Isolation, Fear, and Anger: The Impact of the COVID-19 Pandemic on Pregnancy and Childbirth

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Abstract

This study examines the effect of COVID-19 protocols on women who gave birth during the pandemic. We examine the perinatal experiences of a small sample of mothers and contrast the medical model of perinatal care that focuses on the body-at-risk with the midwifery model that focuses on holistic care. Findings from this study show that both models adapted a more medicalized version of perinatal care during the pandemic that limited women's voice in the process of prenatal, childbirth, and postnatal care. The effect on our respondents resulted in feelings of anger, isolation, fear, and overwhelming sadness. The study highlights the social nature of pregnancy and childbirth and the importance of social support during the transition to motherhood.

Keywords: Pregnancy, Pandemic, COVID-19, Disability, Midwifery

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Introduction

In December 2019, the first coronavirus disease 2019 (COVID-19) case was reported in China. By March 2020, the World Health Organization (WHO) officially declared COVID-19 a pandemic (Cucinotta and Vanelli 2020), and widespread cases in the United States led to a significant public health response, including shutdowns, mask mandates, the shuttering of many schools, and restrictions on most public spaces. In addition, nearly every industry rapidly pivoted to providing services in new ways, including hybrid school instruction, telehealth medical appointments, online grocery shopping, and virtual participation in many aspects of social life. As cases in the United States rose and states tried to control the outbreak, governments and medical facilities issued quickly changing protocols for medical treatment, as hospitals strained under the weight of treating escalating cases, hospitalizations and deaths.

In New York City, one of the early epicenters of the outbreak, the state health department advised hospitals to bar partners, spouses, or other support persons such as doulas from assisting in a woman's labor and delivery in order to reduce the risk of exposure to COVID-19 for hospital staff and healthcare workers (Gan-Or 2020). However, a public outcry against the ban recognized the physical and emotional support women need during labor and delivery and caused a reversal of the policy, backed by an executive order from Governor Andrew Cuomo that would allow one support person to assist (Gan-Or 2020). Hospitals and birthing centers around the rest of the United States quickly followed New York's lead, settling on policies that generally allowed only one caregiver or support person during and after delivery (Rothman 2021).

As the situation in New York City demonstrated, in the scramble during the early days of the pandemic, pregnant women were treated as a medical problem to be solved and were denied agency in their decision-making around their labor and delivery experiences. Hospital spokespeople quickly assured the public that all decisions regarding policies were made "with the best of intentions and safety of the mother, baby, and our staff as our guiding principle" (Van Syckle and Caron 2020), and other medical experts supported a no-visitor policy, noting that "saving lives was more important" than the emotional benefits of a support person. Advocacy from midwives and doulas helped

draw public attention to the issue of supporting people during birth, and ultimately hospitals quickly reversed course on their policies (Van Syckle and Caron 2020). The COVID-19 pandemic exacerbated an existing tension between a legal and medicalized model of pregnancy. This structural strain treats pregnancy as pathology, disabling, compared to a midwifery model of care in which pregnancy and childbirth are everyday life events.

This study examines the experiences of seven people who experienced pregnancy during March 2020 and March 2021 in a large, southeastern city in the United States. Using open-ended, semi-structured interviews, we examine the pandemic's effect on respondents' medical, social, psychological, and work experiences of pregnancy and childbirth during a pandemic. We explore the tensions between the medical model, which pathologized pregnancy and pregnancy-related impairments as disabling, and the midwifery model of pregnancy, which centered on perinatal care in partnership with the woman and the midwife. We concur with Rothman (2021) that the COVID-19 pandemic wiped out some of the gains of decades of feminist advocacy towards humanizing pregnant women and returned to a highly medicalized model of care.

Theoretical and Empirical Background

Medicalization and Disability

Medicalization is a process in which more behaviors and aspects of life are categorized as health or illness (Hartley and Tiefer 2003). Rothman (2021) defines it as "the way more and more of life has turned into 'medical issues,' and more of our conditions, events and experiences are turned over to medical management" (p. 15). Medicalization occurs across three dimensions: discourses that use medical terms to define situations, practices that conform to expected actions, and identities with culturally defined roles such as "doctor" and "patient" (Halfmann 2011). The field of obstetrics initially promoted prenatal care to reduce infant and maternal mortality. Obstetrical control in the perinatal period has grown exponentially, as few women had prenatal care in the 1940s compared to 2016, when over 98% of women received prenatal care (Osterman and Martin 2018; Barker 1998). However, Barker (1998) finds that a drop in maternal deaths can be attributed to aseptic and antiseptic childbirth techniques rather than the institution of prenatal care practices. Further, low-birthweight rates, which are a leading cause of infant deaths, remain high despite prenatal care, and the maternal death rate in the U.S. is the highest of all developed nations (Melillo 2021).

Some researchers assert that the authority of the medical profession makes it difficult to reclaim agency in the birthing process as obstetrics discounts women's knowledge, intuition, and experience and still dominates the childbirth arena (Simonds, Rothman, and Norman 2007; Simonds 2002; Goer 1999; Murphy-Lawless 1998). Women feel pressure exerted by medical professionals, state agencies, women's magazines, and pharmaceutical marketers to monitor their diets, weight, appearance, activities, behaviours [sic], and thoughts for any signs of abnormality or illness. During pregnancy, this surveillance effort increases as medical doctors and nurses conduct tests to ensure that mothers comply with best medical practices and fetuses are developing normally (Johnson 2008:894).

While some feminists view medicalization as a negative effect on women's autonomy (Simonds 2002; Simons, Rothman & Norman 2007; Murphy-Lawless 1998), others take a practical approach since women actively seek medical care and advice in the perinatal period and the transition to motherhood (Neiterman 2013). Counting on such advice, women view their pregnancy through the medical model and modify their lives to promote a healthy pregnancy and take care of the unborn child by taking care of her body (Neiterman). Similarly, Rudolfsdottir (2000) finds that women have agency in the perinatal period and choose closely to follow medical advice. As a result, they accept some of the technology, interventions, and medical knowledge in the process but reject others as they seek to maintain control over their bodies.

