID fall-out*'.

Sub-theme 4.1: balancing COVID-19 and quality care

Trying to complete ultrasounds and antenatal and postnatal assessments in less than fifteen minutes while trying to limit touching the woman was described as extremely challenging. Midwives constantly worried about missing something important. They spoke about the need to balance protecting themselves and the woman they care for while also trying to provide the '*best care we could*' (MW7). The change in many aspects of care from face-to-face interactions to telephone communication was described as a significant barrier to building trusting relationships. Intimate conversations about domestic violence, sexual abuse and mental health were hindered by the loss of eye contact and non-verbal communication.

> '*You need to have that rapport; you need to look at the woman. The woman needs to be able to trust you*' (MW2)

Even when midwives were face to face with women the use of PPE, face masks, goggles and hats left very little of the midwife for the women to see and connect with. Midwives felt strongly that videos, pictures and telephone calls could not replicate the individualised care that midwives strive to give. This was particularly evident in supporting women with breastfeeding, attempting to observe position and attachment on video calls, and assessing cracked nipples and engorged breasts was difficult and took extended periods of time. Midwives recounted telephone calls with distressed women with a crying baby in the background trying to verbally provide instruction on good positioning and attachment.

> '*It was very hard trying to assess how well they were doing or giving advice because visually you see so much without anything being said*' (MW9)

Providing reassurance on newborn wellbeing was also described as problematic; for example, having to request photos of newborns to assess for jaundice. Midwives found this deeply unsatisfactory and regularly expressed concern about their ability to provide evidence-based care to mothers and their babies. Midwives suspected that some women might be traumatised from their experience of maternity care during this time. Being told of fetal demise without their partner being present, experiencing labour and birth without the support of their partner, and the lack of postnatal midwifery support was considered contradictory to their core value of woman and family-centered care.

> '*she's going through this traumatic thing, she's experiencing a miscarriage and I look like something out of ET*' (MW4)

Sub-theme 4.2: medicalisation

Midwives described an increased medicalisation of birth during COVID-19. In the initial wave of COVID-19 and before the vaccination programme was introduced all women who were COVID-19 positive had their labour induced, for many at 37 or 38 weeks gestation. These women were cared for in isolation rooms with one midwife in full PPE. As a senior anaesthetist only could insert the epidural catheter in women who were COVID-positive, this resulted in distressed women with no birth partner waiting for pain relief. Midwives described feeling profound sorrow for these women and made efforts to provide as much emotional support as they could while tending to clinical needs.

> '*Everything [became] all medicalised, all induction of labour, all people treated as like infected people and not more as women given birth*' (MW13)

Sub-theme 4.3: COVID fall-out

Heightened workloads, staff shortages, burnout, exodus from the profession and an inability to go through the experience imposed by the pandemic again was something midwives spoke of. Midwives felt they had given everything they had both professionally and personally and would not have the reserves to work through a similar experience again. Initially, absences due to illness and being in close contact with a person who was COVID-positive resulted in reduced numbers of staff on duty. However, staffing issues persisted at the time of the interviews. Midwives in the study described how some midwives from overseas, for example, in the wake of the pandemic, decided to return to their home country, and how other midwives will now only engage in agency work where they have greater control over their working lives. It was the extended length of time of working under intense pressure that ultimately left midwives feeling '*burnout*' with many stating that working conditions were worse at the time of the interview than at the onset of the pandemic.

> '*But we're still doing that now 3 years later, it's even worse now than it was you know… we'd gone through 3 waves of the virus where restrictions were coming and going, coming and going. That is the toughest part*' (MW6)

A consequence of midwife burnout and a significant fallout from COVID-19 was midwives leaving the profession entirely. A common thread, however, amongst those who considered leaving midwifery, but had not left, was their love of midwifery.

