Title

A Pragmatic Approach to Pandemic Postnatal Care: Lessons Learned from a Qualitative Study of Women's Experiences of Giving Birth in Canada During the COVID-19 Pandemic

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ABSTRACT

Background: Postpartum mental health struggles have worsened during the COVID-19 pandemic**.** Health care providers lack information on how to support pregnant and postpartum patients at this time. This study draws on women's experiences of pregnancy and birth during the pandemic to consider how care providers can better support women who are negatively impacted by policies aimed at limiting social contact to reduce COVID-19 transmission, specifically those that limit the presence of support persons in hospital postpartum and during the early weeks at home with a newborn.
Methods: Qualitative interviews were collected from 60 women who gave birth during the pandemic and were analysed through thematic analysis.
Results: Postpartum mental health struggles and recovery from complicated births were complicated by policies which separate postpartum women from supports. Some women experienced pain and suffering in hospital without a support person. Most experienced poor postpartum mental health and needed emotional and logistical support at home. Some interviewees accepted outside support despite concerns about COVID-19 once their mental health had become precarious. Some abandoned breastfeeding due to lack of support.
Interpretation: Policies that restrict the presence of support persons in hospital and at home during the postpartum period are harmful. A pragmatic approach to postnatal care is needed, especially for patients with pre-existing mental health conditions and/or medically complicated births. This could entail 1) encouraging pregnant women to plan for additional postpartum support and coaching them on how to choose a suitable person 2) allowing a support person to remain with the postpartum woman for her entire hospital stay, especially in the case of medically complicated deliveries 3) offering additional breastfeeding support.

Introduction

Limiting close contact between individuals in both clinical and community settings is recognized as a crucial tool for curbing the transmission of COVID-19.[1,2] However, a growing body of evidence shows that policies and recommendations aimed at limiting contact, such as social distancing guidelines, are associated with increased feelings of stress, anxiety, and depression[3,4]. Furthermore, emergent research suggests that mental health challenges are particularly acute among people who have given birth during the pandemic,[5,6] exacerbating struggles that affect many postpartum women.[7,8] For example, a recent online survey of pregnant and postpartum women found that 15 percent of respondents showed signs of clinical depression prior to pandemic, and this increased to just over 40 percent once isolation measures were in place[6]. The same study found that 29 percent of respondents showed signs of moderate to high anxiety prior to the pandemic, increasing to 72 percent since the pandemic began.[6]

While this emergent research documents an increase in postpartum mental health problems during the pandemic, existing research on the impact of COVID-19 on postpartum wellbeing relies on surveys that aim to assess changes in mental health status. This documentation is crucial for understanding the scope of the problem, however the lived experiences that underlie pandemic postpartum mental health struggles remain unexplored. Accordingly, the kinds of

supports that pregnant and postpartum women need from policymakers and from their health care providers remains unknown. To address this lacuna, this paper draws on qualitative interviews from across Canada to examine how pregnant and newly postpartum people have been impacted by policies aimed at limiting social contact to reduce the possibility of COVID-19 transmission. Specifically, the focus here is on the impacts of policies that limit the presence of support persons in hospital postpartum, and of social distancing policies during the early weeks at home with a newborn. To my knowledge, this is the first study to draw on in-depth qualitative interviews to explore postpartum experience during the pandemic, and the first to connect postpartum experience during the pandemic with the work of health care providers.

Methods

Study Design

This article draws on in-depth semi-structured interviews that were collected as part of an ongoing study of experiences of pregnancy and birth in Canada during the pandemic. The study is guided by a qualitative descriptive methodology and takes a social constructivist standpoint.[7,8] As such, the forms of knowledge that inform and are generated through the study are socially produced and embedded in sociocultural context.

To facilitate interviews, a guide was developed through close consultation with literature on pregnancy, birth, mental health, and pandemics, and was pilot tested and subsequently refined. The insights gained from pilot testing encompassed participant perspectives and scholarly insights, as the pilot interviewee is an expert researcher in the areas of gender and health and was pregnant and located in Canada at the time of interview.

Sampling and Recruitment

Sampling methods were purposive, using a mix of convenience and snowball sampling.[9] A scripted recruitment email was approved by the McGill University Faculty of Medicine Institutional Review Board, and the author subsequently posted it on social media. The post was shared individually and via online "mom groups." Interested participants from across Canada contacted the author via email or Facebook Messenger. The response rate greatly exceeded expectations. Study participation was open to anyone located anywhere in Canada who was either pregnant or had given birth since the onset of the COVID-19 pandemic, provided they were over the age of majority and were cognitively capable of providing informed consent. Although the study and recruitment materials were deliberately inclusive of non-binary persons – that is, worded to explicitly recruit pregnant *people*/*those who had recently given birth* rather than pregnant *women/new mothers* – all respondents were women.

