

*Midwifery in the Time of COVID-19, an Exploratory Study from the Perspective of
Community Midwives*

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Abstract

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Chair of the Supervisory Committee: Dr. Jodie Katon of the Department of Health
Services

Abstract

Significance The decision of where to give birth is an important decision an expectant person must make. Possibly driven by rising maternal mortality rates, an increasing minority of people in the United States are choosing to give birth at home or in a freestanding birth center^{12,3,4}. There is anecdotal evidence that interest in community birth further increased during the COVID-19 pandemic⁵ and that COVID-19 likely impacted community birth in other ways as well. **Purpose** The purpose of this study was to explore how community-based midwives in the greater Seattle area were affected by the COVID-19 pandemic to understand the needs, barriers, and successes of community midwifery during COVID-19. **Population** Study participants included 11 community midwives (N=8 licensed midwives, N=2 midwifery students, and N=1 certified nurse-midwife) from the greater Seattle area actively practicing in Washington State during the COVID-19 pandemic. **Methods** This was a qualitative study that used semi-structured interviews conducted online using the online platform Zoom video technology and were audio recorded (with participant consent) for accuracy. Interviews were transcribed verbatim from recordings. **Analysis** Transcripts were analyzed using deductive and inductive coding. Initial a priori codes were informed by an adapted version of the

Provider Burnout Model.⁶ The codebook started with a select few deductive codes created by the PI, while the majority of codes were added to the codebook inductively during the data collection period. Two coders independently coded one data transcript, using a tentative codebook. The codebook was revised and definitions were clarified through a consensus meeting. Following this, all 11 interviews were each coded by the two coders (the PI and a second qualitative researcher), and coding was revised to ensure substantial inter-coder reliability for each transcript. Codes were then clustered to identify themes. **Results** Primary themes included 1) practice changes related to COVID-19, 2) COVID-19 and increased demand for community midwifery, 3) COVID-19 and exacerbated disparities 4) relationships with hospitals and institutions and, 5) opportunities for the future of community midwifery. **Conclusion** This study provided rich insight into the experiences of community midwives providing care during the COVID-19 pandemic. Being forgotten in the state's COVID-19 response; lack of access to vaccines and personal protective equipment; unfavorable interactions with other providers; additional uncompensated labor; exacerbated racial disparities; and lack of diversity in the current community midwifery workforce created challenges during this time. Support from other community midwives and the Midwives Association of Washington State (MAWS) and telehealth options helped to ensure community midwives could continue to serve their patients. These experiences can provide insight for future emergency planning to better protect the community midwifery workforce or other birth workers.

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Introduction

In February of 2020, Washington State was the first US state to report a COVID-19 case and confirmed death.⁷ The COVID-19 pandemic affected and continues to affect many aspects of the daily life of individuals, including the way that many people experience major life events, such as pregnancy and birth, and how they access medical care. Concerns regarding risk of infection in hospitals and other health care facilities contributed to many people seeking pregnancy and birth care options elsewhere. With the number of individuals seeking community midwifery care increasing during COVID-19, questions arose regarding the impact of the COVID-19 pandemic on midwives providing care in a *community* setting (at home or in a birth center) in the greater Seattle area and how these changes be used to identify strategies to support community midwives going forward. Therefore, we sought to explore how community-based midwives in the greater Seattle area were affected by the COVID-19 pandemic to understand the needs, barriers, and successes of community midwifery during COVID-19.

Background and Significance

Community births (birth center and home births)

All expectant people must decide where they plan to give birth. The majority of birthing people in the United States give birth in a hospital setting; however, the number choosing to give birth outside a hospital has been growing, with home births in the US increasing by 77% from 2004–2017, and births occurring at a birth center more than doubling.¹ There are many reasons that an individual may choose to give birth at home

or in a freestanding (not connected to a hospital) birth center, including a desire to birth without medical intervention, the ability to give birth in a familiar place, religious or cultural concerns, lack of trust or satisfaction with hospital care, lack of transportation, or lower cost.⁴ Notably, out-of-hospital births are more common in the Pacific Northwest, and less common in the southeastern states such as Alabama, Louisiana, and Mississippi¹. Washington State currently has about 175 licensed midwives, often referred to as community midwives, who are regulated by the Midwifery Advisory Committee.⁸ The relatively high prevalence of out of hospital births and community midwives in the Pacific Northwest provides a unique opportunity to study this population. For the purposes of this study, freestanding birth center and home births will be referred to as community births.

The American College of Obstetrics and Gynecologists (ACOG) states "hospitals and accredited birth centers are the safest settings for birth, however, each woman has the right to make a medically informed decision about delivery,"⁹ and recommends that community providers have access to consultation with doctors or specialists in a collaborating hospital.⁹ These recommendations have traditionally failed to acknowledge the all too common issue of abuse during hospital births, including "lack of informed consent, misrepresentation of medical situations, and threats."¹⁰ One study describing the lived experiences of maternity care in diverse populations found that experiences of mistreatment in childbirth differed significantly by place of birth—5.1% of women who gave birth at home versus 28.1% of women who gave birth at the hospital.¹¹ This paper states that while mistreatment does not always occur during hospital births, "it is a systemic problem, enabled by a lack of accountability and a culture of impunity in the hospital hierarchy, where abuse and harassment come from the top-down, affecting hospital staff as well as patients."¹⁰ It is important to note that the ACOG recently released a statement titled, *Patient-Centered Care for Pregnant Patients During the*

COVID-19 Pandemic. In this statement, ACOG states, "patients who are questioning the settings in which to give birth should have access to the most accurate health information about safety and risk. Hospitals and birth centers that are both licensed and accredited remain safe places to give birth in the United States" adding

We are listening to the people we care for and share their concerns about the impact of this pandemic on their intended plans for labor and birth. We stand in solidarity with our patients and are committed to working tirelessly to deliver evidence-based, respectful, patient-centered care to ensure parents and their families are supported during this time of pandemic.¹²

Safety of community birth

Both in and out-of-hospital births come with an array of risks and benefits. Despite the United States' massive spending on health care, giving birth in the US is more likely to result in severe maternal morbidity or mortality than in any other high-income country¹³ and this risk is particularly pronounced for Black and Indigenous birthing people.¹⁴ While medical organizations such as American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) state that hospitals and accredited birth centers are the "safest places to give birth" and do not actively endorse home births, they do acknowledge individuals' rights to choose where to give birth and provide recommendations regarding what supports are needed and which patients are lower risk candidates for home birth.⁹ However, others such as the Washington State Healthcare Authority in their 2018 *Birth Centers* report to the legislature, claim that "outcomes for mother and baby are as good or better than delivering in a hospital setting for low-risk clients".¹⁵ Ultimately, the decision regarding where to give birth and what provider to choose *should* be up to the birthing person and their family.

Midwifery in WA state

Washington State currently recognizes two entry paths for professional midwives. The first path is for certified nurse-midwives (CNMs), who are trained in both nursing and midwifery and are certified through the American Midwifery Certification Board. CNMs in Washington state must be advanced registered nurse practitioners (ARNPs)¹⁶ and usually work in hospital settings. The other path for recognized midwives in WA state is licensed midwives (LMs),¹⁷ who are licensed under 18.50 RCW and must meet various requirements,¹⁸ including having certification as a professional midwife (CPM).^{19,20} Licensed midwives, who are often referred to as *community-based* midwives, provide care in community settings, such as homes or freestanding birth centers and are licensed to perform all procedures necessary during normal, low-risk pregnancy, birth, and postpartum periods.²¹ They are required to file a plan annually with the Department of Health for medical consultation, referral, and emergency transport.¹⁷ As of 2019, there were approximately 175 licensed midwives (LMs) in Washington State.²¹ Data from the Washington State Department of Health shows that in 2016²¹ there were 30,953 infants born in King County, and 2,753 of these were delivered by certified nurse-midwives, 666 delivered by licensed midwives, and 165 delivered by “other” midwives.²²

Washington State Health Care Authority (HCA) data show that licensed midwifery care for low-risk individuals results in lower cesarean birth rates and reduced costs when compared to hospital-based care of low-risk birthing people resulting in a cost savings of \$1.9 million every year for Washington State alone.²³ Licensed midwives are covered by all Washington State insurance plans, including Medicaid, as required by WA insurance regulations.^{24,25} As of 2018, there were 18 licensed birth centers in Washington State, all of which were eligible for Medicaid coverage.¹⁵ The Washington State Health Care Authority recognizes birth centers as a safe and cost-effective delivery site option and the importance of this option for Apple Health patients and continues to

support the provision of this service to improve the quality of care and to capture savings from improved birth outcomes.¹⁵

Racial disparities

In the United States Non-Hispanic Black women are *over three times more likely* to die of pregnancy and birth-related causes than their White counterparts,^{3,2} and Indigenous, American Indian, and Alaskan Native women are *twice* as likely than White women.²⁶