> '*I did think of leaving a few times and I love my job. And I feel I contributed and I wanted to stay to contribute. But it's difficult*' (MW11)

Discussion

This study provides in-depth perspectives of the views and experiences of midwives working during the COVID-19 pandemic in the Republic of Ireland. While some positive experiences were identified, including increased collegiality and strengthened professional relationships with midwifery colleagues, overall, the findings highlight that providing midwifery care during COVID-19 was challenging and was interlaced with feelings of fear, stress, worry and burnout. The confusion, especially in the early days of the pandemic, sub-optimal communication, and rapidly changing care policies and guidance that midwives in this study experienced, is echoed in midwives' accounts across the globe. Fumagalli et al. (2023), for example, interviewing midwives from Northern Italy, reported how midwives in their study described having to deal with rapid and continuous change, including receiving information and instructions in the morning that by the afternoon were reversed or contradicted. Similarly, midwives in Australia recounted how they experienced rapidly evolving policy changes, often confusing, and which required midwives to adapt continuously to care provision daily or even hourly (Stulz et al., 2022). These rapid and confusing changes heightened stress, fear and anxiety for midwives, with many midwives finding themselves in situations where they were trying to balance providing quality care while also adhering to the latest COVID-19 care advice (Flaherty *et al.*, 2022). Working in an environment with rapidly changing policies could lead to care provision for women that was inconsistent and of a questionable evidence base. This summation is supported in women's accounts of care during COVID-19 across studies with many women reporting care that was unsettling, confusing, rushed and unsatisfactory (Ajayi *et al.*, 2021; Riley *et al.*, 2021; Sanders and Blaylock 2021; Lalor *et al.*, 2023) which consequently led women to experience increased stress, fear, anxiety and worry (Panda et al., 2021; Atmuri et al., 2022; Cooper and King 2021; Meaney et al., 2022; Mortazavi and Ghardashi 2021; Perez et al., 2021). The altered care processes, including moves to telehealth, shorter and less frequent appointments, and reduced partner or support person attendance further impacted midwifery care provision. In the current study, for example, midwives were challenged when trying to advise women about breastfeeding or caring for their babies in the absence of being able to see these women face-to-face. The need to use PPE, although acknowledged as a protective necessity, hindered midwives from

building a rapport with women and diminished, in their view, effective communication. In other studies midwives also reported challenges experienced by rapidly changing care environments; for example, although telehealth was viewed positively by some as a means of providing continuing care (Flaherty et al., 2022), many midwives viewed the lack of personal contact as having a negative impact on their capacity to provide optimal care, with one midwife describing it as a '*dehumanization of childbirth*' (González-Timoneda et al., 2021, p.4).

Inherently associated with these challenges, and with an increased medicalisation of childbirth, were challenges experienced by midwives in maintaining care that aligned with their philosophy of midwifery. Ismaila et al. (2021), in their grounded theory study involving 29 midwives from Ghana, described how midwives' strong affection for the midwifery profession helped them cope with some of the barriers imposed by COVID-19 and motivated them to '*keep going*' utilising strategies such as improvisation and maintaining support networks to help them cope and provide the best care that they could. Similarly, Shoorab et al. (2022) recount how midwives' commitment to and pride in their work provided them with hope amidst the chaos and related anxieties. Midwives in the current study struggled, however, in the face of COVID-19 challenges to remain committed, with many describing how they considered leaving the profession despite their love for the job.

