10-26-2022 2:00 PM

Autoethnography of a Pregnant Doula: An Anthropological Investigation of Birth Experiences During the COVID-19 Pandemic in Ontario and Quebec

Fattimah A. Hamam, *The University of Western Ontario*

Supervisor: Dr. Lindsay Bell, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in Anthropology

Abstract

The COVID-19 pandemic has exposed weaknesses in the existing systems and institutions people depend on in all areas of life. Birth is no exception. This research shows that COVID-19 replicated dominant North American cultural scripts treating birth as a risky and stressful medical event. It goes further to explore how birthers themselves described their experiences. Drawing on autoethnographic reflections, ethnographic interviews and a WhatsApp group chat, this thesis documents the nuance in predominantly middle class, cis-gendered women's experiences giving birth in Ontario and Quebec during the pandemic. It uncovers the overarching non-birther centric nature of local birth culture and argues for a more balanced view of the advantages and disadvantages of giving birth during a pandemic. The research highlights the increased labor women were burdened with but also points to the 'things that worked' for people giving birth during a pandemic. This study contributes to the broader literature on anthropology of birth by offering in depth autoethnographic reflections to understand the complex phenomenon of pandemic births.

Keywords: COVID-19, Birth Experiences, Pandemic Pregnancy, Pandemic Birth, Birth Culture, North America, Autoethnography, Anthropology of Birth

Summary for Lay Audience

The COVID-19 pandemic has exposed cracks in the healthcare system and deepened gender inequalities. This work is an anthropological investigation of some women's birth experiences during the various phases of the COVID-19 pandemic in Quebec and Ontario. I use my unique perspective as a birth worker who also gave birth during the pandemic to answer the questions: how do women experience birth during the COVID-19 pandemic and what can this tell us about the broader cultural treatment of birth in these places? Using data collected from nine-semi structured interviews and a WhatsApp group chat of women who gave birth during various phases of the pandemic in Quebec and Ontario, I document the nuance in these women's experiences, including my own, to show the confusion and inconsistency we experienced as we tried to navigate our births and transition to parenthood during uncertain times. The interviews underscored an increased reliance on online supports which were useful in finding alternatives to gaps in support but also added to the mental workload of 'COVID cautious' women as they tried to locate supports that were safe during a pandemic. Finally, the thesis outlines positive aspects or "silver linings" of giving birth during COVID-19 which I suggest point to the weaknesses in our shared birth culture and present areas for increased attention and improvement to women's experiences. I argue that looking at the positives in addition to the negatives gives a more complete picture of what continued to work well despite the standstill in other areas of life and what can be learned from these experiences to improve pre and postnatal care for women. At the end I recommend some cultural and institutional changes to implement over time to make birth a more dignified experience during and beyond crisis.

Acknowledgments

First, I would like to thank the All-Knowing and Merciful God for always opening (and closing) all the right doors for me and guiding me to where I am today.

I want to thank Dr. Lindsay Bell for her guidance and support throughout this project and in her openness to being able to share our experiences together. I want to especially thank her for every minute she gave me in those early months after her baby girl was born.

To Dr. Kim Clark, for her wisdom over the years and who I am particularly grateful to for the spontaneous offer to apply to this program when it became possible to do so at a distance.

I appreciate all the faculty, staff and my colleagues in Western's Anthropology department who offered so much support and flexibility as I navigated full-time studies and motherhood.

I would like to thank all my participants for their valuable time and sharing with me intimate details of their lives and in particular to my beautiful "BIZZZZMFF" sisters for all of their love and care over the years.

Lastly, to my family. Everyone who prayed for me, cooked us a warm meal or lovingly cared for my son while I worked, Thank you. To my parents for their trust and endless love. To Mahmoud my life partner, for his selflessness and sacrifice in supporting me through this project and our first year as parents. Finally, to my son Hamza, whose entrance to this world during this strange time inspired this project (and for his long naps where this project was born).

This is dedicated to you *habibi*.

Table of Contents

List of Figures

List of Appendices

1 Chapter One: Introduction

Figure 1 - Nurse baby dolls wearing masks who at the time made me think of labour and delivery nurses during COVID.

One fall day during a weekly check-in on Zoom with my supervisor, Dr. Lindsay Bell, I waited for the opportune moment to reveal to her that I was pregnant. Excited as to how this would change the course of my project which was still in gestation, she mentioned that she had something to share with me. By the end of that meeting we found out that we were both pregnant and expecting babies a month apart in the summer of 2021. From this point on, every so often I would hear about another friend or relative of mine become pregnant, in what eventually felt like a mini baby boom.[1] What better time would there be to take up the study of reproduction during a crisis than during this moment? This became an

[1] While many predicted there would be a baby boomlet of some type, statistics show that one in five Canadian adults said the pandemic made them delay having children or choose to have fewer leading to an overall drop in population growth (Government of Canada 2022). Perhaps another interesting area of inquiry, why on a micro level it seemed everyone was having a baby while national statistics showed a general decrease. Where there baby booms in certain cultural communities that would not be reflected in national statistics?

opportune moment to make sense of bringing a new life into the world in the midst of an unprecedented global pandemic. Living through these conditions in tandem with my supervisor made the design and execution of research on "pandemic births" ever more relevant.