These racial disparities persist even when controlling for "protective" factors such as socioeconomic status and education.²⁷ Many community midwives are committed to the goal of reducing maternal mortality, stating that the midwifery model "emphasizes community-based care, close relationships between providers and patients, prenatal and postpartum wellness, and, avoiding unnecessary interventions that can spiral into dangerous complications".^{28,11}

Jennie Joseph, a midwife, leader on the *National Perinatal Task Force*, and an expert on racial perinatal disparities in the USA²⁹ states that this model of midwifery is key to buffering against the impact of racism on birth outcomes.²⁸ Transforming the perinatal workforce by increasing the number of community-based midwives, and adjusting mainstream medical systems to center community midwifery could be a critical step as in addressing racial disparities in maternal and neonatal outcomes as "community-informed models grounded in reproductive justice are better positioned to achieve and sustain equitable experiences and outcomes for patients, communities, and PRH systems given the high degree of authentic engagement, trust, collaboration, transparency, reciprocity, and accountability."³⁰

Racial mistreatment

Another reason that some, especially Black, Indigenous, and other People of Color (BIPOC) birthing people may choose an out of hospital birth is risk of mistreatment in the

hospital setting, especially race-based mistreatment, as rates of mistreatment for women of color are consistently higher even when examining interactions between race and other maternal characteristics.¹¹ Factors that lower one's risk of mistreatment during birth include having a vaginal birth, a community birth, a midwife, being White, multiparous, and older than 30 years.¹¹ Many out of hospital midwives consider themselves *community-based* and feel a strong connection to the communities that they serve³¹, and previous studies have found that "community-based midwives seemed to be less affected by organizational imperatives, and relationships with clients were of key significance."³²

Midwifery and equity

While expanding midwifery care is becoming more widely recognized as a potential part of the solution to reducing maternal mortality in the United States,³³ there are still inequities and a major lack of racial diversity that exists in this field. According to the 2019 data from the American Midwifery Certification Board (AMCB), the vast majority of AMCB certified CNMs/CMs identified as White (86.87%) and as non-Hispanic or Latino (90.22%), with midwives who identified as Black or African American as the next most common group but making up less than 7% of the workforce (6.31%).³⁴ These statistics do not mirror the population of birthing people in the United States. According to the 2018 Center for Disease Control Vital Statistics data, 14.5% of births in the US were identified as Black or African American, 23.4% of births as Hispanic, and 51.6% as White.³⁵

This lack of racial diversity in the workforce is a major issue especially because of the potential role that midwifery could play in mitigating the impact of systematic racism.³⁶ A systematic review from 2016 found that racism is "common in midwifery education, professional organizations, and clinical practices... and racism and

midwifery's lack of racial diversity act as a barrier to people of color completing midwifery education programs and fully participating in midwifery professional organizations."³⁷

The study concluded that both patients and midwives of color identified midwives of color as "uniquely positioned to provide high-quality care for communities of color."³⁷

This was also demonstrated in a literature review conducted by the US Department of Health and Human Services Health Resources and Services Administration (HRSA) which reported that "health professionals from underrepresented groups disproportionately care for underserved populations and that non-White patients tend to receive better interpersonal care in race concordant interactions."³⁸

Community midwifery has a long history in the United States, started by Black and Indigenous women, who were traditional midwives and/or sometimes known as "granny/grand" midwives³⁹ here in the US well before White women and men started becoming midwives and other birth workers.^{39,40} Before colonization, Indigenous people had already been practicing midwifery in the US, and enslaved people of African descent who were brought to the United States brought their sacred midwifery practices as well³⁹. Beginning in the early 1800s, many states created laws that prohibited "lay midwives,"⁴¹ and community midwives were systematically ousted as the White male physician replaced the role of the midwife, particularly among upper and middle-class White Americans.⁴¹ While the midwifery profession as a whole has a "long history of service to underserved populations, including communities of color,"⁴² most professional midwives today in the US are White.³⁴ Based on the HRSA³⁸ review, greater racial diversity in the health care workforce will improve access to care and the quality of patient-provider interactions for people of color and is an important intervention to reduce racial disparities in health.³⁸ This well-supported need for racial diversity in the context of direct-entry midwifery was explored further in the thesis of a Washington-based community midwife.⁴³

Note on language

It should be noted that while the language in this paper was careful and thoughtfully chosen, it may not be consistent at all times. When possible, inclusive terminology is used when describing a pregnant or expectant person, "birthing or pregnant person" and "chest or breastfeeding" when describing feeding a child human milk from a person's chest or breast⁴⁴. In some cases, less inclusive terms such as, "pregnant mother(s), moms, breastfeeding, etc.." are used in order to retain the original language from studies or literature cited. The PI would like to acknowledge that not all birthing people are women or mothers, and not all women are birthing people.⁴⁵ It is important that all birthing and parenting people have access to the pregnancy and childbirth care and support they need.

It is also important to explain what BIPOC (Black, Indigenous, Person of Color) is meant in the context of this paper. The *BIPOC Project* states that "the term BIPOC highlights the unique relationship to Whiteness that Indigenous and Black people have, which shapes the relationship to White supremacy for all people of color in the US". In this study, we acknowledge the unique racial disparities present in maternal mortality and morbidity are most severely affecting Black and Indigenous communities in the United States¹⁴. However, the author acknowledges that the term BIPOC can relate to and/or identify several other People of Color, who may not identify as Black, African American, or Indigenous. It is important to address the unique challenges, barriers, and inequities that all People of Color face in a system that is still fueled by White supremacy. The PI would also like to make a note about the choice to categorize race/ethnicity in the way chosen. The choice to combine individuals identifying as multiple racial identities was done solely to protect participant confidentiality, as the community which the sample drew from is relatively small.

The PI states her positionality and acknowledges her biases and her identity as a cis-gender, White woman. In addition, PI is a certified birth doula, who works in community (out-of-hospital) settings, as well as hospital settings. These disclaimers are provided in transparency as positionality should be taken into account throughout the entire study and findings.

Birth during the COVID-19 pandemic

Due to the rapid spread of COVID-19, hospitals and health care facilities worldwide adjusted and changed policies around visitors, outpatient protocol, elective care, and even perinatal care. These changes have affected the way that people are permitted to and choose to seek maternity care during this time.⁴⁶ Most health care facilities, including the University of Washington Medical Center, have updated their obstetric visitor policies during this time, in order to "protect the wellbeing of staff, patients, and visitors."⁴⁷ The University of Washington Medical Center restricted obstetric patients to only one support person during their visit, which meant that many birthing people had to choose between a partner, friend, family member, doula, or another support person when giving birth. Even more extreme, some hospitals have not allowed any support persons in the room with the birthing person.²⁷ This policy, among others, such as separating newborns from COVID-19 positive parents⁴⁸ and increasing elective inductions and cesarean births to reduce hospital census,²⁷ was intended to protect patients, visitors, and health care workers from the spread and burden of COVID-19.⁴⁷

However, in many cases, these policies did not solve the additional issues of providing staff with adequate personal protective equipment (PPE) and failed to address other concerns for staff and patient well-being.⁴⁹ It has been noted that a policy of limited or no support persons "unduly impacts marginalized communities and implicitly reinforces the "sacrificial" or expendable status of Black and Indigenous parents, who

have long borne the consequences of mistreatment and abandonment in their health care experiences."²⁷ These policies also came at a time when Black, Indigenous, and People of Color (BIPOC) communities are being disproportionately affected by the COVID-19 in terms of stigma, healthcare access, economic consequences, COVID-19 cases, hospitalizations, and deaths.⁵⁰

Telemedicine

To further reduce patient and provider exposure to COVID-19, other modes of care, such as virtual/telehealth or telemedicine, have expanded in most health care settings, including prenatal and postnatal care. Telehealth refers to any health care delivery enhanced by telecommunication and has increased in uptake during the COVID-19 pandemic.⁵¹ ACOG encourages practices and facilities that do not yet have the infrastructure to offer telehealth to begin strategizing how telehealth could be integrated into their services when appropriate.⁵² Transitioning to increased use of telehealth can be challenging for some practices and patients due to resource constraints and privacy concerns but can also alleviate barriers for some patients accessing care.

As the pandemic continues and looking beyond, investment in telehealth will likely depend on "developing models for how to finance the use of telemedicine in pregnancy, investments in broadband, research demonstrating improved maternal and infant outcomes, and willingness to reimburse providers for services provided to patients through a telemedicine platform."⁵³ Expanding telehealth services could hold great promise in improving access and maternal/infant health disparities; however, there are many challenges in implementing this service for some midwifery care.

Importance of Study

The COVID-19 pandemic has changed the way that providers care for their patients and has changed the models of care that midwives provide. The United Nations COVID-19 response *Stories from the Field* noted, "midwives, in particular, have had to rethink how they can support pregnant people in a time when, in some countries, they cannot even be in close physical proximity".⁵⁴

There have been COVID-19 response statements put forward by several Washington State midwifery groups, such as the Midwives Association of Washington States' WA State COVID-19 Midwifery Response Coalition, who collaborated with Public Health professionals to create the Crisis & Contingency Standards of Care: Community Midwifery Collective Policies, Procedures, & Protocol,⁵⁵ and the Midwives Association of Washington State's Interim Guidelines for Community-Based Midwives During the COVID-19 Pandemic.⁵⁵ This study will focus on community midwives, as this is an understudied population and one of particular importance in the context of COVID-19.