Midwives across the globe, including midwives in the current study, experienced the effects of staff shortages as a direct or indirect result of COVID-19. These shortages, especially when sustained, had a detrimental effect of causing exhaustion and burnout in midwives, with midwives using phrases such as *'exhausted', 'broken'*, and *'unable to carry on'* to describe how they felt (Cordey et al., 2022). In a 'Work and Wellbeing Survey' of nurses and midwives in Ireland ($n = 2018$) which was carried out between January and March 2023 and published in May 2023, 73.8 % of participants reported that they had considered leaving their employment over the past month. Of these, 30 % indicated that this was largely due to workplace stress, and a further 24 % reported feeling exhausted. Alarmingly, however, 67.4 % reported always or very often feeling physically exhausted and 94 % reported that their work was negatively impacting their psychological health (Irish Nurses and Midwives Organisation, 2023). In a sub-study of a larger study exploring health and social care workers' quality of life and coping during the pandemic (McFadden et al., 2021), McGrory et al. (2022) report on data collected at three time-points from a total of 426 midwives: Phase 1 May to July 2020, Phase 2 November 2020 to February 2021 and Phase 3 May to July 2021. The findings revealed that stress reported by midwives became more pronounced across the phases, for a myriad of reasons, including staffing shortages, with some midwives describing increased stress because of continually having to cover extra shifts at short notice. Similar to the current study, midwives in McGrory et al. (2022) study also reported a perceived waning of public support between phases 1 and 3, mainly due to the ongoing restrictions on visiting, and this too had a diminishing effect on midwifery morale. The potential for midwives to exit the workforce because of the strain of working through the pandemic will have long-term consequences on services in Ireland and internationally. In an already stretched system, where the health and wellbeing of midwives, as well as the provision of quality care to women may already be undermined, it is paramount that the midwifery workforce are supported, emotionally and physically. Strategies must be embedded to help midwives recover from the strain and exhaustion of the pandemic.

Strengths and Limitations

This study adds to the global body of evidence on experiences of maternity care during COVID-19, specifically from the perspectives of midwives. The study findings will be useful for inclusion in future evidence synthesis on the topic of maternity care during COVID-19 or in updates of already published qualitative evidence syntheses (Flaherty et al. 2022; Dasgupta et al. 2024). The study was conducted rigorously, implementing activities to enhance credibility, dependability and confirmability, thus providing reassurance that the findings directly reflect midwives' personal views and experiences of maternity care during COVID-19. The voluntary participation of 13 midwives provides depth and richness to the data, with representation from midwives across grades, years of experience, and settings in the hospital. Limitations of our study are also acknowledged. These include a study population that lacked representation from the antenatal ward and outpatient clinic, although participants working on the COVID unit would have engaged with pregnant women and antenatal care. Furthermore, the study was undertaken in one maternity hospital in Ireland, which was urban-based, largely obstetric-led, and acts as a tertiary referral centre. As study context in qualitative inquiry plays a pivotal role and one which can affect the transferability of the study findings, it is useful to consider if the study had taken place in a regional or more rural-based maternity unit, the findings might be different. Acknowledging this, however, as many of our findings are reflected in international studies, the transferability of our findings beyond our study's specific context, with informative relevance globally, is assured.

Conclusion

The findings of our study, which resonate with those of other studies internationally, highlight the need to consider the impact of COVID-19 on midwives and maternity services now and in the future. The potential for probable post-traumatic stress disorder, as highlighted in the introduction section (Couper et al., 2022) and supported in the current study through midwives' narratives pertaining to fear, worry, vulnerability, exhaustion and stress, is alarming. As a priority, embedding strategies to support midwives regain and sustain psychological and physical well-being, is required. Examples of these could include resilience training, debriefing or mental health workshops for midwives, a re-examination of workforce planning, and adequate leave to rest and recuperate sufficiently between clinical shifts. Attending to these factors now, and getting them right, may engender midwives to remain in the profession and may aid in sustainable recruitment and retention of the midwifery workforce into the future. Ultimately, working through the COVID-19 pandemic has impacted midwives and is likely to continue to do so for some time. Having protective factors in place to support midwives is essential. Consideration of these factors for service-level crises that could emerge, potentially, in the future is also required.

Ethical approval

Ethical approval was granted by the Research Ethics Committee of the study site. Midwives voluntarily took part in the study and provided written consent indicating their willingness to participate prior to being interviewed.

CRediT authorship contribution statement

Paula Barry: Conceptualization, Data curation, Funding acquisition, Writing – original draft, Writing – review & editing. **Sunita Panda:** Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Deirdre O'Malley:** Conceptualization, Data curation, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Nora Vallejo:** Investigation, Methodology, Writing – original draft, Writing – review & editing. **Hazel Cazzini:** Data curation, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Valerie Smith:** Conceptualization, Investigation, Methodology, Project administration, Supervision, Validation, Writing – original draft, Writing – review & editing.

