European Position Statement: Midwifery units and COVID-19

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Midwifery units (MUs) are maternity units led by midwives that offer safe care to healthy women with uncomplicated pregnancies. MUs can make a positive contribution when maternity services are stretched to the limit by the effects of COVID-19. The Midwifery Unit Network (MUNet) is committed to supporting managers and frontline staff by collaborating in the pursuit of constructive solutions to the current unprecedented challenges.

MUNet is concerned about the introduction of intrapartum practices which are not based on evidence and the risk of nosocomial acquisition of COVID-19 infection by concentrating all births in hospital obstetric units.
During the ongoing COVID-19 pandemic, health systems all over the world are stressed to their maximum capacity by increased workloads and lack of staff due to sickness. The population is advised *not* to attend a hospital setting unless strictly necessary, yet this advice seems to apply to all but healthy women during childbirth. Throughout this crisis, women will continue to be pregnant and give birth, deserving the same right to safe maternity services and compassionate care as they always have (1).

We join the World Health Organization (WHO) and International Confederation of Midwives (ICM) in reiterating women's right to high quality care before, during and after childbirth. All women, regardless of confirmed or suspected COVID-19 infection, have a right to a safe and positive birth (2). This includes being treated with respect and having a companion of choice with them during labour and birth. Furthermore, women, even those with confirmed or suspected COVID-19, should not be separated from their babies after birth, and skin-to-skin contact and breastfeeding should be supported.

We also call on health systems across Europe to strengthen their community-centred antenatal, intrapartum and postnatal care. Maternity services should support and/or implement as a matter of urgency alongside and freestanding MUs, in order to reduce stress on hospital obstetric units. This will contribute to keeping healthy women safe by attending them in separated settings/environments from those dedicated to attending COVID-19 patients.

From European countries highly affected by COVID-19, we are learning that hospitals might be the main infection carriers, as well as the importance of moving towards a community-centred approach to care (3). Hospital facilities are at high risk of being more contaminated with COVID-19 as a significant but unknown percentage of carriers are asymptomatic. Health care practitioners, who may have been exposed to the virus, might have limited access to diagnostic testing and PPE equipment. Skilled and dedicated healthcare staff are overworked, and units understaffed.

There is clear and well-documented evidence that for women with uncomplicated pregnancies, giving birth in a MU is safer due to lower rates of unnecessary intervention for the mother (4, 5). Birth in MUs is as safe for the babies of these women as birth in an obstetric unit (hospital delivery suite). Providing maternity care for women with uncomplicated pregnancies in MUs has been shown not only to reduce unnecessary interventions during childbirth (therefore providing safer care) but also to decrease costs to healthcare systems and improve women´s satisfaction with their birth experience (6-8).

During this unprecedented strain on acute hospital services, supporting the obstetric unit and other hospital services, including intensive care units and anaesthetic services, involves avoiding the admission into higher level care unless clinically necessary. This is why we are calling on health systems to strengthen their community-centred care and support MU services.

Maintaining, expanding or creating new MU services would benefit women, babies and services in two key ways:

a) Reduction in the number of unnecessary obstetric interventions, which put further strain on resources and staff, and of possible admissions to high dependency or intensive care units.
b) Reduction in the risk of infection from hospital settings for women, their babies, their birth supporters and midwives skilled in midwife-led birthing care in MU settings.

During the COVID-19 crisis it is important to:

1. **Keep what works and is evidence-based:** continuous support for women in labour is associated with shorter labour, lower rates of intrapartum analgesia, caesarean section or instrumental delivery and associated with better perinatal outcomes (9). Continuity of care midwifery models are associated with a 24% reduction in premature birth (10). Unnecessary interventions, such as routine induction of labour for 'post-dates', ARM, continuous CTG, vaginal exams, augmentation of labour, use of caesarean section, separation of mother and baby, and prohibition to breastfeed, should be avoided (11-12).
2. **Network and share knowledge:** this pandemic is teaching us that we are all interconnected. We must learn from other services and other countries, share knowledge to maximize the spread of solutions (3).
3. **Utilize and mobilize midwifery skills appropriately**: supporting a midwife-led, physiological birth outside of an obstetric setting is a skill with a defined philosophy (13). Home birth and caseload midwives have an abundance of skills which are well-placed in a MU setting. Independent Midwives (IM) may be able to support MUs if local health services take the necessary decisions that will facilitate IM collaboration. Similarly, midwives returning to practice to help overstretched maternity services can be deployed locally in MUs and to give additional support in primary care settings, as can midwifery students, doulas, experienced maternity support workers, and other volunteers.
4. **Make best use of resources and facilities available**: where MUs are not established yet, healthcare facilities which are currently not in use (e.g. empty wards or closed community centres) could be turned into MUs located in the hospital or freestanding in the community. In places where small maternity units were previously closed, these units could be re-opened and utilized as primary care centres for healthy women. This would reduce the burden from the secondary and more acute points of care, reduce the risk of contamination and allow to make the best use of resources and facilities.
5. **Create 'pop-up' midwifery units**: where healthcare facilities are not available, with collaborative interdisciplinary planning and support, 'pop-up' FMUs can be created effectively and quickly in separate buildings close to acute services, following the example of the Netherlands, which have developed MUs in hotels near or very close to hospitals (14).
6. **Establish COVID-19 operational procedures for transfer from freestanding MUs and home birth**: new emergency Standard Operating Procedures (SOP) can be established for supporting the safe transfer from freestanding MUs or homes to obstetric units. Firstly, the majority of non-emergency transfers can be facilitated by private transport or taxi. Secondly, in cases of emergency transfer, there should be an escalation procedure involving both public and private ambulance services, army, or other forms of medical transport. Services should be thinking seriously about those alternative solutions.

We understand the difficult situation and ethical considerations our maternity services face at this current time. Midwifery services need to be considered an essential service which should be maintained fully to avoid harm to maternal and child health in both the short and longer term. We need to join forces, strategically finding the best solutions for dealing with the current crisis. It is essential that throughout these difficult times we focus on our duty of care to women and their families. We need transformational midwifery leadership and lateral thinking.

Statement by Midwifery Unit Network Director team
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