Research Question and Specific Aims

This study seeks to understand the impacts of the COVID-19 pandemic on community-based midwives in the greater Seattle area. Many of these midwives aim to provide equitable care to underserved populations in their communities. To best support their work, patients, and communities, these midwives have had to adjust their practices and models of care during the pandemic.

Purpose

The purpose of this study is to explore how community-based midwives in the greater Seattle area were affected by the COVID-19 pandemic to understand the needs, barriers, and successes of community midwifery during COVID-19. The research question is two-fold: what was the impact of the COVID-19 pandemic on community-based midwives in the

greater Seattle area and how can these experiences be used to identify strategies to support community midwifery going forward?

Specific aims:

1. Describe the experiences of community midwives providing care during COVID-19, including emotional labor, barriers to providing their usual level of care, and coping strategies employed to mitigate the pressures that came with providing care during a pandemic.
2. Identify practices and strategies put in place by community midwives during the pandemic that have the potential to improve models of care post-pandemic.

Methods

Model

This study was informed using the "Factors Affecting Clinician Wellbeing and Resilience Model" or, "provider burnout model"⁶ (Figure 2).

The provider burnout model can be "used by individuals and organizations to understand the causes and effects of burnout, identify strategies to prevent and treat burnout and promote well-being,

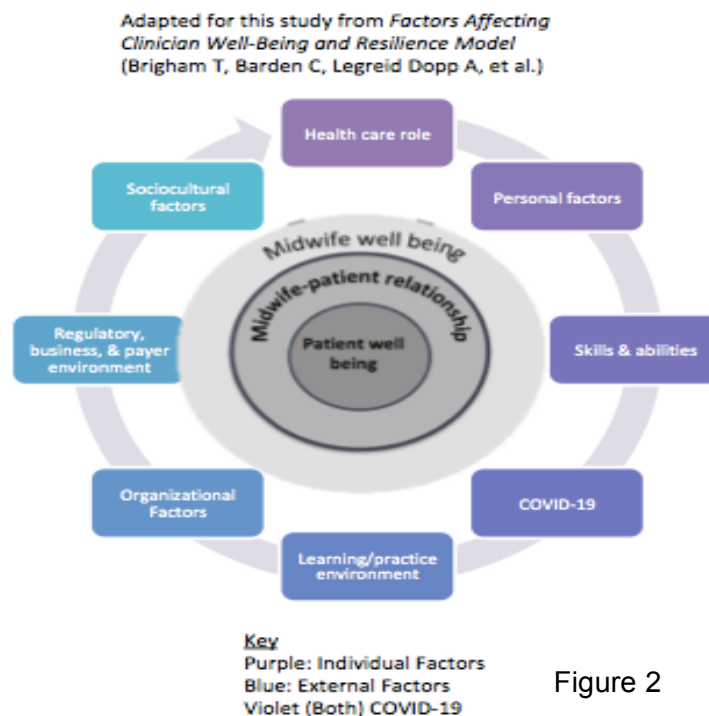


Figure 2

and improve health care delivery and patient outcomes"⁶; therefore, this model was used to inform the interview guide and the thematic analysis. This model was created by a working group at the National Academy of Medicine who took into account the "diversity of the health care team, types of practice setting, and career stage", and created a "model that is not used to measure or assess burnout, but rather reflect the factors affecting clinician well-being and resilience."⁶

Study design

This study was approved by the University of Washington Institutional review Board and utilized a phenomenological qualitative research design with one-on-one semi-structured interviews with community-based midwives. Due to the timely nature of this study and the relevance to the current COVID-19 situation, this study had the unique opportunity to interview participants while the world was still dealing with the immediate effects of the pandemic.

Study setting

This study took place in the greater Seattle area within Washington State. Interviews with midwives occurred securely over Zoom, a video conferencing platform, at the convenience of the participant.

Study participants

Interviews were conducted with 11 midwives in the Greater Seattle area. Inclusion criteria included: being a licensed midwife (LMs), student community midwife, and/or a certified nurse-midwife (CNM). Additionally, participants must currently work primarily in a community (out of hospital) setting, be at least 18 years of age, and have been/be practicing during the COVID-19 pandemic in the greater Seattle area (at some point since February 2020).

Recruitment strategy

Participants represented a heterogeneous sample of ethnicities and racial identities, as this is a major gap in the literature and the current makeup of the midwifery workforce in Washington. It was especially important to over-sample individuals who do not identify as White, particularly midwives who specifically serve under-represented populations.³⁷ Participants were recruited through purposive and convenience sampling. Midwives were contacted by the PI and invited to participate, and approved digital flyers were shared with several local midwifery groups in order to share information about the study. After participants' verbally or electronically consented to be interviewed, interviews were scheduled according to their availability. Participants provided verbal consent again before proceeding with the interview and again before audio recording.

Data Collection

Participant interviews took place between February and April 2021. The interview guide was developed, pretested, and all procedures were approved and deemed exempt by the University of Washington's Institutional Review Board before recruiting prospective study participants. Questions in the interview guide were developed to answer the specific research question. The interview guide was informed by the provider burnout model⁵⁶ and consisted of open-ended questions and probes, which allowed the interviewer to elicit rich data (appendix, interview guide). The PI conducted the interviews in a safe, supportive, and confidential manner. The interviews were audio-recorded, with participants' consent, and transcribed without identifiers, using transcription software Otter.ai. All participants were sent a \$25 gift card after completing the interview. The PI verified transcription accuracy and participant anonymity, removing any identifiers before sharing with the second coder.

Analysis

Coding

All 11 interviews, ranging from 22-63 minutes were individually coded. The coding strategy consisted of a combination of both inductive and deductive coding. A preliminary codebook was created deductively, while inductive coding was used in conjunction to allow for new codes to emerge. A combination of descriptive, sub-coding, and simultaneous coding methods was used. Two coders (PI and another qualitative researcher) independently coded one transcript and afterwards met to review the codes and revise the codebook and definitions. Following this, both coders independently coded all remaining 10 interviews, meeting after coding every 2nd interview, and coding was revised to reach consensus and ensure inter-coder reliability. An overall kappa score of 68 was calculated manually to ensure inter-coder reliability, with the most prevalent codes having higher individual agreement. Qualitative analysis software Dedoose was used, which was used to link data to codes and later used to calculate agreement.

Results

Characteristics of study sample

A total of N=11 participants agreed to participate in the study. 72% (N=8) were licensed midwives (LM), 18% (N=2) were student midwives working under LMs, and 9.09% (N=1) was a certified nurse-midwife (working in a community setting). 72% (N=8) identified as White, 18% (N=2) identified as two or more races, 9.09% (N=1) identified as Black, and 9.09% (N=1) identified as Asian. 90% (N=10) identified as women, and 9.09% (N=1) identified as non-binary.

Thematic analysis

The semi-structured interviews elicited rich data with five themes with 12 subthemes among the themes. The primary themes identified were: 1) COVID-19 practice changes 2) COVID-19 contributing to increased interest of community midwifery 3) exacerbated disparities 4) relationships with hospitals and institutions, and 5) desires for the future of community midwifery.

1.0 COVID-19 practice changes

Participants all mentioned COVID-19 playing an enormous part in the changes they have faced in their practices since February 2020 and explicitly described changes and accommodations they have had to or chosen to make. Three subthemes regarding use of personal protective equipment (PPE), telehealth, and changes around family/support people at appointments and births were found.

1.1 Personal protective equipment (PPE)

All participants confirmed that they incorporated extensive and consistent use of PPE in their practices. Many noted that the use of masks in particular, was a big change, describing them as *"totally a new thing and weird. But it's fine. It's worth doing"*. While some said they wouldn't mind wearing a mask while providing care "post-COVID", in order to reduce exposure to other illnesses, most expressed that they find that masks make communication difficult, especially people who provide care for people who are hard of hearing, and who have a history of abuse making it difficult to establish trust with patients.

I was never anti-mask, and I mean once we figured out that it actually really helped and that was fine I was happy to do it and I wanted my clients to do it for safety but you can definitely feel that it decreases the connection and therefore I think the trust and I think it increases people's likelihood to transfer, because they just don't know you as well, and they can't see you as well. And there's only so much you could communicate with your eyeballs. And it just feels like a barrier,

because it is like it feels like a physical barrier to people getting close and trusting.

Most participants felt that it was reasonable to not require the birthing person and sometimes even their partner to wear a mask during labor *"because they're both working so hard."* While many made this exception, they did ask that anyone else at the birth (except very small children) wear a mask.

1.2 Incorporating telehealth

Another common practice change participants described was the use of telehealth. Some saw telehealth as a great option to increase equity and reduce access barriers, as one participant said, *"I think all healthcare should now have telehealth as an option for patients because it clearly works and it just increases access and equity which is so important, obviously, in what's going on in our healthcare system right now".*

However, others noted that it could create access barriers and safety concerns for some patients.