Data Collection and Participant Information

Sixty (60) interviews were collected between June 1st and November 10th of 2020. Interviews ranged between 25 and 75 minutes in length, were collected over-the-phone, were digitally recorded, were transcribed verbatim, and were anonymized at the point of transcription. Although repetition of key themes – a widely-held indicator of qualitative data saturation – was

apparent at approximately 30 interviews, an additional 30 interviews were collected both to ensure a broader representation in terms of geographical location, age, and ethnicity, and also to ensure that all interested respondent were included in the study. All interviews were collected by the author, who is a medical anthropologist with extensive experience in qualitative interviewing, an Assistant Professor of Family Medicine Research, and a mother.

Interviewees ranged between 22 and 43 years of age, with an average age of 34 years. Ontario was most represented province with participants recruited from numerous municipalities (22 participants, 11 municipalities), followed by Newfoundland and Labrador (13 participants, 5 municipalities), British Columbia (10 participants, 6 municipalities), the Northwest Territories (4 participants), Quebec and New Brunswick, (3 participants apiece), Nova Scotia and Manitoba (2 participants apiece), and Alberta (1 participant). Thirty-eight (38) participants live in communities defined as "large" according to Statscan[10] (population at or above 100,000), five (5) in "medium-sized" communities (population 30,000-99,999), 15 in "small" communities (population 1000-29,999), and one in a community categorized as "remote" (population under 1,000). The overrepresentation of interviewees located in Newfoundland and Labrador was unanticipated; the recruitment email was shared on a province-wide Facebook "mom group" that included many women who were unsatisfied with the care that they had received, and who viewed participation in the study as a means of making their concerns heard. The overrepresentation of the Northwest Territories reflects the desire of members of a "mom group" to ensure the inclusion of Northern communities. No participants were successfully recruited from Prince Edward Island, Saskatchewan, the Yukon, and Nunavut; recruitment in these regions is ongoing.

The pregnancy and birth that were the focus of the interview were the first viable pregnancy for 31 participants, the second for 20 participants, the third for 8 participants, and the fifth for one participant. Fifty-two (52) interviewees had already given birth at the time of interview, and 8 were interviewed while still pregnant. Thirty-eight (38) interviewees were followed by an obstetrician, ten by a family doctor, and 11 were in midwifery care. One participant did not know if her doctor was an obstetrician or a family physician.

Of the 52 participants who had given birth at the time of interview, 35 had given birth vaginally, seven via scheduled C-section, and ten via emergency C-section. Of those who had already given birth, twenty-one (21) had delivered at academic hospitals, and 22 at community hospitals. An additional six had delivered in hospital but did not know if the hospital was an academic or community hospital, and it was not possible to ascertain this from the interview. Finally, three interviewees had delivered at home; all three had made the switch to a planned home birth due to concerns about COVID-19 transmission in hospital, or because their local Birth Centre had closed.

Analysis

As with all approaches to qualitative analysis, the researcher was the analytic instrument, making informed judgements about the meaning of the data.[11] Data were analysed through thematic analysis,[11,12] a flexible, iterative approach that is especially suited to summarizing meaningful features of large qualitative data sets.[13] First, each transcript was read several times for the

purposes of data familiarization,[12] and informal notes were made about possible emergent patterns. Then, a hierarchal coding approach[12, 13,14] was employed that involved identifying and labeling sections of data firstly according to characteristics with high specificity ("initial codes," e.g. "no lactation support"), and then into broader, "higher order" codes (e.g., "poor aftercare"). Once ten transcripts had been coded in this way, a provisional coding template was developed that clearly specified the meaning of each code. The remainder of the data was then coded according to the template, with occasional modifications made to the template as new codes emerged. From there, it became possible to apply greater analytic judgement about the meaning of the data, allowing the identification of "themes" (e.g., "increased medicalization") by bringing together similar ideas and experiences from across the data set through the coding process, as codes with similar meaning were grouped together.[12] Although described in a stepwise manner for ease of explanation, developing codes and themes is an iterative process that entails constant back and forth between raw data and its interpretation as reflected in the codes and themes.