The risk-management perspective of obstetrics is evident in the restrictions to normal life placed on pregnant women. Over the decades from the 1920s to today, restrictions of certain activities, foods, beverages, medications, and surveillance of the pregnant body increased during pregnancy and childbirth to monitor the condition of the baby. Routine checks during pregnancy monitor women's weight, blood pressure, glucose levels, and the growth of the fetus. The risk perspective is heightened when maternal age is "advanced" (over age 35), which Cardin (2020) suggests is a social construction that perpetuates a stigma on the aging body and requires even more medical surveillance and intervention than younger pregnancies.

Through this lens of increasing medicalization, pregnancy is pathologized and treated as disabling. Pregnancy is not considered a disability under the Americans with Disabilities Act (ADA). However, the 2008 Americans with Disabilities Act Amendments Act (ADAAA) has broadened the legal usage of the ADA, and courts have ruled that

"complications" resulting from pregnancy can be significant enough to invoke the ADA (Cox 2012; Donnelly v. Capital Vision 2021; Shapiro 2018). For example, a recent District Court ruling found that a plaintiff was eligible for ADA protection based on the fact that "Plaintiff gave birth under the specific circumstances of the early stages of the COVID-19 pandemic, which led to fears around accessing medical care during pregnancy more broadly that could have led to health problems surrounding the pregnancy" (Donnelly v. Capital Vision 2021, emphasis added). In addition, several other lawsuits filed by the Equal Employment Opportunity Commission (EEOC) against corporations such as M&T Bank, Party City, and Rural/Metro Corp / American Medical Response have resulted in settlements in favor of the plaintiffs for discrimination in the workplace due to pregnancy (U.S. Equal Employment Opportunity Commission 2019, U.S. Equal Employment Opportunity Commission 2020, U.S. Equal Employment Opportunity Commission 2020) Legally, while pregnancy itself does not rise to the definition of a disability meriting ADA protection, impairments, and complications, including fears of accessing medical care for pregnancy during the pandemic, have been considered disabling.

In the United States, workplaces policies regarding pregnancy, childbirth, and adoption are inconsistent and do not adequately support many families. For example, the Family Medical Leave Act (FMLA) allows for up to 12-weeks of unpaid leave for families after the birth or adoption of a child but only applies to workplaces with more than 50 employees and to full-time employees who have worked for the company longer than a year (AAUW). In addition, at many workplaces, employees can use accumulated sick leave during pregnancy or after delivery or file for short-term and long-term disability benefits to have a portion of their salaries covered while recovering from childbirth. Thus, the medical model of pregnancy extends both to the legal framing of pregnancy as disabling and the workplace policy accommodations around pregnancy and childbirth (as inadequate as they may be).

Midwifery Model of Care

In contrast to the medical model of pregnancy, the midwifery model of care views pregnancy and childbirth as normal life events rather than diseases with symptoms and risks. According to the Midwives Alliance of North America (MANA), the Midwives Model of Care includes:

> Monitoring the mother's physical, psychological and social well-being throughout the childbearing cycle; providing the mother with individualized education, counseling, and prenatal care; continuous hands-on assistance during labor and delivery; and postpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention. (MANA.org 2021).

Midwifery's goal is to assist, educate, support, and nurture with as few interventions as possible. Support extends to the mother and the entire family and continues beyond the birth into the postpartum period. The midwifery model situates the pregnant woman within her social networks (particularly her family), emphasizes community and social support, and views pregnancy holistically as an event the body is capable of handling with few interventions. Hansson et al. (2020) suggest that besides fewer interventions, midwifery emphasizes women-centered care in which a partnership between woman and midwife results in a dialog, respect, and safety:

> Women-centered care also shifts the locus of control from the institution and professionals towards the woman (Fahy, 2012; Leap, 2009). An ambition in midwifery work is that midwives should recognize each individual woman's physical, emotional, social, spiritual and cultural needs, expectations, and context. All this should be defined by the woman herself, not by the caregiver (Hansson et al. 2020).

Wong et al. (2015) found that midwifery for first-time mothers "increased rates of normal vaginal birth…and spontaneous vaginal birth…and decreased rates of instrumental birth…and cesarean sections." In addition, they suggest that avoiding c-sections with first pregnancies leads to fewer c-sections in subsequent births, which mothers are often pressured to have once they undergo a cesarean birth. Moreover, because midwifery is available to women with private insurance policies, Courtot et al. (2020) suggest that making midwifery available in birthing centers to Medicaid recipients would improve outcomes for both mothers and infants and reduce costs associated with Medicaid-covered perinatal care.

Return to Medicalization during COVID-19

Research on pregnancy in the pandemic has shown increased medicalization and less focus on social and community support. As Rothman (2021) notes,

> There have been decades of work, of social movements, to improve [birth conditions], to provide women companionship and support. Pregnant people could bring companions,

> typically the father, to see the ultrasound, hear the heartbeat as the pregnancy developed, hold her hand, wipe her brow, and help her through labor and birth. The COVID-19 moment wiped that out... The work to humanize birth—permit companionship, ensure respect and comfort—is being wiped out. Women go to prenatal appointments alone. In some places they are allowed no one with them in labor, though a lot of pushback on that has happened. A companion, the partner, or a doula, can now be allowed in again, after those first rough months of the early COVID-19 pandemic. Pressure for inductions of labor and Cesarean sections, done just to ease institutional management, has grown. (Rothman 2021:103).

Women who were pregnant and gave birth during the pandemic faced an escalating medicalization of their pregnancies, where their wishes and the best practices for their psychological and physical health were ignored in favor of medical interventions to speed up delivery (Townsend et al. 2021).

In this project, we explore the tensions between the medical model of pregnancy, which treats pregnancy as disabling, and the midwifery model, which emphasizes the importance of the social network, within the backdrop of the COVID-19 pandemic. We examine the effect of increased medical control of pregnancy necessitated by the pandemic and the reduced focus on social aspects of pregnancy during the pandemic.

