Original Article

Psychological Well-Being and Coping Strategies of Midwives during the COVID-19 Pandemic in Indonesia: A Qualitative Study

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Abstract

Background: The COVID-19 pandemic has affected many individuals, including midwives. **Objectives:** This study aimed to explore the Indonesian midwives' psychological well-being and to investigate their coping strategies during the COVID-19 pandemic. **Methods:** This qualitative study investigated 10 midwives, from 9 provinces in Indonesia, who provided care during the COVID-19 pandemic. Semi-structured online interviews were conducted. Prior to the interviews, an online survey was distributed to identify potential participants. The interview data were analyzed using thematic analysis. **Results:** This study summarized the midwives' psychological distress and coping strategies during the COVID-19 pandemic, categorizing the information into four themes and fourteen subthemes: (a) "I am worried," (b) professional and personal responsibilities, (c) coping strategies, and (d) policy and expectations were the main themes emerged. **Conclusions:** Midwives experienced challenging situations that negatively affected their psychological state, due to the COVID-19 pandemic. The biopsychosocial and cultural contexts influenced the midwives' psychological well-being and coping strategies. Midwives should be empowered to prevent and manage their psychological distress, as well as their patients' concerns, during this unprecedented period.

Keywords: *Coping strategies, COVID-19, Midwives, Psychological distress*

Introduction

Nurses and midwives reported much higher levels of anxiety, sadness, and stress during the COVID-19 pandemic than other health-care professions.[1,2] During the COVID-19 pandemic, nurses also reported psychological tiredness, increased working hours, significant depersonalization, diminished personal achievement, and burnout.[3-5] Health-care professionals were also afraid of the consequences for themselves and their family members[6] of taking care of patients with COVID-19.

Due to the confinement policy during the COVID-19 pandemic, the Indonesian Women's Commission found that women had a greater workload than men.[7] Like other health-care professionals, midwives could face the risk of experiencing psychological distress during the COVID-19 pandemic. Their professional obligations might also be overshadowed by the risks of having multiple burdens in their family life.[8] The WHO revealed that 40% of midwives perceived that their working life had severely affected their personal life. Such a negative effect was intensified during the COVID-19 pandemic and in several cases led to burnout and moral distress.[9,10]

Several quantitative studies which examined Indonesian health-care professionals' and midwives' mental well-being reported the prevalence of psychological distress among the participants.[11-13] However, no study explored midwives' coping strategies during

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the COVID-19 pandemic. Qualitative methods can discover the underlying causes and situations around the phenomenon which cannot be generated by using a quantitative method.

Objectives

This study aimed to explore the state of Indonesian midwives' psychological well-being and to investigate their coping strategies during the initial COVID-19 pandemic.

Methods

This qualitative study was conducted by employing online interviews with midwives from various provinces in Indonesia. Data collection started 2 months after the peak of the first wave of COVID-19 in that country.

Data collection

The data were collected via phone calls. The researchers developed and shared a website, as well as published and shared a poster, presenting the details of the study in order to invite more potential participants through social media such as Whatsapp, Instagram, and Facebook, with the help of the Indonesian Midwives Association (IMA) in several branches and "Mother Hope Indonesia." Potential participants were selected using an online survey consisting of three sections. The first section aimed to identify the midwives' workplaces, education level, working experience, marital status, number of children, and COVID-19 history. The second section was the Depression, Anxiety, and Stress Scale-21 (DASS-21). The participants' responses were used to purposely select potential participants with a variety of characteristics and DASS-21 scores. Midwives with DASS-21 normal scores and those who had symptoms of mild, moderate, severe, and extremely severe of depression (≥5), anxiety (≥4), and stress (≥8) were selected as participants.

An open-ended interview guide was developed by the research team. The interviews were performed by both researchers (CSP and ERW) using a phone call, based on the preferences of all participants. The questions of the interviews focused on their initial responses. The participants were also asked about their perception on their own psychological well-being, as well as their coping strategies and any support they received. During their interview, the participants' responses to DASS-21 were also used to identify the psychological condition and symptoms of the participants. For instance, when a participant gave a score 3 on a statement on DASS-21: "*I found it difficult to relax,*" the researcher then asked: "*Could you please elaborate this statement*?," "*How often do you feel that way*?," "*What do you think cause that*?" or "*What can you do about it*?"