Declaration of competing interest

None to declare.

Acknowledgments

We would like to thank the Friends of the Coombe which provided funding to cover the cost of interview transcriptions. No other funding or funding source supported the study. We are grateful to the midwives who gave their time willingly to share their experiences for this study.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2025.104428.

References

Ajayi, K.V., Harvey, I.S., Panjwani, S., Uwak, I., Garney, W., Page, R.L., L, R., 2021. Narrative analysis of childbearing experiences during the COVID-19 pandemic. MCN Am. J. Maternal. Child Nurs. 46 (5), 284. https://doi.org/10.1097/NMC.0000000000000742.

Atmuri, K., Sarkar, M., Obudu, E., Kumar, A., 2022. Perspectives of pregnant women during the COVID-19 pandemic: a qualitative study. Women Birth 35 (3), 280–288. https://doi.org/10.1016/j.wombi.2021.03.008.

Bailey, E., Nightingale, S., 2020. Navigating maternity service redesign in a global pandemic: a report from the field. Midwifery 89 (102780). https://doi.org/10.1016/j.midw.2020.102780.

Braun, V., Clarke, V., 2021. Thematic Analysis: A Practical Guide. Sage, London.

Cooper, M., King, R., 2021. Women's Experiences of Maternity Care During the Height of the COVID-19 Pandemic in Australia. Australian College Midwives. www.midwives.org.au.

Cordey, S., Moncrieff, G., Cull, J., Sarian, A., the ASPIRE-COVID 19 Collaborative Group, 2022. There's only so much you can be pushed': magnification of the maternity staffing crisis by the 2020/21 COVID-19 pandemic. BJOG 129 (8), 1408–1409. https://doi.org/10.1111/1471-0528.17203.

Couper, K., Murrells, T., Sanders, J., Anderson, J.E., Blake, H., Kelly, D., et al., 2022. The impact of COVID-19 on the wellbeing of the UK nursing and midwifery workforce during the first pandemic wave: a longitudinal survey study. Int. J. Nurs. Stud. 127 (104155). https://doi.org/10.1016/j.ijnurstu.2021.104155.

Cronin, P., Coughlan, M., Smith, V., 2015. Understanding Nursing and Healthcare Research. Sage, London.

Dasgupta, T., Bousfield, E., Pathak, Y., Horgan, G., Peterson, L., Mistry, H.D., et al., 2024. Healthcare providers' experiences of maternity care service delivery during the COVID-19 pandemic in the United Kingdom: a follow-up systematic review and qualitative evidence synthesis. Front. Glob. Women. Health 5 (1470674), 1–12. https://doi.org/10.3389/fgwh.2024.1470674.

Fallon, V., Davies, S.M., Silverio, S.A., Jackson, L., De Pascalis, L., Harrold, J.A., 2021. Psychosocial experiences of postnatal women during the COVID-19 pandemic. A UK-wide study of prevalence rates and risk factors for clinically relevant depression and anxiety. J. Psych. Res. 136, 157–166. https://doi.org/10.1016/j.jpsychires.2021.01.048.

Flaherty, S.J., Delaney, H., Matvienko-Sikar, K., Smith, V., 2022. Maternity care during COVID-19: a qualitative evidence synthesis of women's and maternity care providers' views and experiences. BMC Pregn. Childb. 22 (438). https://doi.org/10.1186/s12884-022-04724-w.

Fumagalli, S., Borrelli, S., Ornaghi, S., Vergani, P., Nespoli, A., 2023. Midwives' experiences of providing maternity care to women and families during the COVID-19 pandemic in Northern Italy. Women Birth 36 (1), e57–e64. https://doi.org/10.1016/j.wombi.2022.04.011.

González-Timoneda, A., Hernández Hernández, V., Pardo Moya, S., Blazquez, R.A., 2021. Experiences and attitudes of midwives during the birth of a pregnant woman with COVID-19 infection: a qualitative study. Women Birth (3495), 465–472. https://doi.org/10.1016/j.wombi.2020.12.001.