Pandemic Pregnancy Experiences

While the COVID-19 pandemic is still an ongoing public health threat, early data suggests that many of those who experienced pregnancy during the COVID-19 pandemic experienced substantially elevated anxiety and depression (Lebel et al. 2020; Moyer et al. 2020; Werner et al. 2020), social isolation (Milne et al. 2020), and stress (Preis, Mahaffey, and Lobel 2020). Additionally, research suggests that pandemic-related restrictions exacerbated already-existing disparities in health outcomes (Arora, Mauch, and Gibson 2020; Minkoff 2020; Pirtle and Wright 2021). In their analysis of an online support forum, Chivers et al. (2020) noted that pregnant women expressed themes that included heightened distress, despair, and altered support relationships. While longitudinal research on the effects of the pandemic is ongoing, it is clear that the pandemic has had a significant impact on pregnant people's emotional and physical experiences.

Research has also shown that the pandemic significantly impacted prenatal experiences. For example, Lebel et al. (2020) found that "89% of their participants reported changes in prenatal care due to the pandemic, including canceled appointments (36%), or not being allowed a support person (90%)." In addition, the respondents believed the quality of their prenatal care decreased, 74% had trouble accessing other healthcare during their pregnancy (including psychological services), and 35% made changes to their birth plan because of the pandemic. These changes in prenatal care threaten to exacerbate already existing inequalities in access to care and health outcomes.

Pandemic Inequalities

Pre-pandemic maternal mortality rates are higher in the U.S. than in any other developed country (Melillo 2021), with an average of 17.2 maternal deaths per 100,000 live births. That number changes when race is taken into account: for non-Hispanic Black women, the average rate is 43.5/100,000; for non-Hispanic white women, the rate is 12.7/100,000; and for Hispanic women, the average rate is 11/100,000 live births (Melillo 2021). Pirtle and Wright (2021) find that racial and gender inequalities within social institutions, particularly the home, work, and healthcare, contribute to such disparate health outcomes. These disparate outcomes need to be understood in the context of structural racism, as community support for women during pregnancy is crucial to reducing them (Davis 2019). Inequalities begin before childbirth due to a widening gap between maternity services offered in poor or minority communities (Minkoff 2020).

The same general risk factors that impact maternal outcomes (pollution, lack of green spaces, food deserts) also "may accelerate the progression from COVID-19 infection to death from COVID-19" (Minkoff 2020:1053). In addition to physical risk, women of color have generally carried a more significant mental burden during the pandemic. Pirtle and Wright (2021) note that black women experienced "role overload" during the pandemic, where they were asked to care for families and communities while simultaneously navigating the stresses of distance-learning, working, and pandemic isolation. Overall, during the COVID-19 pandemic, women of color "reported higher pandemic-related stress [than white women]" (Preis et al. 2020). This stress was exacerbated by institutional racism, and this, combined with the fear of catching the COVID-19 virus, reduced perinatal care even if pregnant women did not become infected with the disease (Minkoff 2020).

Social Support in the Perinatal Period

Research shows that social support networks are a crucial element of the perinatal period. Social support is a protective factor in reducing anxiety and depression (Chrzan-Detkos, Walczak-Kozlowska, and Lipowska 2021; Hetherington et al.2020). In addition, social support promotes better maternal mental health, fewer preterm births, and improved child development (Hetherington et al. 2020). During the perinatal period, support from friends and family is visible in cultural celebrations of pregnancy in events such as routine doctor visits and tests such as ultrasounds, baby showers, and gender reveal parties. In addition, support within the community is offered through prenatal education courses, support groups, and parenting classes. The restrictions placed on general populations during the COVID-19 pandemic removed many of these supports during the perinatal period and increased isolation and loneliness, leading to increased levels of anxiety, depression, self-harm, and suicide attempts (Chrzan-Detkos et al. 2021; Rhodes, Kheireddine, and Smith 2020).

Rhodes et al. (2020) found that respondents in their study overwhelmingly expressed higher levels of anxiety around pregnancy, birth, and new parenthood in the COVID-19 pandemic due to three causes: fear of contracting COVID-19; current disruption in their daily lives, such as access to food and medicine, job security and financial stress; and future uncertainties such as the long-term impact of the pandemic on their baby's development, socialization, and reaction to parents' return to work. Chivers et al. (2020) identify five areas that increased anxiety during the perinatal period in a pandemic: 1) lack of risk information "…(e.g., risk during pregnancy, risk to baby in utero, risk to a new born baby, risk from the hospital environment, risk to mental health from reduced social supports);" 2) grief due to loss of support of family and friends; 3) interfamily conflict around irresponsible failure to follow social distancing guidelines; 4) guilt for feeling happiness in light of the struggles of others; and 5) postponement of plans to become pregnant. Hetherington et al. (2020) examine the continuity of social support throughout the perinatal period and find that women who have strong networks in place before a baby is born are likely to have strong support after giving birth.

Finally, Sahin and Kabakci (2021) find that the unknowns of the novel coronavirus caused pregnant women to fear for their health and the health of their fetuses and their families, which increased their perinatal anxiety and depression. To stay safe, the women in their study changed their daily routines, social life, and leisure activities, increasing their feelings of isolation. With these experiences in mind, we set out to research people who experienced pregnancy and childbirth during the COVID-19 pandemic.

Methods and Data

Description of Sample

Participants were recruited through the social networks of the researchers, and as such, they represent a convenience sample. The sample included seven women who experienced pregnancy and childbirth between March 2020 and March 2021. The women ranged between 28 and 44, with an average age of 35. This is notably higher than the average age of first pregnancy in the United States, 26 in 2018 (Bui and Miller 2018). Four of the women in the sample experienced their first pregnancy and birth during the COVID-19 pandemic, while two respondents had their second child during the pandemic, and another had her third and fourth (twins) during the pandemic. Four women in the sample identified as White, two identified as Hispanic, and one identified as Black. All respondents had at least a Bachelor's degree or higher, with several holding advanced degrees. All but one was married, and six of the seven respondents identified as heterosexual. All participants lived in the metropolitan area of a large, southeastern city in the United States, where rates of COVID-19 were high during the time of our study.