At first we were doing more telehealth and we realized that that was problematic. And we scaled back on that and that was problematic on a number of levels, one is because of access. Most of our clients have lots of access to technology and Wi-Fi you know we're in a very privileged area for the most part, but not everyone. And not everyone has a quiet private space, and you know if there's any question of intimate partner violence like someone's, you know someone could be standing right there...

There were also concerns regarding the unintended consequences of fewer in person visits.

I actually have some concerns about decreasing visits in person, and how that might impact pregnancy outcomes. We can't measure bellies over zoom. We can't check blood pressure over zoom. And yes people can get a blood pressure How to do it at home but they're not as accurate. It also decreases that continuity of care that is really a part of the

midwives. Like that's our mission is to be there with people and journey with them through their pregnancy.

Overall, all participants used a hybrid model of care and made their telehealth decisions based on the safety and needs of the patient.

I do keep my office open for people who really want to come in. I have sort of a recommended like timeline of visits like which ones would be really easy to do as telehealth that don't require, necessarily, in person, follow up.

1.3 Birth and appointment support

Necessary changes and policies allowing support people and family to accompany patients to appointments and births were particularly fraught. Participants felt that banning support people and family altogether was an inequitable and unrealistic policy. For example, not all patients were able to get childcare during appointments, as one participant noted, *"for the clientele that I'm wanting to serve, it is not always possible to find childcare, talking with a single parent who doesn't have any other place to bring their kid."*

Most participants described this transition as being a huge change for them as providers as they were used to *"having visits with the partner and all the kids all people's children and their mom and their doula and whoever they wanted to bring to visit..."* Participants also noted that hospitals introducing strict limits on the number of support people allowed at births increased interest in their services as they could provide additional flexibility to have the kind of birth they [the patients] wanted. One participant quoted their patient, saying, *"I want to be at home with my mom and, you know, my dogs and, like I actually can ask for the things that I need"*.

While more flexible than hospitals, participants still described the necessity of implementing new policies around limiting number of support people at births, *"we used*

to not limit number of support people, and now we limit it to three support people in our birth center or at home, who are healthy and symptom free".

2.0 COVID-19 and increased interest in community midwifery care

Another major theme almost all participants discussed an increased interest or "a kind of a surge" in community midwifery services since COVID-19.

2.1 Differing motivations of patients

Motivations for seeking midwifery care at this time varied and participants were not sure if it was directly *caused* COVID-19 although they all speculated on how COVID-19 may have contributed. For example, participants perceived a need for care with a more "personal touch."

People are so isolated, they're really fatigued by, you know, a year plus of pandemic, and often don't have as much support, you know they're not able to be with their families and all of that.

Additionally, for some patients already interested in community midwifery COVID-19 catalyzed their motivation to seek out this type of care. Participants described how many seeking their services *"had always thought of, or always wanted a home birth... just never really had the motivation to like a real motivation to go and seek it."*

Many of these patients used COVID to "justify" pursuing community birth to their friends and family, or even, themselves.

Now they had a motivation to be able to tell other people like so many people don't do the birth that they want, because their mom thinks it's crazy, or because their bestie thinks that it's dangerous or whatever and now they have this thing where they could say, 'but COVID, I gotta stay out of the hospital for that!' but it's what they always wanted.

On the other hand, many participants felt that fear of COVID-19 or fear of the hospitals during the pandemic motivated many patients to pursue community midwifery care for the first time.

I think that that it was 100% fear based. And I don't think that they had inklings of home birth, I think that they had a sudden reactions to fear of getting COVID in a hospital and being in the hospital, and the restrictions.

Some participants mentioned that the individuals seeking care for fear-based reasons did not always understand community birth, and often ended up transferring back to hospital care.

Those people, actually, they didn't really proceed with care because I think there was a misunderstanding with some people thinking like, maybe I could still get an epidural or, or something like that.

Many participants expressed their concerns regarding patients who sought them out for fear based reasons alone and so took the time to really understand their motivations.

I ask them in some way, like what brought you to seeking an out of hospital birth? I have long conversations with people, if they give me fear based reasons, because I don't think that it's safe to make fear based reasons about things like this and so, and it's not necessarily trying to talk anybody into or out of anything.

2.2 Increase in uncompensated labor

The increase in interest and need to meet with potential patients led to additional uncompensated labor. This was on top of existing pre-COVID-19 expectations for a large amount of emotional labor that was uncompensated and perceived to be provided "out of the goodness of your heart", such as free consults, information, and/or tours prior to a client officially entering their care.

People were freaking out and we did definitely get a lot of calls from people who just needed to talk and ask questions, and midwifery is unique among medical professions in that, if you call a doctor's office and you're not a patient there you're not going to get to talk to a doctor, but if you call a birth center, you're probably going to get to talk to a midwife for free.

Some stated that this additional uncompensated labor was not sustainable, and they needed to start building boundaries around their time and services.

...And so I felt like, we're gonna have to put some limits on this because I'm spending hours on the phone with people. And we've always you know we give free consults we give free tours, we'll happily give people an hour if they're seriously considering coming into care because we want them to make an informed choice, but I can't be the therapist to strangers, even though I recognize that it's a super stressful time.

Demand for this additional labor was particularly challenging, as reimbursement rates for community midwives are already low. *"And yet, like none of the reimbursement matches that extra additional difficulty and the emotional toll. I don't think we'll really understand it for years, how hard, emotionally, this has been I think about it all the time, because I'm like this is a pretty big trauma on everybody, and we're gonna not really understand it for a really long time"*. Consistent with the model, this theme illustrates that both external and internal factors can lead to provider burnout.

3.0 Exacerbated disparities

While the majority of participants indicated that their patient populations were majority White they described an increase in interest from Black, Indigenous, and People of Color (BIPOC) patients, which was due to several factors, mostly around desiring culturally concordant care, and exacerbation of racial health disparities by COVID-19. Participants discussed actions they were taking to make community midwifery more accessible to all pregnant and birthing people.

I'm kind of talking about all those things you know we know like the data shows most people in Washington that seek midwifery care, you know, upper middle upper class White, hetero [sexual] people and I think that's sort of something that I think from what I understand, [our organization] is trying to address and kind of change but to make it more accessible.

All of the participants who identified as BIPOC (36%) expressed a deliberate interest in working specifically with BIPOC communities.

I'm pretty clear about who my target clientele is like of course I'm going to serve, you know, wealthy White educated folks if they come in and they feel like they're a good fit and they want my services but I am making it really clear that my passion is for serving the BIPOC and LGBTQ community.

This desire of BIPOC midwives to serve their own communities may have also been driven by disparities in perceptions of BIPOC midwives with one participant noting, *"being a BIPOC midwife I feel like I have to work harder to gain people's trust because they might not be used to having a BIPOC provider, even if they are BIPOC themselves."*

3.1 Race and equity

Participants were keenly aware of stark racial disparities in outcomes by pregnant birthing people as well as these related to COVID-19 and discussed concerns regarding the impact of this in the population they served.

I'm in constant conversation with our clients about what their feelings are about COVID, what their wishes are about health care that they receive in light of COVID, and this kind of loops back around to that most of the clients that we serve are folks that are disproportionately impacted by COVID.

This also deeply affected the participants themselves, as one said,

Given that COVID has impacted disproportionately people of color, you just see like the greater divide. And how hard it how much harder it is for Black midwives, you know.

This increase in disparities led to many community midwives to employ additional flexibility to address these effects in order to keep their patients who are facing additional barriers and risk factors safer.

I do almost exclusively home based care to keep folks from having to come in to a clinic space...I just wanted to help them to relieve one stress from they're already really hard

COVID days because a lot of them are having to manage online schooling with their kids or not being able to work because of COVID. And so, like some of our clients don't have enough money for gas anyway, so they couldn't reach it to a visit, if they wanted to.

Other strategies included providing care outdoors in order to keep the patients more comfortable.

We also got really creative when the weather is good. I am happy to meet people outside for their visits. So for example, there is one client who has a really large outward carport. So every other Tuesday, I go to her home and we sit for an hour, and we do visits outside and her carport rain or shine. Usually rain. So, I try to be creative that way too, for folks who need more in person time for whatever reason.

4.0 Relationships with hospital providers and institutions

Participants asserted while hospitals play a very important role in our healthcare system, they might not be the best place for everyone to give birth.

I think hospitals are wonderful places and serve really important purposes in our community. And are part of the reason that homebirth is safe. But there isn't, as you know, each provider doesn't have as much autonomy over a lot of the particulars, because it's a much more complex system.

The relationships that participants had with hospitals varied, and while participants acknowledged the important role of hospitals in the health care system, most described stigma, and misperceptions about community midwifery they faced both from the "mainstream" medical community and policy makers. These stigma and misperceptions had specific negative impacts during COVID-19.