While subjective judgement is an inevitable feature of this analytic process, practices of reflexivity and member checking were employed to enhance rigour and trustworthiness of data.[15] This included regular informal debriefs of study data with expert peers, including clinician colleagues, and more formal dissemination of emergent findings through seminars and conferences. The coding framework was revisited and reworked in response to feedback gained through these exercises in dissemination and debrief.[12,16] At all stages memoing and journaling were carried out to create an audit trail of the decisions and reflexive exercises that shaped the analysis, and this was regularly revisited to confirm the cogency of analytic decisions.[17] NVivo 12 was used for data management.

Ethics

Ethical approval was obtained through McGill University, a process which entailed external peer-review of the research protocol.

Results

Theme 1: Negative Impacts of Policies Restricting the Presence of Support Persons in Hospital

A few participants felt that the pandemic had little impact on their hospital stay. These women were generally second or third-time mothers with no pre-existing mental health conditions, and whose pregnancies and births had been free of medical complications. While some were impacted by policies that required their birth partners to leave the hospital shortly after the birth, these women needed limited support in-hospital during the postpartum period and welcomed the opportunity for undisturbed rest with their newborns. This experience is exemplified by the quote in Text Box 1.

[insert box 1 about here]

However, for women whose deliveries entailed medical intervention, the lack of postpartum support in hospital resulted in suffering. For example, Text Box 2 provides the experience of a woman who was alone in hospital after her husband was required to leave shortly after she delivered via emergency caesarian (see also Table 1), and Text Box 3 conveys the experience of a woman who has longstanding clinically diagnosed struggles with anxiety and is hard of hearing. Her husband was required to vacate the hospital four hours after she gave birth to her second child by scheduled caesarian. Like many interviewees, she abandoned breastfeeding sooner than she might have otherwise, due to lack of support.

[insert Text Boxes 2 and 3 about here]

Finally, several interviewees had babies that required intensive care postpartum. For example, the woman whose words are captured in Text Box 4 was treated for septic shock following an emergency caesarian and was discharged the next day. Her baby was also treated for septic shock and was kept in intensive care for one week. Her narrative captures the challenges of trying to care for a baby and establish breastfeeding at a time when hospital policy prohibited more than one visitor.

[insert Text Box 4 about here]

[Insert Table 1 about here]

Theme 2: Poor Postpartum Wellbeing

Interviewees' narratives suggest that having a newborn at home during the pandemic was extremely challenging for most women (see Table 1), and these challenges were compounded by lack of support. This was amplified for those with pre-existing mental health conditions, and those who were recovering from difficult births. For example, Text Box 5 conveys the experience of new motherhood during the pandemic for some women with pre-existing mental health conditions. As exemplified by the second quote in Box 5, many interviewees eventually *did* allow support persons into the home to help them. However, this decision was accompanied by stress about the risks associated with close contact and was usually undertaken only when the mother had become desperate and unstable (see Table 1).

Discussion

This study shows that policies that restrict the presence of support persons both in hospital and at home during the postpartum period have negative consequences for women who are giving birth in Canada during the pandemic. While a minority of women cope well and value the opportunity for uninterrupted time with their newborns, for those with pre-existing mental health conditions and those whose deliveries entail medical complications, pandemic-related policies amplified their pre-existing struggles. There are several lessons to be learned from their experiences.

Firstly, this study shows that the challenges posed by of postpartum mental health struggles and recovery from complicated births are exacerbated by pandemic-related policies which separate

postpartum women from the supports that they need. This is concerning given mental health struggles are widespread in Canada, including among pregnant women,[18, 19] and many births entail complications.[20] Furthermore, despite feelings of stress and guilt, some postpartum women are, of necessity, letting people into their households to provide needed support. Yet most are doing so only when they have reached a point where they are no longer able to safely care for themselves and their babies. Not only is it dangerous to reach a state of mental breakdown and instability, it also means that the person who is invited into the home is someone who is immediately available – usually an older parent who is in a high-risk demographic with respect to COVID-19.

Accordingly, this study implies that health care providers, administrators, and policymakers should take a pragmatic approach to supporting pregnant people during the pandemic, especially for those patients with pre-existing mental health conditions and/or medically complicated births. Many postpartum women clearly need a support person in hospital, and many will open up their household for the sake of their mental health and wellbeing regardless of public health policies that discourage doing so. A pragmatic approach would entail: 1) encouraging pregnant women to plan for additional postpartum support, and coaching them on how to choose a suitable person (for instance, a sibling rather than an older parent) and plan ahead so that their support person has the opportunity to reduce their own social contacts prior to joining the postpartum woman's household. 2) allowing a support person to remain with the postpartum woman for her entire hospital stay.