The children were born to our respondents between May 2020 and March 2021. Four women knew they were pregnant and had received at least some medical care prior to the mid-March COVID-19 shutdown, while three others experienced their entire pregnancy and birth during the pandemic period. All but one participant gave birth in a hospital setting; one participant gave birth in a birthing center.

Data Collection and Analysis

Respondents participated in an interview with one or both researchers via Zoom, generally lasting around one hour. The interview instrument contained open-ended questions about prenatal, childbirth, and postnatal experiences that let respondents describe their experiences in their own words. Interviews were recorded and transcribed by the authors. Upon reviewing the transcripts, we analyzed them using a modified grounded theoretical approach (Glaser and Strauss 1967). We employed microanalysis (Strauss and Corbin 1990) to identify themes through our respondents' language to describe their experiences. Each author separately coded the transcripts (one author using a paper-and-pencil method and one

organizing through Word comments), and then we discussed the dominant themes present in the data. While the sample was small (n=7), the respondents used remarkable consistency when they described their experiences navigating healthcare, pregnancy, and work during the COVID-19 pandemic. The themes that we identified are described below. Participants have been assigned pseudonyms to protect their identities.

Results

Medical Care: Prenatal Experiences

The interview was organized into three discrete sections: prenatal, childbirth, and postnatal experiences. During the prenatal period, all the mothers in our sample experienced similar precautions and medical advice. They wore masks, underwent temperature checks, and all but one mother was required to attend appointments alone. Kate, the only mother who had her baby in a birthing center rather than a hospital, had her appointments partially online and partially in her car in the parking lot of the birthing center. Unlike the mothers who gave birth in hospitals, her spouse was able to be with her in her car for some of her visits, and she described her prenatal experience with midwives as "very hands-on thinking about emotional, spiritual even, well-being as well as physical well-being." She recounted that she was provided a "wealth of information about how to, you know, how to keep our bodies healthy during pregnancy." However, this pregnancy differed from her pre-pandemic pregnancy:

> I think the biggest difference in terms of prenatal care was that I stopped being asked to go in for appointments. And so obviously the birthing center had to reconfigure how they were going to do appointments because they had to still continue providing care for women, but they also didn't want women to be exposed or themselves to be exposed, so what was really different was that the birthing center started doing a drive-up clinic.

Charlotte, a second-time mother who sought perinatal care with an obstetrician and gave birth in a hospital, described the procedure upon arriving at the obstetrician's office and noted that this procedure differed from her first pre-pandemic pregnancy:

> They screened you as soon as you got off the elevator before you even went into the office, and then once you got into the office you didn't wait in the waiting room at all, you just went straight back. So, they didn't have anyone congregating in waiting rooms. So, the appointments were more spaced out. The appointments were a lot more efficient since you weren't waiting in the waiting room. They'd take you straight back and do your vitals and take you to the room where you'd be seen almost immediately and they'd send you back out.

Although the precautions made visits more efficient, the solo visits precluded the spouse or partner from being present for the routine check-ups and the milestone visits such as hearing the baby's heartbeat or watching the ultrasound. Respondents described this as feeling sad for the spouse/partner and alone and anxious. For example, Sofia, a first-time mother, described being "anxious" and "nervous" about going to the 20-week ultrasound alone and also sad for her spouse that he couldn't share the experience with her. Abigail, also a first-time mother, described it as her "greatest disappointment" that her spouse couldn't "participate in most of the process of pregnancy. Like, she couldn't come to ultrasounds; she missed out on seeing him kick on the screen and things like that." Similarly, Chloe, experiencing motherhood for the first time, described her spouse missing appointments as "one of the saddest parts" of pregnancy. She was nervous about being alone for the 20-week anatomy scan but also regretted that her spouse missed out on "how cool it was to see her moving around and stuff, in the earliest times before I could feel her."

> Especially for first-time mothers, excluding the spouse or support person from prenatal visits increased their anxiety and fears and created sadness that they could not share the experience with them. Although Kate could have her husband with her for most visits, she recalled the strangeness of switching from in-person visits at the start of her pregnancy to a drive-through clinic in the clinic's parking lot during the pandemic. During the drive-through check-ups, a midwife would check her abdomen for pregnancy progression while she laid back in her car seat and even did an ultrasound outside on a bench in the parking lot to determine if the baby was breech. Kate's distress was the fear of having any kind of complication, which would mean she would be sent to a hospital for labor and delivery because the birthing center would not handle complicated pregnancies. The midwives also told her that the clinic was being asked to take on some uncomplicated

births to relieve hospitals' patient load since hospitals were overrun with caring for COVID patients, which also heightened her anxiety.

> So my biggest fear was yeah, I was gonna need special care, a c-section, or need to go to the hospital for some reason, and that the hospitals were going to be so focused on COVID patients that, you know, something would happen to me and my baby. That was my biggest concern.

So while Kate had her husband's presence for her prenatal visits, the birthing center's policy of taking only uncomplicated pregnancies caused her anxiety.

Birthing Experiences

All the mothers were allowed a single support person during childbirth except for Kate, who was allowed two at the birthing center. Most of the respondents had to undergo COVID testing during labor but prior to birth, which proved to be a stressful experience as they awaited results. None of the respondents tested positive for COVID-19 during their pregnancies or postnatal periods. For respondents who gave birth in a hospital, masks were required for themselves and their support person, though for some, exceptions were made once they confirmed a negative COVID test. Sofia describes a nurse just "reaching up and removing" her mask during active labor without discussing it with her.