4.1 Unsupportive during transfers

Most participants perceived that their transfer rate increased during this time. Many noted that this could be due to increase in risk factors such as chronic stress, "chronic stress, definitely increases transfer rates and complications" and things like high blood pressure. However, since many patients seeking their services were unfamiliar with

community birth they were not prepared for certain aspects of it such as lack of access to epidural and this likely also contributed to an increase in transfers to hospitals.

I think they all pretty much got to labor, but I do think we had a higher transfer rate in labor because those people weren't necessarily signing up for a pain medication free birth.

Unfortunately, these transfers were not always smooth, and participants did not always feel respected due to stigma and misperceptions about community midwives from hospital providers. When describing interactions with hospital providers during transfers, one participant said, *"There is nary a hospital transfer that I can speak to where we're not treated by some member of the staff, like dirt."* There were some very extreme examples of disrespectful transfer experiences, as one participant described,

I'll often start an IV before we go so that I can say "look, she's had 750 mLs already, right, like, we can like cut the show on the road as soon as you trace that baby for a bit. And, and at a couple of places. They tell me. "Oh that IV was placed in the field so we have to put our own in," so they'll take out this dripping patients IV, just as like a power play to put their own same IV in, because it was put in in the field and not by a medic, and I'm like, you've like just punctured a hole in this human's body, right, to make some political point about that you don't legitimize the work that we do.

However, several participants actually mentioned that several hospital providers have been their patients or sought out community birth for themselves, as one participant noted, *a lot of the people there [their transferring hospital] have chosen out of hospital births themselves so it's been received well, the transfers have been received well, okay, and other than transferring sucks to begin with.*

Regardless of how they were treated, COVID-19 regulations additional difficulties during transfers, such as community midwives not being able to stay in the hospital with their patients to provide essential support.

The nurse and the doctor and the registration people are all like bombarding this laboring person with questions. I like to be able to be that barrier but when they don't let you in, and you can't be that so that's not as good for them.

4.3 "Forgotten in the shuffle"

Many participants mentioned that misconceptions and under-valuing of community midwives could be a part of what led to being largely left out of the Washington States' COVID-19 response.

I do think that midwives and birth centers get forgotten in the shuffle around, around health care and essential health care so there's that... I'm not sure if we would have been included, if the state had been able to do that but I don't think the state was able to do that.

Most participants mentioned how this was a very difficult time for all health care providers and felt lucky to work in what was often perceived as a lower risk setting

Since we are a more low-risk site, having access to all of the stuff, though, incredibly helpful isn't as necessary as, say, a hospital or another clinic that's like urgent care, you know who's seeing potentially people who aren't wearing masks or may have been exposed to COVID.

However, others felt they were inherently at a higher risk due to the nature of their work, and that they were sacrificing their safety for that of their patients.

In a lot of ways, doing what I do felt like it was protecting the clients, but not as much us because we had a greater exposure than people did in the hospital as staff and longer term and poor access to PPE.

Being "lost in the shuffle" meant that nearly every participant reported difficulty-accessing things like personal protective equipment (PPE) to keep them and their patient's safe.

I was super irritated by this at the time and still a little bit because they were preventing us as smaller, outside of the system health care providers that don't have access to PPE,

from getting the order we had just placed when we couldn't get it anywhere else and that was beyond frustrating.

Even when they could get PPE and cleaning equipment, it wasn't the highest quality, as many participants mentioned.

We can't get high quality stuff you know we're pretty much stuck either ordering you know whatever is available online, or if we get to Costco when they have like the sanitizer wipes and can grab a pack of those, you know.

Participants also discussed the frustration in not being able to wear N95s at births due to lack of supply, and not being able to provide their patients with masks.

I think the problems that we faced at the beginning, in terms of like knowing that we probably should be wearing N95, but there's just no way to get them and wishing that we had enough surgical masks to just give them out to people who didn't have a mask.

The exception to this was participants who worked for non-profit organizations. Some of these participants felt that they "*did get a bunch of PPE from King County. We didn't take the one from MAWS because we had direct connection with King County.*" In addition to this, some providers took advantage of the small loans and grants offered through the state, which they used to purchase supplies or filtration devices, or offset general costs.

Being "*lost in the shuffle*" also led to limited vaccine access and information for community midwives. While many participants felt that they qualified for the vaccine early on, they had no way of accessing it, since most are small independent practitioners.

We had less access to PPE. So made sense that we would be on kind of the first tier [of the vaccine], but unfortunately, there was not really a way to access the vaccine. So most people who were in that first tier were getting it from their workplace.

4.4 Support from other midwives

Fortunately, most participants stated support from other community midwives, and the Midwives Association of Washington State (MAWS) helped to address some of these challenges. Additionally, participants described how their work as community midwives made them particularly well suited to address the challenges raised by COVID-19.

I think midwives are really good at adapting on the fly because it's what we do all the time. We work in a low resource setting and we're used to that. So we're really good at improvising and I think, because again, we are a smaller system of independent providers, we're, we're good at kind of mobilizing and sharing resources. That's not always the case in a bigger system.

Participants frequently relied on support from their community of other community midwives for help accessing things like PPE and vaccines.

Most of us who wanted to get the vaccine had to find our own sources, and there was a bunch of phone calls and networking that happened, and when somebody would find a source, if they were able to share it depending on whether or not the source allowed us to share it, there was a listserv going on in our Facebook group where we are as licensed midwives kind of have a space to talk about things like that.

In addition to word of mouth information, MAWS organized to get supplied to community midwives.

There was also a big push to get a bunch of cloth masks to midwives really fast and that was a grassroots like people were sewing them and driving around collecting them and shipping them out and like my friend said somebody showed up at her door with like a box of masks for her out of nowhere. So that was, I think, I think MAWS and a lot of really dedicated volunteers did everything possible to help.

Most participants felt that MAWS "... did its best, it's a small professional organization, they tried to hook us up with more PPE, but it was very limited." And some felt lucky that through MAWS they could be "connected and we could, you know, have enough people to figure it out". However, some were less than satisfied with MAWS efforts to get

vaccine information out. *"I think MAWS was a little late to the party on trying to get connected but it's been really, really challenging."*

5.0 Future of community midwifery

The next theme relates to the future of community midwifery. It was very clear that all of the participants felt passionate about this work as a calling rather than just a job.

Despite the dedication to this work, participants expressed that this has been a challenging season to provide care. Going forward, most participants had thoughts about how this will change the future of community midwifery in this area. While the overall model of midwifery care "won't change", several participants said, providing care during this time has revealed a lot, and most participants said that they see the demand for their services to continue to grow. The subthemes related to the future of community midwifery include the importance resilience, diversifying the field, and collaboration.

"I definitely see it growing, but it was already growing before COVID I think it's definitely made it more of something that is known for people that wouldn't have considered it before. And I also think it may have highlighted the fact that hospitals are not always safer, in a way that people understand more now than they did before. But I don't know that it's gonna change how like the midwifery model of care or what our goal is in terms of providing safe care for low risk people."

5.1 Resilience and acknowledgment

It was clear from the data that providing care during this time required an enormous amount of resilience. This is a key part of midwifery care, and is necessary to recognize moving forward, as all of the participants said they hoped "we" could learn from this experience.

"My hope for the future is that we learn from this. And that the, our governmental health agencies learn from this, and reach out to midwives to coordinate, because this probably will happen again in our lifetimes right, like another pandemic is likely and it would be"

really easy to just let this one go and not do the work to really incorporate midwives but if we could really be more incorporated and be included and that they learned a lot during this pandemic that will carry on into their future practice.

Most participants expressed a desire for their performance to be acknowledged, "we functioned so well during the pandemic". Participants felt that the pandemic highlighted the critical importance of community midwifery and the work that they do.

I really believe in individualized care and informed consent and informed decision-making, so that people are making their own choices, even if it was something that I wouldn't choose either as a midwife or as a person who has received midwifery care. I want people to be able to make their own decisions. I feel like that's something that only truly community birth can offer people."

However, participants noted the need for more support and recognition to continue to build the resilience required of community midwives and avoid burnout.

I think that one thing you know as midwives we are caregivers, and we're always looking for ways to make our patients lives easier, and to care for them better. But I don't think there is a lot of support around how the pandemic has affected midwives, themselves, whether it's gas for driving all the way around places, or the emotional toll that it takes on someone who has a vulnerable family member, but then still has to go out and see patients and take care of them, or chooses to do that because that is their service to the world. I think that was missing and that's missing everywhere.

Some participants did feel that they have recognition and support from the Department of Health in general (COVID aside), and that they are able to advocate for themselves as a profession.

I think first, like, we have had a lot of support through the pandemic, and we've had a lot of tools that we've drawn from and, and I feel like we've had enough information to make decisions. And that's been good. In terms of, like, COVID, aside, I think we have pretty good support from the Department of Health, which is your kind of oversees the

midwifery advisory committee and our license. And we, I think, are a small but mighty profession when it comes to like lobbying, and we have a lobbyist, and we do our best to, like, show up and advocate for ourselves, and also other kind of Allied legislation.