Beyond pragmatism, the right to dignity, respect, and support in the early postpartum period is guaranteed in Canada.[21] This was denied to some participants in this study. Sitting in their own urine while in extreme pain, crying alone for hours, being yelled at while trying to care for a sick newborn just days after abdominal surgery; these are inhumane, and this study shows that these are outcomes of policies that limit the presence a support person during the postpartum period. While these are rarely the experiences of women with smooth vaginal deliveries, they are also the price that women who have had complicated births are being asked to pay for the sake of minimizing traffic into and out of hospitals during the pandemic.

Finally, interview data indicates that lack of support resulted in women deciding not to breastfeed. Given the benefits of breastfeeding as upheld by the Canadian Pediatrics Society,[22] additional breastfeeding supports should be provided to postpartum women within the constraints of the pandemic.

Limitations

As with all interview-based qualitative research, the results of this study are not necessarily generalizable. However, the clear emergence of common themes across 60 interviews from nine provinces and territories suggests that the experiences documented here are widespread in Canada.

Study recruitment via social media excludes potential participants with limited internet access. The overrepresentation of residents of Newfoundland and Labrador in the study sample may have skewed findings in the direction of postpartum care issues as manifest in that province.

However, identified themes that emerged in the interviews carried out with Newfoundlanders also emerged from interviews in other provinces, suggesting commonality of experience beyond the province of Newfoundland and Labrador.

Conclusion

Reducing close contact between individuals is necessary to prevent the spread of COVID-19. However, this study shows that policies aimed at limiting contact are misaligned with postpartum women's needs and have consequences that call these policies into question on both pragmatic and ethical grounds. Despite the increased risk of COVID-19 transmission, many postpartum women are "opening up" their households in order to access needed support. They do so, not out of selfishness, but rather to protect their precarious mental health. Good health care provision entails guiding them in how to do so as safely as possible. Furthermore, policies that prohibit the presence of support persons in hospital during the postpartum period cause unconscionable suffering for women who experience medical complications. These women must have access to a support person at all times. Finally lack of support resulted in some women abandoning breastfeeding earlier than they might have otherwise. Additional breastfeeding supports are needed, and efforts should be made to develop COVID-safe mechanisms for coaching postpartum women who want to breastfeed. In identifying areas where COVID-19-related policies are negatively impacting on postpartum women's health and wellbeing, this study offers evidence for how healthcare providers, administrators, and policymakers can provide care to pregnant and postpartum women that is pragmatic, ethical, and compassionate during the pandemic.

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Text box 1

Looking back, it was nice to not have any visitors and just be with the baby. I think that was something that a lot of people didn't really consider when they found out that they weren't allowed to have any visitors. I don't think people really realised the benefit of just having that alone time with the baby (Interview 20).

Text box 2

I had lost a significant amount of blood during my C-section. My hemoglobin dropped down to 74, and they usually give you a blood transfusion at 70. And I wasn't putting out enough urine so they kept the catheter in me, so when they took the catheter out, I couldn't pee. My bladder became incredibly distended and it was the worst pain I had ever felt in my entire life. They had one of those little hats on the toilet where they wanted to measure my urine output, and I just kept flooding it, and flooding it, and flooding it, and finally I was just sitting there in my own urine because I couldn't get up [because of] the pain from the C-section, the [hip] pain from [carrying the baby] ...I was just a total wreck sitting there (Interview 12).

Text Box 3

I didn't cope [with the lack of support person] very well. The second night was horrific. I cried pretty much the entire night. I was trying to breastfeed but it wasn't working, so after the second night I basically decided to formula feed him. And you can't even really see anyone's faces because they were all wearing masks. You didn't really know like who you were talking to. My problem was I couldn't hear what they were saying because I couldn't lip read (Interview 19).

Text Box 4

I was using a wheelchair to move around because the NICU is up several floors. We would try and sneak [my husband] in to just wheel me to the place, but then a nurse recognised us, and we got yelled at and he had to leave, and so I had to start walking to the NICU by myself. Again, this is days after the surgery, to go on these huge walks, up to the fourth floor…I was just breaking. Then I had to go sit in this crazy uncomfortable chair with the baby, and it was just really hard physically, by myself, to do all this stuff. At first the nurses were helping, and then the policy changed and they were no longer allowed to come near me. I'm like, "I need help, I need help with all of these wires, my baby is attached to 7,000 wires. I can barely move, the baby is nursing, my water is over there," and no one could help me. We were reprimanded. Instead of just being understanding we were being yelled at. We were like, "don't you understand?! I just had a surgery, and my baby is sick." ... I was pretty depressed. I would cry every day, I was so upset (Interview 25).