The words Sofia used to describe this event exemplify the dominance of the medical model that exerts control that bypasses the woman's agency in labor and delivery. Even if the nurse's action was intended to make Sofia more comfortable, the effect was removing her control of the situation. In contrast, the midwifery model places importance on continued dialog and partnership in the process of perinatal care and childbirth, which would have given Sofia a choice to continue with or without the mask rather than making the decision for her. Sofia's recall of this event illustrates that she, the laboring woman, felt her voice was diminished as communication between her and the healthcare provider was absent, with decisions made on her behalf by the medical staff. Despite some anxiety about wearing masks during labor, most respondents did not recall masks significantly impacting their delivery experience. As Charlotte noted, "it wasn't very difficult, and so I didn't really think anything of it."

The restriction of only one support person for hospital births impacted decision-making for some mothers. Erica, who gave birth to twins, described a tension between having to choose between her spouse and one of her parents in the delivery room and the days after her children were born. "Just having an extra support person would have been helpful, but because of the pandemic, I could only have one person there. And then I had to decide who that person was going to be [between my parents and my husband], which put me into limbo because, of course, I have to choose my husband. But it was emotional, yeah."

Erica had two other children, and both of her parents and her spouse were present during the older children's births. Chloe noted that in her ideal childbirth plan, she would have incorporated a doula, but "once I found out I wouldn't have been able to have them come with me to the hospital I changed my mind. I know people were using doulas during birth on Facetime or whatever, but it didn't seem worth it." In this case, the pandemic protocols discouraged her from incorporating a midwifery model of care into her perinatal experiences.

Despite precautions that made childbirth more stressful, ultimately, all our respondents safely delivered healthy babies. Two babies spent some time in the neonatal intensive care units, and others experienced minor postnatal complications such as mild jaundice or tongue ties. However, none of these complications were directly related to the COVID-19 pandemic (and likely would have occurred regardless of external factors created by the pandemic).

Postnatal Experiences

The typical postpartum visit with a medical provider occurs six weeks after giving birth, and all our respondents had a 6-week check-up with their obstetricians, although Kate, who delivered at a birthing center and went home a few hours later, had a brief visit the next morning from a midwife who had her come out on her front porch to check her and the baby, and then had her follow-up visit by phone six weeks later. (It is important to note that Kate gave birth in May 2020, only two months into the pandemic, so she may have experienced more restrictions than the other respondents because of the timing of her delivery).

The midwifery model that birthing centers typically follow adopted more of the medical model of perinatal care during the pandemic, as the emphasis shifted to physical care with less focus on emotional support. Two respondents noted that the lack of follow-up for in-person medical care or earlier care after childbirth led to missed diagnoses. Kate said,

> One thing that I felt was missing from my postnatal experience was that my six-week check-up was over the phone. And, I thought

> the check-up was very thorough [for a phone call], but four months ago I went to see a pelvic floor physical therapist and I realized I have a bladder prolapse, which I think they would have been able to diagnose if I had actually been seen [in person]. So because I didn't go in and actually have someone touch my body and diagnose this, I really missed out on being nurtured and physically checked out.

In Ana's case, she did not see her obstetrician until the 6-week check-up, even though she experienced hypertension and preeclampsia just prior to delivery, and labor was induced as a result. She, too, was diagnosed with organ prolapse.

> They induced me for two days. I was diagnosed with hypertension and preeclampsia. I was admitted, and then because of the hypertension, the baby was born on Thursday, and we left on Saturday. I only got the 6-week visit, and then he diagnosed me with a prolapsed organ, a pelvic prolapse. I have to do physical therapy.

The Mayo Clinic notes that preeclampsia after giving birth is a serious condition that, if left untreated, could result in serious complications, including seizures, damage to vital organs, and stroke, among others (Mayo Clinic 2021). The six-week delay in care typical in non-pandemic times, and at least partially as a response to COVID precautions, resulted in delayed healing and problems that could have been addressed earlier.

Pediatric Experiences

Finally, we discussed with respondents their experiences navigating pediatric care. They were required to follow similar precautions for prenatal visits (such as masks and screening), but several respondents described confusion and stress regarding whether they could attend appointments with their child's other parent. In addition, due to protocols, Kate was not allowed a support person for a minor tongue tie surgery for her baby, which took place three days after delivery.

> When my daughter was three days old, I took her by myself to get a tongue tie fixed. I drove, three days postpartum, and I drove her 30 miles away. So here I am with this three-day-old baby strapped to me, still bleeding from delivery, wearing a mask...I couldn't send my husband with her for that long because he can't breastfeed her, and I couldn't bring my husband with me because of the protocols, so I just had to do it by myself. I cried a lot on the way home, and I probably shouldn't have been driving because I was an emotional wreck.

Other mothers described confusion about the rapidly evolving rules for pediatric visits. For example, Abigail missed the first pediatric visit because she thought only one parent was allowed, and she could not lift the baby carrier while recovering from a cesarean section. In addition, Sofia described the medical office staff as "side-eying" her husband, who arrived late to an unscheduled follow-up visit to check for jaundice, feeling that they judged him for not accompanying his wife only a few days postpartum. Other parents described arriving at the pediatric office, only to be told that one parent was allowed inside.

During the COVID-19 pandemic, medical providers have had to rapidly create protocols that balance patient care and the safety of both patients and providers. Unfortunately, these protocols adhered to the medical model as they focused solely on the pregnant body as disabled and in need of medical control, which strictly limited respondents' access to support during their perinatal experiences. Even the birthing center's patient support was affected by pandemic protocols, as Kate notes:

> I was seven months pregnant so 28 weeks or something. But basically no one talked to me for like three weeks and I was just kind of nervous, because I think at that point I'm supposed to be going in every two weeks. And finally, the woman who runs the birth center gave me, she called me up and she said 'Hey we've realized that you've slipped through the cracks and we want to talk to you about your birth and your pregnancy and how everything is going.' You know, 'How are things going?' So she called me up personally and checked in on me, which was really meaningful to me at the time.

What is clear from this limited sample is that respondents closely followed the recommendations of their medical providers, whether through obstetrical care or midwifery. However, Kate related that she "podded" with her aunt, creating a "bubble" for the sake of social support and childcare for her older child. She stated: "We were two households together, which at that time I feel like was a real no, no, but I did it anyway." The midwifery model supported patients' agency, which allowed Kate to feel confident to take

the necessary steps to have her and her family's needs met. Overall, our respondents' accounts show that the rapidly-changing protocols increased parents' anxiety, fear, confusion, and stress during prenatal, childbirth, and postnatal periods.