Ethical considerations

This study received ethical approval from the Research Ethics Committee of Universitas "Aisyiyah Yogyakarta number 1712/KEP-UNISA/X/2020 (October 6, 2020). All collected information, including data transcription related to participants' details and field notes, were anonymized, and saved temporarily in the researchers" personal password protected computer.

Data analysis

The data were analyzed manually by employing the thematic analysis model suggested by Braun and Clarke.[14] First, the interview transcripts were read and re-read by the researchers. Notes were added to the data to generate initial codes. These codes were then grouped, and initial themes were developed. The themes were then reviewed and "challenged" by the researchers, as were labels/titles. The interpretation of each theme then began and was developed. Table 1 presents an example of data analysis.

Trustworthiness

To maintain the transferability of the findings, this study selected potential participants by considering a wide range of demographic characteristics. The interviews were audio-recorded and transcribed verbatim, in order to enhance the credibility of the study. All research team members had a role as independent analytical coders for all data. The peer-review process was managed fortuitously because the study was conducted by two experts in qualitative research methodology. Both researchers have midwifery backgrounds and routinely held discussions during the data analysis stage. Dependability in this study was attained by recording labels and descriptions of the codes and through the process of theme development.

Results

This study conducted ten in-depth interviews with midwives from nine provinces in Indonesia. The researchers decided to stop data collecting after interviewing the 10th participant as data saturation had been achieved. Table 2 shows the participants' characteristics and their DASS-21 scores. Based on the data analysis, 452 primary codes, 14 subcategories, and four main themes were developed [Table 3].

Main theme 1: "I am worried"

During the early period of the initial COVID-19 pandemic, most participants were worried about, as well as afraid of, the virus. Their worry and anxiety over the virus were mainly caused by the risk of infecting their family members. These worries remained even 2 months after the peak of the first wave of COVID-19 outbreak,

Table 1: Example of data analysis

Subcategory	Primary code	Example of quotations
Negative emotion: Worried and afraid of infecting other family members	Worried and afraid of contracting the virus	"I am afraid if I get infected by the virus, my family and my children will get infected too, as I also have a four-year-old child"
	Fear of infecting their loved ones (higher score of DASS-21)	"I was really terrified and anxious my son had been admitted to NICU, had a ventilator on when he was a baby. And earlier during the pandemic, my mother-in-law, who is staying with us, got a stroke attack in march"
Overwhelmed with the additional professional and domestic roles during the COVID-19	Deal with domestic responsibilities	"My mother-in-law had a stroke and could not do anything. So, I had to take care of her, help her put on a diaper, clean her up, and feed her. At the same time, my baby had developmental issues"
	Multiple responsibilities at the same time	"I had difficulties in time management. I was working as a community midwife, and at the same time, i had to help my seven years old son study at home. Can you imagine when i was helping my child with his school stuff, a patient came?"

DASS: Depression, Anxiety, and Stress Scale

as seven out of the ten participants registered increased DASS-21 scores.

The following excerpts show the participants' negative emotions:

"*I am afraid if I get infected by the virus, my family and my children will get infected too*" (P8).

"*…I was really terrified and anxious…my son had been admitted to NICU, had a ventilator on when he was a baby. And earlier during the pandemic, my mother-in-law, who is staying with us, got a stroke attack in March"* (P2).

Another participant mentioned that media played essential roles in framing their perspective about COVID-19.

"*News daily reported the number of people getting infected by the virus and death totals, including the deaths of doctors and nurses. This information really made us worried and frightened."* (P1).

Some clients who did not believe in COVID-19 ignored or disobeyed health protocols while visiting the health-care centers; acts which negatively impacted the midwives' emotional well-being.