Text Box 5

I think I had a bit of postpartum depression. I do have some anxiety as well, like even before pregnancy. So, the first two or three weeks I felt like I was going crazy. I felt like I was going insane because I was so ill, I couldn't stay awake for long, I was really weak. My incision wasn't healing properly. At this time my boyfriend was trying to work from home and he wasn't sleeping and I wasn't sleeping. I couldn't reach out for help from my mom. She couldn't even come over to my house to help me out. So that was super hard for us. It was hard not being able to reach out and have the family there when you needed them the most (Interview 17).

I have depression and anxiety, for which I am on Prozac and I have a therapist. And thankfully, they are both fine and under control, but it was really, really difficult for the first few weeks being home and isolated and being afraid of catching COVID. And knowing that our baby doesn't have an immune system, we don't want to jeopardise his health or his life by letting people into our house, so we were in essentially full quarantine and that was really difficult for me. And I know that a lot of the hormonal swings are very normal but there wasn't that support for when you're crying and exhausted. My mom wasn't there to hand the baby over to, so that I could take a nap. After [my husband] went back to work it was very difficult, physically and emotionally. And I found that by week six I was crying a lot, the baby was crying, I was crying and exhausted and really feeling the guilt of feeling like I needed help and not wanting to risk our family. How much struggle to endure for their safety versus knowing that our mental health would be so much better if we let one of our parents into the house? And that wound up being the decision that we made with my therapist because it was the simple solution. I needed my mom (Interview 9).

Table 1

Negative Impacts of Policies Restricting the Presence of Support Persons in Hospital	My partner] had to leave four hours after [I delivered]. It was terrifying. I've never had a baby before, and I had the whole night and then the whole next day to take care of a newborn by myself after having a hard labour and delivery. I was there alone, I was on pain medication. It was not set up to help women at all. It was more helpful for the staff than it was for the parent. I felt, not by [my partner], but by our healthcare system during this time, I felt abandoned and forgotten about (Interview 7)	I was so sick, I needed help. I needed someone to walk me to the bathroom and I needed help getting out of bed. At the time your support person was only allowed to be with you for four hours after your child was born. So, I mean that was incredibly, incredibly hard being in the hospital by yourself especially not feeling well and with a new baby. I almost felt like I was in jail honestly, at times (Interview 27)	Directly after the birth when my husband had to leave the hospital and I had to stay in for a whole day and night without him that was probably one of the hardest days of my life. I felt really alone. I didn't know if I was going to get through it. And I had a second-degree tear and I was trying to breastfeed and all that, like just doing that alone was really traumatic to be honest. There was a couple of times where I just really felt like I was at my breaking point because my daughter was crying so much and I just didn't know what to do (Interview 34)
Poor Postpartum Wellbeing	I know a lot of women who gave birth around the same time as me, or during when the restrictions were at the heaviest, they suffered from postpartum depression. I know that I suffered big time from baby blues, and I thought for sure, I'm going to need to be medicated after this, 100%. When I got home, I think I cried for two weeks straight (Interview 7).	It was probably the most difficult thing I've ever done in my life. It was very tough. It was difficult. It felt extremely isolating. Nobody could come and help us. I didn't realize it was going to be that tough (Interview 17)	The isolation was really hard for me. When I look at what has happened in the last six months, I had a baby, I was locked in my house, I couldn't see my mom, I couldn't see my grandmother who's dying. And here I was trying to just pretend that everything was normal for a five-year-old so that he's not scared. Yes, it was a hard few months, thinking about it all like that (Interview 33)

Seeking Support	The isolation and not being able to have any help from your family or friends, I think that was the toughest part. You kind of get squirrelly and start losing your mind a little. So, at seven weeks we just pulled the plug. I was video-chatting with my sister and she was just like, "you know, there's a balance between what's going on and mental health too. Maybe we need to start having these conversations." But my mom lives with her parents who are in their 90s and my sister's husband has compromised immune system, so there was a lot of, "what do we do?" (Interview 13).	At some point, you have to look at what's more important, your mental health or a risk which [in our community] was so low. Absolutely, are you sacrificing your mental health which is, in my mind, just as serious as COVID? That's how we started to feel toward the end (…) The mental health thing was a big factor [in our decision to open up], for sure (Interview 33).	I hemmed and hawed and was very stressed over [letting my dad in to help], because I knew it was opening up to a whole other household. My dad was even popping in and out of work then still, so I did know it was a bigger bubble than what we were allowed. But, I also knew that I didn't really have a choice. I just did what worked for my family and me at the time (Interview 43)