Psychological Experiences

The process of navigating medical bureaucracy created stress and anxiety for respondents. However, they also experienced psychological effects during and after pregnancy specific to the social conditions created by COVID-19, including isolation and loneliness, fear, and anger. Finally, most of the respondents noted an overarching experience of grief on the things that they lost out on during both the pregnancy and the postnatal period.

Isolation, Loneliness, and Grief

Every single respondent discussed, through tears, how isolated and lonely they felt either during pregnancy, or immediately after birth, or both. The first question we asked respondents was an open-ended "tell me about your pregnancy," For many respondents, the first thing they noted was loneliness. For example, Sofia said, "even though it was a relatively easy pregnancy, it was still hard for me because I felt very, very lonely." She described missing out on friends, family, and community and having to celebrate Christmas alone with her husband because of possible COVID exposure. She noted an overarching feeling of loneliness throughout her pregnancy and the postpartum period, which she frequently described as "emotionally draining." Chloe relayed her disappointment in missing out on things she looked forward to while trying to get pregnant, like prenatal yoga and pregnant mom groups, and expressed regret that she could not participate in those sorts of activities. Kate, whose perinatal care was provided through midwives, was told to follow CDC guidelines – wash hands, wear a mask, practice social distancing, etc. This also precluded her participation in social activities and community support.

Another impact of social distancing guidelines was that many of our respondents could not participate in traditional social celebrations such as baby showers, gender reveal parties, and family participation in shopping and decorating the nursery. Respondents expressed grief from being unable to participate in these rituals and rites of passage of pregnancy. Sofia described the feeling:

> I missed out on so many parts of like, the first of everything, you know? Like, picking out stuff for her was all online...it just felt less special in a way, it felt more like just doing regular grocery shopping. It didn't feel like something you would spend a whole day or a whole weekend doing [together], I would just get online in my spare time. So, it did kind of lose the magic...I guess I keep saying "special" because it is special, like, it's that new moment, that bonding that you do, and I didn't get to have that.

The absence of these social events created additional hardship for some mothers, increasing the financial burden of buying necessary baby items on the expecting couple. For example, Ana said, "we didn't get to have a baby shower, so we had to buy everything ourselves, so it was really financially hard."

After the babies were born, participants missed out on community help (like bringing meals, and family and friends meeting and holding the baby). This increased their feelings of isolation and loneliness exponentially. Kate described her postpartum period as "very, very, very, very isolated, and we felt very, very lonely in the postpartum period." Chloe noted that she had some "pretty low" times, and the stress of the postpartum period created tension with her spouse. She felt this tension "was worse because we didn't have any other help, it was really just all on us, and we weren't getting any relief or help from anybody else that we normally would have had. And even just like, [being able to socialize] during that time I think would have helped not feeling so isolated." Every participant in our study mentioned feelings of isolation.

Fear

Whether they gave birth in a hospital or a birthing clinic, every participant discussed the anxiety and fear they felt during their perinatal period, and for most of them, this fear revolved around being exposed to and testing positive for COVID-19. Charlotte noted that her "biggest fear" was catching COVID, especially because "everything was so new and they didn't really know the effects on a pregnant person if you got COVID." Both Abigail and Chloe tried to be proactive and learn about the potential impacts of COVID on newborns or pregnant mothers, which created more anxiety. Abigail describes reading "these horror stories of them separating you from your baby if you were positive," and Chloe noted that even though the hospital she used didn't separate infants from COVID-positive mothers, she still was "terrified" that she would test positive for COVID and not know she had it. Kate described prenatal anxiety that she would have a birth complication at the birthing center and have to be transferred to a hospital that would be overrun with

COVID patients, leading to greater risk for her and her baby. As Ana put it, "I just feared for my life."

It is worth noting that the fears they experienced were medicalized fears around the risk of COVID-19 exposure for most participants. Their fears were solely centered around medical exposure, not about childbirth per se, parenthood, or postnatal bonding. Nevertheless, the presence of the virus loomed large in their thoughts about labor and delivery, and the medicalization of the process served to exacerbate these feelings and continuously create an ever-present threat.

For those navigating their comfort level in the postpartum period concerning things like family visitation, this fear included a responsibility to the safety of elderly relatives, as well. Abigail noted that arranging for her elderly parents to visit their grandchild led to additional stress and fear. When she asked her pediatrician for precautions for her parents meeting the baby, he noted more precautions about keeping her parents safe than precautions about keeping the baby safe. However, after being in the hospital several days after delivery, her concern shifted. "We've been keeping ourselves safe from everybody else, but now do we need to keep everybody else safe from us?" Ultimately, she and her spouse were quarantined for several days before allowing people to meet the baby in person.

Anger

A final emotion common to our respondents was anger. Sofia described it as "the overwhelming feeling" that she had when others, whether family or people in public places like grocery stores, were not taking COVID precautions seriously, which she felt posed a risk to her and her baby. Although respondents strictly followed CDC guidelines and their medical practitioner's recommendations, they were angry, especially when the family they were counting on for help and support continued to live as if things were normal, not following mask mandates or avoiding exposure in crowds. All of this meant having to say, "No, you can't hold him, you have to see him at the door" as Erica had to tell her relatives. This then required mothers to become the gatekeepers in protecting themselves and their babies from exposure to COVID-19, increasing their feelings of isolation.

For many respondents, their isolation and their anger interacted. As Sofia noted, "I kind of isolated myself from everybody because I didn't want to expose myself or my baby to this extremely new thing that you really don't have any idea how it's going to affect us, like what the long-term repercussions are, if it would affect the baby." She described family members' actions as "being selfish and disrespectful of her wishes as a parent" when they brought food against her wishes and expected to stay and visit. Anger also arose in some of the respondents regarding their work situation, which we cover in the next section.