"…I am getting more stressed as society is becoming increasingly apathetic. They assume that Corona is just a common disease. They think that they still can arrange a public event and mass gathering, such as mass prayers, as long as they are wearing a mask and washing their hands" (P9).

"*When I am exhausted, sometimes I get angry spontaneously with patients and their family who do not obey the health protocol*s" (P6).

Meanwhile, the infected midwives, who isolated themselves, expressed their concerns for their children as follows:

"*I thought if I was hospitalized, who will take care of my children? I was very anxious about them*" (P3).

Participants experienced psychological distress symptoms, such as sleeping disorders and irritability. These symptoms were also experienced by the midwives who were never infected by the virus.

"*I had a sleeping disorder, always woke up at night and stayed up to 3 h, and got easily irritated. Thus, I got angry to my children easily.*" (P4).

One of the participants experienced discrimination and experienced negative stigma from her neighbors when they were COVID-19 positive.

"*Most of my neighbors still do not really know about COVID-19. I was discriminated against and received stigma as a healthcare professional… Even my family was worried about this matter"* (P7).

Theme 2: Professional and personal responsibilities

Despite the fear of contracting the virus, all participants acknowledged their risk of getting infected by COVID-19 because they were health-care professionals: "*I work at the hospital; to be honest, I am not prepared for this situation. But I could not avoid it as it is a part of my job and responsibility*" (P1). "*We must provide the best services for the sake of our patients.*" (P8).

Working as a community midwife who had to live nearby or at the clinic and provide health-care services to the community was challenging. Such midwives had to balance their work with their personal lives: "*Working as a community midwife in an urban area is highly unpredictable. We live in the clinic and patients can come at any time*" (P4).

Midwives who work at hospitals or primary health-care centers stated that they were also overwhelmed with the additional roles and tasks facing them during the COVID-19 pandemic. The other responsibilities included: providing screening test for patients at the clinic and in the community, home visiting, and wearing personal protection equipment (PPE).

Table 2: Characteristics of participants

Code	Age	Education level	Workplace	Work experience (years)	Marital status	Number of children	Age of toddlers (if any) (year old)	History of COVID-19	Depression score	Anxiety score	Stress score
P1	33	Bachelor	Public hospital	11	Married	2	3	Rapid test (nonreactive)	1	1	4
P2*	33	Bachelor	Public hospital	10	Married	1	2	–	6 (mild)	2	7
P3	39	Bachelor	Public hospital	16	Widow	3	4	PCR (positive)	0	2	3
P4*	31	Diploma	Community midwife	10	Married	2	2	PCR (negative)	7 (moderate)	9 (severe)	11 (moderate)
P5*	22	Diploma	Independent midwife practice	2	Single	-	-	PCR (negative)	2	6 (moderate)	10 (moderate)
P6	40	Diploma	PHC, independent midwife practice	10	Married	1	-	PCR (positive)	0	2	1
P7*	38	Diploma	Independent midwife practice	6	Married	2	2	PCR (positive)	3	1	9 (mild)
P8*	37	Diploma	Public hospital	13	Married	3	4	Never	8 (moderate)	8 (severe)	10 (moderate)
P9*	28	Bachelor	PHC	6	Single	-	-	No chance	12 (severe)	8 (severe)	11 (moderate)
P10*	33	Bachelor	PHC	10	Married	2	4	PCR (negative)	4	5 (mild)	6

*Participants with higher DASS-21 score. DASS-21 Scoring: Depression: Normal: 4, Mild: 5–6, Moderate, 7-10; Severe: 11-13, Extremely severe: ≥ 14, Anxiety: Normal: 0-3, Mild: 4-5, Moderate: 6-7, Severe: 8-9, Extremely severe: ≥ 10, Stress: Normal: 0-7, Mild: 8-9, Moderate: 10-12, Severe: 13-16, Extremely severe: ≥ 17. PHC: Primary health-care center, PCR: Polymerase chain reaction

Table 3: Psychological well-being and coping strategies of midwives during the COVID-19