This resilience shown is key to supporting, validating, and growing community midwifery in the future.

5.2 Diversifying the community midwifery workforce

Another subtheme under the future of midwifery is the critical importance of diversifying the community midwifery workforce. This theme emerged through conversations around racism, equity, exacerbated disparities, and culturally concordant care. As mentioned previously,

When I think about what the community really needs, like we have a fair number of care providers like if you're just looking at a per capita rate, like, there's no shortage of providers, there's a shortage of providers that like speak languages come from congruent cultural backgrounds.

Many participants stated the importance of the community midwifery workforce representing the racial diversity of the population of the United States.

There's the question of like we need midwives to represent the racial diversity that we have in the States, and like, we just need that that's the biggest gap that we face right now in our maternal health care crisis. We don't have concordant care for most for a lot of folks.

This important notion came up in the conversations again and again.

Folks should have access to midwives, who share a history or share a common present with them, but then we have not yet built a system where that is sustainable, obtainable, and something that is, helps elevate people into the place where they want to be.

Another participant said that a more diverse workforce would open up the option of community midwifery care to more people.

Supporting and encouraging people from all backgrounds and ethnicities to become healthcare providers and I would say specifically midwives, will increase, you know, both people who enter midwifery care, because they will see representation, and they'll also be able to you know have culturally appropriate care. And as much as somebody from an outside culture can try and provide that there's just a depth of understanding that isn't there.

Many people mentioned the major barriers to pursuing community midwifery as a career. The primary barriers discussed were financial (costs of midwifery education and poor reimbursement) and lack of representation in preceptors. It is very expensive to become a licensed midwife or certified nurse midwife, and the options for community midwifery education are somewhat limited.

I think that if I'm honest, that the biggest obstacle for our profession is that we're not compensated very well for the care that we provide. And that has many different sorts of effects; it limits access to the profession for people who want to become a midwife. And a lot of different training programs are expensive or prohibitive in other ways, because they require people to go on call and not work. And then I don't think that we get compensated well enough for a lot of people to pay off their loans or to support their families, or to pay for childcare or whatever.

Nearly every participant shared the idea of cost and poor reimbursement as a barrier, especially for people lacking access to systematic and generational wealth. It is clear that this barrier needs to be addressed in order to diversify the community midwifery workforce.

The reimbursement needs to be better, because right now, people look at how much it costs for them to become a midwife. And then there's the personal cost, and there are many times with many of the Medicaid programs won't actually pay to take care of people because they don't reimburse even to meet basic fundamental visit costs. And so then you're asking folks with no generational wealth available to them, with limited abilities to

buy a home, because of systemic racism, and then we're expecting them to go into a job where they have to work, 80 hours a week to try to scrape by to get a little \$1300 check from Molina at the end of 11 months of care, right, we can't. And they have \$100,000 in student loan debt.

One idea that several participants shared is this concept of bringing back community training.

I think we really need to get back to communities teaching communities how to care for the community in the best way they can. Through evidence, you know, clear you know using evidence based practice in some kind of structure but I just think that having this really basic one size fits all kind of structure isn't going to work when it's like the way that it's written and the way that we're taught is like I have to almost translate that to work with my community.

Many participants felt that there are major structural issues from the medical community at large with how midwives are trained and reimbursed, leading to a lack of respect and compensation.

The medical community doesn't really respect for, at large, doesn't respect or honor the work that we do. And then we look at the system, the system doesn't do it because the only way the system really can express that is by giving us proper reimbursement, right, and doesn't do that either so it's an awful lot of heartwork for very little tangible outcome. And so we're asking these folks to do more heartwork in a system that really still just benefits White people. So how can we ask for that?

Historically, Black and Indigenous midwives have been caring for birthing people for long before certification or licensure began, and some participants discussed the need to incorporate lay or traditional midwifery education into the midwifery education and training system. Not all participants shared this sentiment.

For us in America it's like it's something that I mean we're on stolen land so that's kind of like the root of it all is like it's a stolen practice from the Indigenous people that were here

before us and the ones that were brought here. And then it's like we have to like go through all of these steps and do all of these things and pay all of this money to kind of get back knowledge that was taken for us to go back in the community and undo the damage that was done pretty much.

This idea was brought up as well as a way to mitigate the issue of a lack of representation in preceptors. One participant who identified as Black stated [about most preceptors in the area]

They're serving predominantly White populations so now I'm to this point where I'm like, who's gonna help me to serve my community...and so that has been something that has been very challenging to kind of like figure out who am I'm gonna learn from and now it's like, now I'm at the point I'm like okay like I have to figure out who's the safest White people to work with.

Student midwives must work under a licensed midwife before getting licensed themselves, and two participants in particular discussed how this could be prohibitive and how community training could improve this. *"I'm really wanting to support the community and being more open and receptive and skilled, and being able to help facilitate training for BIPOC midwifery students."*

5.3 The importance of and need for collaboration

Collaboration as one of the main desires and mediators to burnout was mentioned in every interview. Collaboration (between patients and community midwives) is extremely important in their practices, as most participants felt that they use a very collaborative model of care.

You're working together towards, you know, the best thing for them. And only they can decide what they believe is the best for them and what they want. And so, you know, recognizing that and finding different ways to support them in that.

Almost every participant frequently discussed the need for collaboration with other providers as well (both in hospital and community birth workers).

I love being able to collaborate, when it comes to I mean like more brains, the better. You know, like, we all have something different to bring to the table and so I think by making it a community kind of coalition kind of thing, versus just individual is very much, opening the door to the kind of care that we really need.

There were also several participants who felt that collaboration could be a mediator for the challenges related to the stigma and misperceptions that many community midwives felt from other medical providers and the state. Improved inter-professional collaboration could lead to less stigma and misperceptions and reduce burnout. Unfortunately, even pre-COVID-19 there was a noted lack of respect and collaboration from the mainstream medical establishment with one respondent stating:

There's a lot of providers who still don't know what midwives do, they don't know what our training is, you know, there's still some old school OBs out there that think we have like a bottle of whiskey and a towel and that's our, how we catch babies.

As a result almost every participant expressed their desire for other health professionals to learn more about community midwifery and community birth.

I think that the biggest thing, standard kind of health care professionals can do is, learn about midwifery, because so often, people, especially providers that have learned, like that have been educated in other states don't know anything about midwifery, or what midwifery is like here.

Participants noted that COVID-19 highlighted the dire need for inter-professional collaboration, but some felt that COVID put a strain on these inter-professional relationships even as they became more critically important.

I just kind of miss all the progress that we had made up until that point in working with each other and it feels like we have to all just like... take a breath and sit back down and reevaluate what this means, because some of the partnerships have been strengthened...like, some of the collaborations have been really strengthened through

COVID and you see where like, there's a, there could be some benefits of connecting these two systems. And I think that's worth paying attention to.

Participants felt that much of the professional stigma comes from the biases of the institutions that doctors are trained in.

People don't know what they don't know. So a lot of the time, people in the hospital based system because that's where you go when you're pregnant when you are in the US because that's the standard thing that you do, don't even, if someone's inquiring about a different type of style of care or planned place of birth, don't encourage them to research more because they think that what we do is dangerous or just not as something that is available and that can be, that could be easily changed by a little bit of research or, or thought about, are there other options. It would also be great if they would collaborate a little bit more, sometimes.

Although there were some indications that this might be changing.

I think there's a huge cultural shift that has to happen in in med school and OB GYN residency is to really foster more true inter-professional collaboration. ... So yeah, I think, just more integration of professions, and really getting to see what out of hospital, or community birth can look like in different settings so that we grow a new generation of OB providers who actually understand from experience, what care people are getting, I think that would make a huge difference, so that's like one level of systems change.

Additionally, participants described their desire for MAWS to collaborate more with other professional associations, *"I think it would be nice in the future, if maybe MAWS was more connected to other like the Washington Medical Association or other kind of health care providers for future like emergency planning".*

Notably, one participant expressed that they did not like the term "community midwife", as they felt it creates more separation.

I don't understand what this means community, community midwife, like it's so in opposition to what? And then we say hospital-based midwife and we're working so hard

to collaborate. And I feel like the more separations we make with our language, the harder it is to reach each other on the parts that we do you have in common.

Another level of mutually beneficial collaboration that many participants desired is at the State level.

I think there should be a Department of Health campaign about community midwifery and how safe it is and how important it was during the pandemic... how midwives, how capable and safe midwifery is for most people. And you know, we save the government money so they also have an incentive to want to do that.

Discussion

This study found several unique themes regarding community midwifery during the COVID-19 pandemic. These themes included COVID-19 practice changes (PPE, telehealth, and changes in family/support policies) and an increased demand for community midwifery. Other themes included the understanding of COVID's impact on exacerbating disparities, relationships with other medical providers and institutions, and important concepts for the future of community midwifery. While some of these changes were viewed positively, many created additional challenges for providing care for patients that also potentially could contribute to provider burnout.