Work Accommodations

As work changed suddenly for large portions of the population when the nation shut down in the pandemic, the shutdown affected all of our respondents somehow. Six of our seven respondents were full-time employees, and one was a full-time student. Among our respondents, four were able to work remotely during at least part of their pregnancy, and three of those four returned to remote work after their time off after delivery. Abigail, Erica, Chloe, and Kate were all able to use either sick leave or FMLA leave to have many weeks of recovery after delivery. Sofia, a full-time student, finished her classes remotely after delivery and continued taking remote classes the following semester. She gave birth on a Friday and attended her virtual class Tuesday. Ana worked in person until right before she delivered and returned to in-person work after eight weeks. Her leave was paid, but she had to sign a contract agreeing to work for the company for at least six months after returning from leave. Finally, Charlotte worked in-person through her pregnancy and returned to work after her 12-week leave (some paid, some unpaid).

When the shutdown ended, there was hesitancy and fear of returning to in-person work because of the risk of exposure. Charlotte expressed, "There was a little bit of anger for work, making me be at work during a crazy time [when it was just as effective working from home]." Kate was angry when coworkers would ask her to do "the same kinds of things they would ask me to do if I weren't eight months pregnant with a two-year-old at home." The lack of accommodations in the workplace for Charlotte and Kate created feelings of anger because their pregnancy and their health and safety and their baby were not a concern to their employers. But the doctors and midwives that cared for our respondents also did not issue any special directives regarding work except to follow CDC guidelines: wash hands frequently, practice social distancing, and wear a mask. This is another example of the medical model overtaking the midwifery standard that normally would prioritize emotional and individualized support.

Other respondents received a wide range of accommodations, some menial and others very beneficial. For example, Abigail and Kate both moved to virtual work just before the shutdown and continued working virtually because of their pregnancy. Abigail stated, "It was almost like being on maternity leave for

a year! [My spouse and I both] worked from home and didn't have to put [baby] in daycare." Chloe also had generous accommodations: "The baby was almost four months old by the time I had to go back to work." Additionally, she felt she could have had additional accommodations if she had asked because her company granted accommodations to a coworker with a vulnerable child.

On the other end of the spectrum of accommodations, Ana's employer moved her to a less-busy position and required her to work six days a week, but she could sit down or take a break whenever she needed. Ana added: "And he suggested, you know how people get swollen, and he's like well you can wear whatever shoes you like. So I wore Crocs." And finally, Sofia was denied accommodations and was surprised that there was not more focus on the risks of COVID when pregnant: "When I called to make my initial appointment, the first thing they said was that they're not pulling people out of work or school, they're not giving people excuses." She was simply advised to follow CDC guidelines: wear a mask, wash hands, social distance, avoid people who have been exposed to recent cases of COVID. Accommodations to pregnancy in the workplace varied greatly among our respondents from no accommodations to very generous accommodations.

Silver Linings

Surprisingly, even with all the negative experiences and anxiety, many noted a "silver lining" such as having extended time at home, avoiding overbearing relatives, and having a calm hospital experience, among others. Charlotte recounts: "It was actually kind of calming because there wasn't hustle and bustle around, you know, there were limited people in the hospital, it was just me and [husband]. It was kind of nice." Erica was grateful that both she and husband were able to work from home without using up vacation and sick time. She said, "I feel like if it wasn't COVID I would have taken time off because I have to, but with us working from home, it made it easier to get it done."

Similarly, Abigail and her spouse both worked from home and avoided putting the baby in daycare. Instead, they coordinated their work schedules so that one would always be available as a caretaker while the other worked. As Abigail recalls: "There's still grief of like, we didn't get to do a million friends bringing us meals and a million friends coming holding him and all that…. But in some ways that little cocoon or little bubble was kind of nice. And because everything went away, we didn't miss out on anything, and we got to have this time at home with him without missing out on weddings and concerts and things like that."

Similarly, Chloe remarked: "But in another way, it was almost nice that everyone else was also stuck in the house and couldn't really do much and like couldn't go out in months, that I was also going to have done the same thing anyway. And I could sort of just be pregnant."

Discussion and Conclusions

COVID-19 protocols created disruptions to our respondents' lives, resulting in fear, anxiety, and isolation. The first significant disruption in our respondents' lives due to the pandemic was in their medical care. Our respondents all sought medical guidance for a healthy perinatal period, supporting the view that pregnancy in the US is highly medicalized. All but one of our respondents were told things to avoid, such as certain foods and drugs and activities, while the one respondent said her doctor was very relaxed, "old fashioned" in that he did not give her any restrictions and even advised she not take prenatal vitamins because she was "young and healthy." Description of this obstetrician as "relaxed" seemed to indicate respondent's awareness that he was out of step with what most obstetricians recommend to their patients. Medicalization was also visible in that most respondents chose to have hospital births under the care of obstetricians, while one chose a birthing center and care provided by midwives. Their choices were not affected by the pandemic. Instead, such care is strongly encouraged through many parts of US culture, including medical sources, media, social media, family expectations, and tradition. This held even in the pandemic. Rothman states,

> In many places, the pandemic reopened the discussion of home birth. If hospitals were hotbeds of infection, why would you go there to give birth?...And of course the issue of safety and risk remains front and center: Birth became a balancing of risks. Does one dare to risk the hospital? Does one dare to risk the home? For so long we have been taught that hospitals are the only safe place to birth, without data to support that (Rothman 2021:104).