Holloway, I., Wheeler, S., 1996. Qualitative Research For Nurses. Blackwell Science Ltd., Oxford.

Hunter, B., Renfrew, M.J., Downe, S., with the RCM Professors Advisory Group, 2020. Supporting the Wellbeing of Midwives in a pandemic. Guidance from the RCM. The Royal College of Midwives, UK.

Irish Nurses and Midwives Organisation, 2023. INMO Survey Reveals the Extent of Nurse and Midwife Burnout. Accessed on 03 July via. https://inmo.ie/Home/Index/217/14325.

Ismaila, Y., Bayes, S., Geraghty, S., 2021. Midwives' strategies for coping with barriers to providing quality maternal and neonatal care: a Glaserian grounded theory study. BMC Health Serv. Res. 21 (1), 1190. https://doi.org/10.1186/s12913-021-07049-0.

Kolié, D., Semaan, A., Day, L.T., Delvaux, T., Delamou, A., Benova, L., 2022. Maternal and newborn healthcare providers' work-related experiences during the COVID-19 pandemic, and their physical, psychological, and economic impacts: findings from a global online survey. PLOS Glob. Public Health 2 (8), e0000602. https://doi.org/10.1371/journal.pgph.0000602.

Lalor, J., Sheaf, G., Mulligan, A., Ohaja, M., Clive, A., Murphy-Tighe, S., et al., 2023. Parental experiences with changes in maternity care during the Covid-19 pandemic: a mixed-studies systematic review. Women Birth 36 (2), e203–e212. https://doi.org/10.1016/j.wombi.2022.08.004.

Lincoln, Y.S., Guba, E.G., 1985. Naturalistic Enquiry. SAGE Publications, Newbury Park, London.

McFadden, P., Gillen, P., Moriarty, J., Schroder, H., Mallett, J., Ravalier, J., et al., 2021. Health and Social Care Workers' Quality of Working Life and Coping while Working during the COVID-19 Pandemic: Findings from a UK Survey. Ulster University Ulster University, UK. Phase 3: 10th May 2021 - 5th July 2021.

McGrory, S., Neill, R.D., Gillen, P., McFadden, P., Manthorpe, J., Ravalier, J., Mallett, J., et al., 2022. Self-reported experiences of midwives working in the UK across three phases during COVID-19: a cross-sectional study. Int. J. Environ. Res. Public Health 19 (20), 13000. https://doi.org/10.3390/ijerph192013000.

Meaney, S., Leitao, S., Olander, E.K., Pope, J., Matvienko-Sikar, K., 2022. The impact of COVID-19 on pregnant women's experiences and perceptions of antenatal maternity care, social support, and stress-reduction strategies. Women Birth 35 (3), 307–316. https://doi.org/10.1016/j.wombi.2021.04.013.

Mortazavi, F., Ghardashi, F., 2021. The lived experiences of pregnant women during COVID-19 pandemic: a descriptive phenomenological study. BMC Pregn. Childb. 21 (193). https://doi.org/10.1186/s12884-021-03691-y.

O'Farrell, A., Chatzi, A.V., Doody, O., 2023. Midwives' experiences of utilising personal protective equipment during the COVID-19 pandemic: a qualitative descriptive study. Int. J. Infect. Control 19 (23085). https://doi.org/10.3396/ijic.v19.23085.

Panda, S., O'Malley, D., Barry, P., Vallejo, N., Smith, V., 2021. Women's views and experiences of maternity care during COVID-19 in Ireland: a qualitative descriptive study. Midwifery 103. https://doi.org/10.1016/j.midw.2021.103092.

Perez, A., Panagiotopoulou, E., Curtis, P., Robert, R., 2021. Barriers and facilitators to mood and confidence in pregnancy and early parenthood during COVID-19 in the UK: mixed-methods synthesis survey. BJ Psych. Open 7 (e107), 1–8. https://doi.org/10.1192/bjo.2021.925.