Changes in practice regulations related to COVID-19, including PPE use, telehealth, and limiting the number of individuals permitted for appointment and birth support created challenges in creating and sustaining trusting relationships with clients. But, consistent with other studies, growth of telehealth may have also increased access in some areas.^{57,58} Additionally, the data found that the effect of COVID-19 exacerbated disparities on BIPOC pregnant people, which has been discussed in recent work.^{59,60} However, this study is the first to examine this disparity in the context of community midwifery in the greater Seattle area.

The increasing demand for community midwifery services in the context of a relatively small and unchanging workforce, particularly from those whose primary drive was fear of contracting COVID-19 in a hospital setting, meant community midwives spent significantly more time fielding questions and having consultations with new potential patients. Cumulatively, these changes resulted in an increase in uncompensated labor and, as one participant said, an expectation of *"doing things out of the goodness of your heart"*.

While relationships with other community midwives and professional organizations such as MAWS helped to address or mitigate some of these challenges, these changes incurred other barriers and stressors. Community midwives were largely left out of efforts to ensure PPE and vaccine access for health workers and frequently had to be creative to address these needs for the safety of themselves and their patients. Additionally, already tense relationships with mainstream medical institutions may have been further stressed by an increase in hospital transfers during this time.

Targets for growing and improving the sustainability of community midwifery and potentially reduce burnout were identified. This included the importance of diversifying the community midwifery workforce, as several BIPOC participants mentioned the additional barriers and challenges they have faced during this time. As in other studies barriers included financial barriers, and barriers to finding other BIPOC midwives for mentorship and preceptor opportunities³⁷⁴³. Additionally, many participants discussed the need to lean into and be celebrated for their ongoing resilience and creativity during this time. They saw this as an asset to community midwifery that would be beneficial for other providers to recognize. Finally, the desire for inter-professional collaboration as a potential strategy to mitigate burnout was noted. Currently studies on the importance of collaboration between different healthcare fields such as in-hospital and community providers in the context of birth are lacking.

While there are many studies that focus on midwives, most of the literature on midwifery focuses on CNMs and other midwives who provide in-hospital care. Although some studies have been conducted on community providers⁴³, the majority of this work has been done in populations outside of the US^{61,62}. There is an emerging amount of journalism literature on community midwifery in the US^{41,63,8,31}. This study was unique, and the first qualitative study on community midwives limited to the greater Seattle area during the COVID-19 pandemic, from the PI's understanding.

Implications of findings for public health practitioners or clinicians

There were many implications of findings that should be directly communicated and implemented by public health practitioners or clinicians, among other key informants. It was concluded that there is a need for diversifying the field of community midwifery, as well as specific recommendations for midwifery education programs to consider this in their structures. These recommendations included: improved financial assistance; improved reimbursement; better preceptor connections; and more emphasis on the roots and history of community midwifery in the United States. It was clear that these participants see their resilience as an asset to the medical field, and would like recognition of this going forward, partially through collaborative efforts.

This study provides relevant insight into midwives' desires for support, understanding, and collaboration from other healthcare professionals/clinicians, public health practitioners, organizations, and agencies. Other studies have shown inter-professional collaboration can lead to improved patient outcomes⁶⁴, as well as benefits to provider, such as improved job satisfaction and reducing extra work.⁶⁵ Additionally, improved collaboration with the Washington State Department of Health, as one participant mentioned, could be beneficial for all as "we save the state money". There is literature that supports this statement, including the WA Department of Health Sunrise

Review⁶⁶ and as the Washington State Healthcare Authority stated "community births result in decreased cesarean sections, decreased complications of birth, decreased neonatal intensive care unit costs, increased continuation of breastfeeding, decreased inductions of labor, decreased use of epidurals and pharmacologic pain management"- thus costing less.¹⁵ This theme specifically could be directly used in implementation recommendations for relevant key informants, such as the Washington State Department of Health, county specific health care authorities; hospital based providers, and other midwives and midwifery organizations. Specific recommendations included having hospital-based providers shadow community midwives at work and learn more about their training and what it is they actually do.

Implications for future research

The research on community midwifery is lacking but is currently an emerging research area as more evidence continues to show the importance and safety of community midwifery.⁶² With recent discussions on maternal health disparities, birth equity, and community midwifery happening across several disciplines, more attention will be drawn to this area of study. This research will provide helpful and relevant insight in this growing field, especially relating to themes of collaboration and resilience, which are much less discussed in existing literature on midwifery. In order to understand the complete and full effects of the COVID-19 pandemic on community midwifery, it is important to hear from pregnant and birthing people as well as other birth workers and providers, who provide care both in the hospital and in a community setting. It is also very important that more research be done hearing specifically from BIPOC midwives, birthing people, and other providers.

Study strengths and limitations

While this study has the potential to provide valuable insight and help inform future models and studies, it does have several limitations. This study focused on community-based midwives but was not able to seek input that is representative of all community-based midwives in the greater Seattle area, but rather a small sample (N=11). As this study was limited to the greater Seattle area, additional research should be conducted on a greater population level and in other contexts. However, it is expected that this research can provide insight into the practices of additional community midwives in this sample area. It is also important to note that the majority of midwives (CNMS and LMs) working in Washington State are non-Hispanic White, and this lack of diversity is a major gap in not only the data but in the workforce in general.

This study does have several important strengths. While the number of community midwives in Washington State is growing, it is currently a relatively small group in relation to the number of hospital-based midwives. This study managed to collect information from a sufficient number of midwives in order to represent the population to the best of the researchers' ability and managed to reach data saturation on many of the themes. In addition, as mentioned above there is a gap in the diversity of midwifery nationally, including Washington State, this study ended up recruiting a diverse sample of participants. The PI aimed to sample from a diverse group of providers in order to hear many perspectives. This study harbored rich qualitative data, reached thematic data saturation, had substantial inter-coder reliability, and resulted in strong themes, which can be used to inform future plans, studies, and practices.

Conclusion

This exploratory study provided rich insight into the phenomenon and experiences of community midwives providing care during the COVID-19 pandemic. The

results of this study may be used to provide insight and concrete examples of the factors that contribute to burnout that community midwives face in Washington State.

Additionally, these results could be used to implement changes and strategies for collaboration at a community and state level, which is not discussed in other research related to this specific population. These insights could also serve as helpful information to use for future emergency planning, such as in the case of another pandemic, a natural disaster, or other catastrophe, and could be used to better protect the community midwifery workforce, and other birth workers.

"My hope for the future is that we learn from this. And that the, our governmental health agencies learn from this, and reach out to midwives to coordinate, because this probably will happen again in our lifetimes right, like another pandemic is likely and it would be really easy to just let this one go and not do the work to really incorporate midwives but if we could really be more incorporated and be included and that they learned a lot during this pandemic that will carry on into their future practice." - Participant