The onset of the pandemic brought about increased precautions and changes in the prenatal check-up routines such as temperature checks, mask requirements, and solo visits for check-ups and ultrasounds for those under obstetric care. Respondents experienced the most emotional distress, anxiety, and sadness at having to do these visits solo and not sharing the experience with their

spouse/partner. Although Kate could have her spouse accompany her to prenatal check-ups through the birthing center, her care in the midwifery model differed from her first pre-pandemic pregnancy, also in the care of midwives. Check-ups were conducted in her car in the clinic's parking lot, the clinic failed to contact her for three weeks toward the end of her pregnancy when she was due to be checked every two weeks, and a post-delivery check was conducted from her front porch. This reflects an increased medicalization of the midwife experience as COVID precautions became the central focus of perinatal care. All respondents reported feeling very fearful for their health and their baby's health as they were told to simply follow CDC guidelines that applied to the general population: wear masks, wash hands, and practice social distancing. The lack of extra care for women trying to protect their health and their baby's health added to their emotional distress. Further, creating a bubble with primarily those in the same household and practicing social distancing at work or in public spaces sharply curbed the practical and social support needed during pregnancy and childbirth.

The second significant disruption to normal life was the effect of the pandemic on respondents' work environments. Some respondents were able to work from home for some time before returning to their in-person routines, while others were able to work from home throughout their entire pregnancy and the postpartum period. Several reported frustration or anger at returning to their normal work environment when things opened back up or being denied any special accommodations for pregnancy during the pandemic, even though they could have continued to complete their work from home. This meant adjusting to working online for some, being unemployed during the shutdown, and then readjusting when required to return to work. However, all of the respondents continued working right up to the onset of labor, and most resumed work shortly after giving birth. Regardless of whether perinatal care was through obstetrics or midwifery, respondents were simply advised to follow CDC guidelines regarding staying safe in the pandemic.

While the lack of support in the workplace for pregnancy and a longer postpartum recovery put stress on mothers whose work is crucial to their families, the effect of the pandemic was not the same on all our respondents. Some of the spouses were able to work from home, which was a source of support and security for the mothers and a chance for the spouse to bond with the baby and work together as parents. These respondents had a more satisfying perinatal period, except for one mother who experienced tension with her spouse as they struggled alone to take care of the baby and adjust to parenting. Respondents whose spouses/partners had to return to work experienced sadness as they found themselves alone to recover physically with sole responsibility for the baby. This was especially difficult during the pandemic when CDC guidelines promoted social distancing and minimum exposure to others outside of the household. However, it supports the benefit of having paid family leave policies that let both parents adjust to their parental responsibilities regardless of the presence of a pandemic.

The third significant disruption in our respondents' lives was their social lives. This disruption was the source of great emotional distress for respondents. Mothers reported that they strictly followed their healthcare provider's guidelines to protect themselves and their babies from the effects of COVID. This meant isolating themselves from friends and family, especially those not following CDC regulations on staying safe in the pandemic. They felt they missed out on many traditional celebrations such as baby showers and gender reveals. It affected how they shopped for the items needed for the nursery and the baby. However, most of all, they felt isolated, alone, and depressed because they had very little support and no help with the new baby. This was true whether this was their first, second, or third pregnancy, or whether they gave birth in a hospital or a birthing center. Social support was lacking for our respondents, not just family and friends but also community support such as childbirth education classes, parenting classes, yoga for pregnancy classes, and others and not having access to these community resources added to the feeling of missing out on the traditions associated with this particular time in their lives. This finding illustrates the importance of social support during pregnancy, childbirth, and postpartum.

While these three areas presented changes in respondents' lives, not all of the changes were negative. Some found the medical environment more efficient and less chaotic, with fewer people in either medical offices or hospitals. Some embraced the opportunity to work from home, which gave them greater flexibility to recover and adjust to the new baby's responsibilities physically. Some were able to work from home along with their spouse or partner and share care of the newborn. Some who opted to put their child(ren) in a daycare center or home felt comfortable with the decision because they knew the childcare centers' precautions with the children and felt confident of their safety. Furthermore, as the pandemic went on, the precautions that seemed so foreign at the start began to feel normal, and fears started to ease—coping with the fears, frustrations, and changes wrought by the pandemic points to the resilience that mothers exhibit, mostly out of necessity.

Conclusions

The increased medicalization brought about by COVID-19 added layers of bureaucracy and medical domination that decreased respondents' agency and reduced the social support they needed during their perinatal period. The medical model of pregnancy focused on risks, institutional needs, and CDC protocols at the expense of our respondents' physical and emotional care. The ADAAA states that impairments and complications (also interpreted as fears of accessing medical care for pregnancy during the pandemic) have been considered disabling. The disruptions to what respondents thought pregnancy and childbirth would be like, caused by the pandemic, created great emotional distress. These disruptions affected respondents' medical care, work, and social life. Medical protocols established during the pandemic further medicalized the perinatal period at the expense of social support that a midwifery model would traditionally prioritize, which is crucial throughout the perinatal period. The fear of accessing medical care during pregnancy in the pandemic was disabling for our respondents. This was true whether care was provided through obstetrics or midwifery. The unknowns of the effects of COVID-19 on pregnancy, the fetus, or the newborn heightened anxiety for our respondents that neither the medical model nor the midwifery model of pregnancy care could mitigate. Although the midwifery model placed fewer restrictions on the respondent who gave birth in a birthing center, the fear of any kind of complication that would send her to the hospital for the birth loomed over every check-up and every test. This reflects an increased medicalization of standard medical birthing practices and a midwifery model of care.

This study is not without limitations. The small sample size makes it challenging to infer these findings to a larger population. Further, the convenience sample limited the study to a particular group of respondents known to the researchers, which afforded respondents comfort and familiarity in openly describing their perinatal experiences, which might not have been present in an unknown group of respondents. Additionally, our study included women with much more excellent SES and educational privilege, which likely impacted their ability to navigate the medical bureaucracy during pregnancy, and all of our participants were partnered (either married or in long-term relationships). Single women would have likely encountered even greater social isolation during the COVID-19 pandemic.

Despite these limitations, our study supports research that shows the importance of social support for women in the perinatal period and studies that have examined the effects of the pandemic on perinatal experiences. In addition, future studies that examine the scope of the disability in larger samples of women who experienced pregnancy in the pandemic, or inequalities that the pandemic may have exacerbated, or those that examine the effects of the pandemic's limitations on fathers or partners would be beneficial in meeting the needs of all families in the perinatal period, whether or not in future crises such as pandemics.

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