Power, A., Atkinson, S., Noonan, M., 2022. Stranger in a mask" midwives' experiences of providing perinatal bereavement care to parents during the COVID-19 pandemic in Ireland: a qualitative descriptive study. Midwifery 111 (103356). https://doi.org/10.1016/j.midw.2022.103356.

Riley, V., Ellis, N., Mackay, L., Taylor, J., 2021. The impact of COVID-19 restrictions on women's pregnancy and postpartum experience in England: a qualitative exploration. Midwifery 101 (103061). https://doi.org/10.1016/j.midw.2021.103061.

Sandelowski, M., 2000. Focus on research methods. Whatever happened to qualitative descriptive? Res. Nurs. Healthc. 23, 334–340. https://doi.org/10.1002/1098-240X(200008)23.

Sanders, J., Blaylock, R., 2021. Anxious and traumatised": users' experiences of maternity care in the UK during the COVID-19 pandemic. Midwifery 102 (103069). https://doi.org/10.1016/j.midw.2021.103069.

Shoorab, N.J., Mirzakhani, K., Aradmehr, M., Irani, M., 2022. Trying to control the situation: a theory of Iranian midwives' Experiences of the coping process with their professional roles following COVID-19. Iran J. Nurs. Midwif. Res. 27 (4), 294–300. https://doi.org/10.4103/ijnmr.ijnmr_245_21.

Smith, V., Panda, S., O'Malley, D., Vallejo, N., Barry, P., 2021. COVID-19 and clinical outcomes of pregnancy: a comparative study. Br. J. Midwif. 28 (11), 642–647. https://doi.org/10.12968/bjom.2021.29.11.642.

Stampini, V., Monzani, A., Caristia, S., Ferrante, G., Gerbino, M., DePedrini, A., et al., 2021. The perception of Italian pregnant women and new mothers about their psychological wellbeing, lifestyle, delivery and neonatal management experience during COVID-19 pandemic lockdown: a web-based survey. BMC Pregn. Childb. 21 (473). https://doi.org/10.1186/s12884-021-03904-4.

Streubert, H.J., Carpenter, D.R., 2011. Qualitative Research in nursing: Advancing the Humanistic Imperative, 5th Edn. Wolters Kluwer Health/Lippincott Williams and Wilkins, Philedelphia.

Stulz, V.M., Bradfield, B., Cummins, A., Catling, C., Sweet, L., McInnes, R., et al., 2022. Midwives providing woman-centred care during the COVID-19 pandemic in Australia: a national qualitative study. Women Birth 35 (5), 475–483. https://doi.org/10.1016/j.wombi.2021.10.006.

Tomfohr-Madsen, L.M., Racine, N., Giesbrecht, G.F., Lebel, C., Madigan, S., 2021. Depression and anxiety in pregnancy during COVID-19: a rapid review and meta-analysis. J. Psych. Res. 300 (113912). https://doi.org/10.1016/j.psychres.2021.113912.

Tong, A., Sainsbury, P., Craig, J., 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int. J. Qual. Health Care 19 (6), 349–357. https://doi.org/10.1093/intqhc/mzm042.

Wilson, A.N., Ravaldi, C., Scoullar, M.J.L., Vogel, J.P., Szabo, R.A., Fisher, J.R.W., Homer, C.S.E., 2021. Caring for the carers: ensuring the provision of quality maternity care during a global pandemic. Women Birth 34 (3), 206–209. https://doi.org/10.1016/j.wombi.2020.03.011.

Woody, C., Ferrari, A.J., Siskind, A.J., Whiteford, H., Harris, M.G., 2017. A systematic review and meta-regression of the prevalence and incidence of perinatal depression. J. Affect. Disord. 219, 86–92. https://doi.org/10.1016/j.jad.2017.05.003.

World Health Organisation, 2023. WHO Coronavirus (COVID-19) Dashboard. https://covid19.who.int/. Accessed 28 June 2023.