Category	Subcategory
I am worried	Negative emotion: Worried and afraid of infecting other family members
	Media depiction about COVID-19
	Adherence to health protocol of lay persons
	Concerns for children of the infected midwives
	Experienced sleeping disorders and irritability
	Stigmatization
Professional and personal responsibilities	Altruism (acknowledged their risk of getting infected)
	Challenging life as community midwives
	Overwhelmed with the addition of professional and domestic roles during the COVID-19 pandemic
Coping strategies	Sources of support
	Forms and types of coping strategies
Policy and expectations	Workplaces applied policies on the prevention of the infection of COVID-19
	Unequal incentives and incomes reduced
	Limited psychological support from employers and professional organizations (IMA)

IMA: Indonesian Midwives Association

"*We must screen our patients who visit our clinic using a rapid test."* (P5).

"We still do home visits during the COVID-19 pandemic, even more frequently because pregnant women and mothers with babies and toddlers were afraid of visiting the primary healthcare center" (P10).

"*…I feel really tired because I must wear full PPE for a long time*" (P1).

While the midwives had additional tasks due to COVID-19 at their workplace, they still had to deal with domestic responsibilities, such as taking care of a sick person in the family and helping children study at home during the pandemic.

"*… I was really depressed. My mother-in-law had a stroke and could not do anything. So, I had to take care of her, help her put on a diaper, clean her up, and feed her. At the same time, my baby had developmental issues…"* (P2).

Theme 3: Coping strategies

After the participants had expressed their negative emotions and described the challenging situations at workplace or home, the respondents also stressed that family members, particularly husband and parents, were their most prominent supporters.

"*Because my husband is self-employed, he basically has a flexible time. Thus, he is in charge of taking care of my child"* (P6).

Some of the participants also received practical and emotional supports from neighbors and colleagues particularly when they got COVID-19.

"My *neighbors are really caring. When I was self-isolating, my neighbors really helped me take care of my children at home"* (P3).

"*When I self-isolated due to COVID-19, my colleagues and the director of the primary healthcare center called me frequently. To check my health progress*" (P7).

The midwives, particularly the infected ones, stated that religious practices, such as praying, zikr (the practice of remembering God in Islam), and reciting the Quran were also coping strategies.

"... during the confinement, the government arranged several programs, such as routine zikr, praying, and Quran recitation conducted at the isolation center" (P6).

Theme 4: Policy and expectation

The participants mentioned that most of their workplaces applied policies on the prevention of the infection of COVID-19. The policies included limiting visitors or patients, providing multivitamins, extra food, and PPE, and paying incentives to the midwives.

"...We are provided with sufficient PPE. We also received extra food, such as egg and milk at the beginning of the pandemic" (P10). *"The (hospital) management has limited the number of visitors. We are provided with a proper and healthy meal during our shift. Sometimes we got multivitamin too and had additional incentives as our workloads have increased."* (P5).

However, the incentives were not equally distributed to all the participants. Some of them reported that their income decreased because the number of visits was reduced.

"*As a provincial employee, I experienced a delay in salary payment. The medical service fee was also reduced because we had to limit patient visits in maternity wards"* (P6).

The midwives reported that they had not received any psychological support services from their workplace/employers. Moreover, they explained that support from their professional organization (IMA) was limited.

"*There is no such thing as psychological support for us"* (P10). "*I expected that the board of IMA in this province or branch would have given more attention. There have been several midwives who died due to COVID-19 in this province"* (P4).

Discussion

This study revealed that the midwives' psychological well-being was affected negatively during the COVID-19 pandemic. The affecting issues have been categorized into four main themes: I am worried, professional and personal responsibilities, coping strategies, and policy and expectation. Following the thematic analysis, our final synthesis shows that biopsychosocial contexts influenced the root problem and situation around midwives' psychological well-being. Midwives were physically at risk of getting the COVID-19 infection. If that event should occur, they had to self-isolate and separate from their family members. They expressed their fear, anxiety, and worry about the illness and its potential impact on their family members, which led to their increased levels of psychological distress. Meanwhile the "social domain" refers to: The midwives' personal and professional lives, which were shaken due to the COVID-19 pandemic and the roles of their families and colleagues in shaping the Indonesian midwives coping strategies.