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Appendices

Figure 3 code application cloud

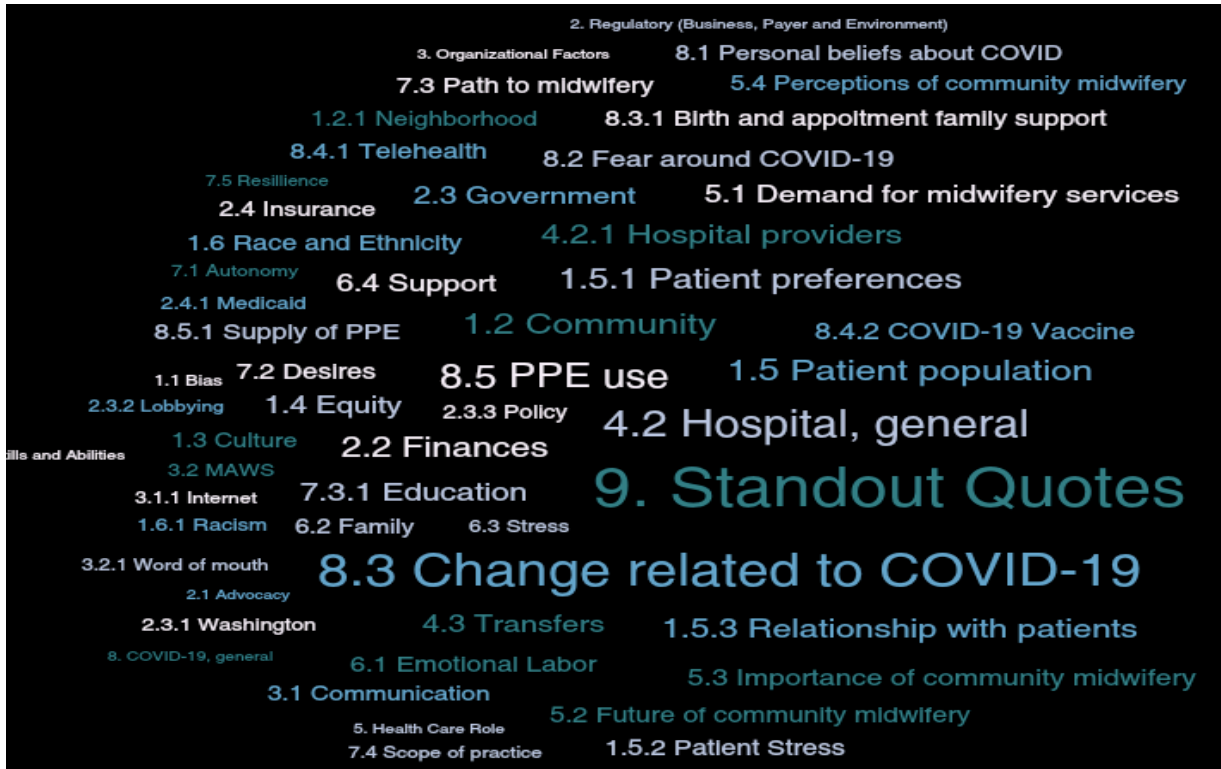
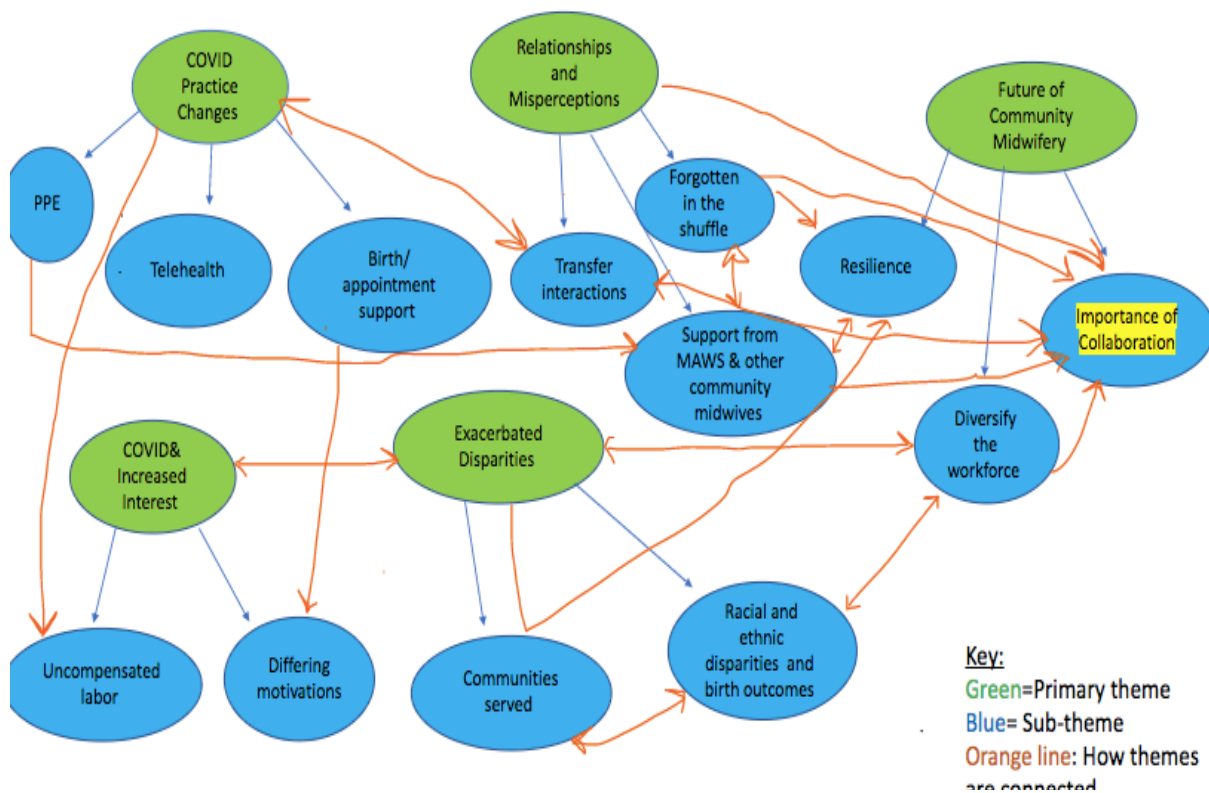


Figure 4 Thematic Map



Interview Guide

Semi-structured interview guide: *Midwifery in the Time of COVID-19, and Exploratory Study from the Perspective of Community Midwives*

Interviewer name: Kate Jacobsen
 Participant ID & title (CNM, LM, etc.):
 Date:
 Mode: Video call Phone call

Screening questions:

- *Are you at least 18 years of age?* Yes No
 - *What term/licensure best describes your midwifery practice? (Possible options: CNM, LM, student midwife)*
 - *Do you attend births occurring outside of the hospital?* Yes No
 - *Have you been actively practicing midwifery since March 2020 (during the ongoing COVID-19 pandemic)?* Yes No
 - *Do you practice in the greater Seattle area?* Yes No
- * If answered "no" to any of the following, "Thank you for your time. Unfortunately, you are not a good fit for this study. Have a great day". (Terminate interview)

If they are eligible to participate, proceed to verbal consent script [on separate document]

NOTE: Generic prompts: If responses are limited or require clarification, probes may be used to elicit more detailed responses. Probes should use words or phrases presented by the participant using one of the following *formats*:

1. *What do you mean by _____?*
2. *Can you tell me more about _____?*
3. *Can you give me an example of _____?*
4. *Can you tell me about a time when _____?*
5. **Going off of that.....**

Questions about your practice	<p><i>Tell me about your path to midwifery.</i></p> <ul style="list-style-type: none"> • <i>Are you affiliated with a specific midwifery group?</i> • <i>What locations/areas of WA do you practice in?</i>
	<p><i>Tell me about your current midwifery practice.</i></p> <ul style="list-style-type: none"> • <i>Where do most of the births you attend currently occur?</i> • <i>Where does most of your pre/post natal care occur?</i>
Community-based midwifery	<p><i>What does being a community-based midwife mean to you?</i></p> <ul style="list-style-type: none"> • <i>Can you describe the patient</i>

	<p><i>population you serve as a community-based midwife*?</i></p> <ul style="list-style-type: none"> <i>How do you incorporate an equity lens into your work? Can you give me an example?</i> <p><i>*(If clarification is needed) When I say "community-based", I mean births occurring outside of the hospital setting; with an emphasis on tailoring care to the specific communities you are serving.</i></p>
Changes in practice	<p><i>Tell me about what kinds of changes you had to make in your practice due to the implications of the COVID-19 pandemic.</i></p> <ul style="list-style-type: none"> <i>(Examples: change in visit schedule, reducing visitors accompanying patients, requiring masks, changes to lengths of visits, use of PPE by staff/yourself/patients)</i> <i>What kinds of resources or supports were needed in the operations of your care/organization to make these changes possible?</i> <i>What kind of support did you receive in order to enact these changes? (Technical help, government relief, financial, volunteers, donated PPE, other)</i> <i>If at all, how did your provision of care change?</i>
	<p><i>If you work for a specific organization, what kind of support was or was not offered to you by your workplace during this time?</i></p>
	<p><i>What kind of additional support could have been beneficial to you?</i></p> <ul style="list-style-type: none"> <i>[Financial, emotional, workforce, supplies, family/social]</i>
Changes and patients	<p><i>How, if at all, did your interaction with your patients change during the COVID-19 pandemic?</i></p> <ul style="list-style-type: none"> <i>What was the most challenging factor(s) of interacting with patients during COVID-19??</i> <i>How did the needs of patients' change during this time?</i>
	<p><i>If at all, how do you feel that need for your services changed during the COVID-19</i></p>

	<i>pandemic?</i>
Safety	<i>Tell me about your feeling of safety practicing during COVID-19?</i>
Vaccine	<ul style="list-style-type: none"> • <i>What are some things you could have done to be safer in your practice during COVID-19?</i> • <i>What has made it easier to take these precautions?</i> • <i>What has made it challenging?</i> • <i>How have you been given information regarding your eligibility to receive the COVID-19 vaccine?</i> • <i>What are your thoughts on receiving the vaccine when you are eligible?</i>
Transfers	<i>If applicable, please describe your experience with hospital transfers during COVID-19.</i>
	<i>Did the number of transfers you do change during this time? How so?</i>
	<i>In the event of a transfer, did you accompany your patient to the hospital? Tell me more about that experience.</i>
Future of care	<i>Will any of these changes be incorporated into your practice after COVID-19 restrictions have been lifted?</i> <ul style="list-style-type: none"> • <i>If so, which ones, and how?</i>
	<i>How do you see community midwifery changing in the long-term after the pandemic?</i>
	<i>How can other providers, researchers, and the state support community midwifery in Washington?</i>

0. Demographic and basic Information

Before we finish up, I'd like to ask you a few demographic questions if you are comfortable with that. Again, feel free to skip any questions you are not comfortable with.

- *Do you identify as are you Hispanic or Latinx?* Yes No
- *How would you describe your race?*
- *What is your current gender identity?*

- *What are your preferred pronouns?*

Those are all the questions I have for you today. Do you have anything else you'd like to add before we end today? Do you have any questions for me?

Thank you very much for your sharing your time and for your participation.