Most of our participants experienced depression, anxiety, and stress symptoms at the time of data collection. Evidence from previous research in India and Italy has confirmed the high prevalence of depression and anxiety among health-care professionals during the COVID-19 pandemic.[15,16]

Negative emotions expressed by the midwives in this study might have been influenced by media news related to COVID-19. A study in China discovered a high frequency of mental health disorders, which was positively connected with frequent exposure to social media.[17] Another study also found that repeated exposure to community crises during the COVID-19 pandemic significantly increased the social media users' anxiety symptoms.[18] Recent research has also confirmed that midwives' worry and anxiety are also caused by the public's nonadherence to the mask-wearing requirement.[19]

Despite the midwives' negative emotions and their challenge in managing their work/life balance, they were aware of their professional responsibilities. Our midwives believed that they have crucial roles in saving the lives of their clients. Therefore, they must deal with challenging situations in both clinical settings and more domestic areas. In the clinical setting, this study has confirmed that several policies and practices have been implemented to optimize the health-care services, such as providing incentives for midwives during the COVID-19 pandemic. However, not all the midwives received the incentives. A study conducted in Nepal suggested that

government should strengthen its incentive program for health-care professionals in order to increase their work morale and, as a result, improve the psychological well-being of the health-care employees.[20]

This study revealed that the infected midwives worried about their children during the self-isolation period. Midwives' concerns regarding family members were similar to worries of nurses in an earlier study.[21] It has been shown that the epidemics can result in a huge number of negative emotions, such as fear, worry, and helplessness.[22,23] A midwife in this study also reported stigmatization from her neighbors when she contracted with the virus and was self-isolating at her home. A study from Iran also reported the stigmatization of nurses during the COVID-19 pandemic.[24] Such stigmatization may led the health-care professionals to seclude themselves from others.[25]

This study highlighted that social support from family members, colleagues, and neighbors played an important role in shaping the midwives' responses to stressors. Social support can also accelerate a person's recovery process following treatment of certain illnesses.[26] Social support can be provided by one or more family member, husband, peers, and community. A study in Spain also suggests that social supports can facilitate adaptive coping strategies.[27]

In the present study, the description of the influence coming from their religion was proposed by the midwives who performed some spiritual practices when self-isolating due to having contracted the COVID-19 infection. A study showed that religious coping was positively associated with adaptive coping strategies when dealing with stress.[28]

During the pandemic, midwives must adapt to new practices. This situation probably leads to psychological distress.[29] This situation can be exacerbated by the people's fear of infecting their family members. Meanwhile, studies have suggested that hospital management must give particular attention to health-care professionals, including midwives, and conduct prevention and intervention programs.[29,30]

This study has several limitations. First, given Indonesia's geographical location as the world's largest archipelagic country, with varied races and cultures, the results of this study may not apply to larger settings as only midwives from 9 provinces were interviewed. Second, even though this study employed DASS-21 to assess midwives' psychological distress, it did not perform a statistical analysis that could reveal more information, such as protective factors associated with psychological distress. The researchers' goal of "maximum variation" was partly achieved as there were no senior midwives with more than 25 years of work experience in this study. One reason for this omission could be that senior midwives rarely use social media and have difficulties in filling in the survey used in this research compared to the younger midwives. Nonetheless, the use of DASS-21 could provide more objective evidence and information on the type and level of distress that the midwives experienced.

Conclusions

This study explored the Indonesian midwives' strategies to deal with their psychological distress when they had to work professionally and perform domestic responsibilities during the COVID-19 pandemic. The findings of this study highlighted that biopsychosocial contexts exerted a strong influence which shaped the midwives' psychological well-being and coping strategies. There was evidence to suggest that such an influence could modify and weaken the negative outcomes of psychological distress during the COVID-19 pandemic, as experienced by the participating Indonesian midwives. Hence, it is necessary to inform policymakers about targeted programs to prevent and/or manage psychological distress experienced by health-care professionals, such as those featured in this research.

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Conflicts of interest

There are no conflicts of interest.

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