In contrast to the joy and excitement I had about this project and the autoethnographic direction it was about to take; I saw how the COVID-19 pandemic was exposing weaknesses in existing systems and institutions people depend on in all areas of life and birth was certainly no exception. As prenatal care shifted to align with public health protocols, constantly changing restrictions were placed on birthing practices in hospitals and birthing centers, forcing expectant families to make difficult decisions when it comes to their birth plans (Davis Floyd et al. 2020; Gildner and Thayer 2020; Castañeda and Searcy 2020; König 2020).[2] Government restrictions and hospital protocols drastically limited (and continue to limit) families' options in choosing the place of birth and who would attend. The earliest research findings show that the pandemic created new challenges in navigating unnecessary medical interventions and required birthing people to reimagine postpartum support (Gildner and Thayer 2020; Davis Floyd et al. 2020; König 2020). In their study of birth plan alterations among American women, Gildner and Thayer (2020) documented that 45.2% of their respondents made changes to their birth plan because of COVID-19, some of these changes included: modifying an existing hospital birth plan (i.e. shortening the hospital stay, altered pain management strategies and accommodating new policies like wearing a mask while labouring) or changing birth locations and/or providers (i.e. opting for an out of hospital birth, forced provider/location change because pandemic has limited availability, selecting hospital birth because of fear complications); and other COVID related concerns (i.e. having fewer support people at birth, visitors not permitted following birth, care disrupted because moved in response to shelter-in-place orders).

Obstetricians and gynecologists, among other specialists researched the transmission of the virus and other medical implications on pregnant people who contracted COVID-19.

---

[2] At the time of writing this thesis the pandemic was still very much a lived daily reality for me, thus the use of both past and present tenses.

Findings at the very beginning of the pandemic concluded that the seriousness of the COVID-19 virus in pregnant women was not apparent, and that the virus does not increase the rate of miscarriage, stillbirth, or preterm labor (Hayakawa et al. 2020). Similar research conducted by Goyal et al. (2020) provided a comprehensive review of what was known so far about COVID-19 and pregnancy and lists the ways to 'manage' pregnant women who test positive for the virus, even suggesting separation of mother and infant. The shift of care in response to the pandemic has retreated to what David Floyd calls a "technocratic" approach to care which is damaging to the physical, mental, and emotional health of women and their families to say the least (Davis Floyd et al. 2020, Davis Floyd 2001).

When I began this work, a study centered on the diverse birth experiences of expectant families during the COVID-19 from the perspective of an anthropologist who was pregnant herself during the pandemic had not yet been done. My entry point for this research is that which confirms the body of literature related to the anthropological study of birth and takes a unique approach in autoethnography during a crisis, responding to calls for an anthropology of the good (Robbins 2013) or "bright spot ethnography" (Osterhoudt 2021).

1.1 Literature Review

Childbirth was rarely studied by early anthropologists primarily because of a gender bias (male anthropologists did not have access to childbirth in 'primitive' societies) but the omission can also be explained as a general bias of earlier generations of anthropologists towards social and cultural phenomenon rather than biological ones (Davis-Floyd et al. 1997). It wasn't until early scholars, namely Brigitte Jordan (1978) approached the anthropological study of birth ethnographically by comparing and contrasting cultural treatment and knowledge about birth in different societies which inspired countless others to take seriously the anthropological study of childbirth. This new interest emphasized the interacting aspects of biology and culture and not merely on ritual practices and food taboos. Jordan analyzed each culture's birthways as a system that made internal sense and could be compared with all other systems (Davis-Floyd et al. 1997). Jordan's book about birth in four cultures, Yucatan, Holland, Sweden, and the United States, in particular is a foundational work in this field which challenges the American obstetrical treatment of pregnancy, labour and birth as a medical event and argues that understanding birth more

profoundly requires us to consider the social and cultural aspects in addition to the biological elements (1978). She does this by pointing out that birth is universally treated as a life crisis and the immediate postpartum period as a time of 'ritual danger' for the family because of the existential uncertainty. As a result, people tend to produce practices and beliefs (social patterning) to deal with these aspects of the birthing event. She argues that birth is a candidate for consensual shaping and social regulation with the pattern coming to rely on local history, social structure, and technology (Jordan 1978). This work introduces childbirth as a culturally significant event and as a worthwhile subject of anthropological inquiry. I find these initial explanations of the birth event to be particularly useful in understanding that due to its universal biological nature, this sets the ground for a myriad of cultural treatments of the birthing event that manifest in diverse ways in human societies all over the world. This project, which explores birth under the circumstances of the COVID-19 pandemic has brought a new meaning to Jordan's idea of 'ritual danger' and contributes an analysis on rifts in North American birth culture[3] as it shifts social, political, biological, and economic circumstances that expecting families find themselves in.

Scholars such as Robbie David-Floyd, Carolyn Sargeant and Rayna Rapp (1997) represent the next generation of anthropologists of birth who continued Jordan's foundational work and produced research around birth that has engaged a more complex view of culture as produced, reproduced, and resisted as well as situating these cultural complexities in history, economy, and politics of particular contexts (Van Hollen 1994). Their book *Childbirth and Authoritative Knowledge* (Davis-Floyd and Sargent 1997) compiles a diverse set of essays that present ethnographic case studies on authoritative knowledge of birth from sixteen societies. They expand on the role of power in the social construction of authoritative knowledge on childbirth and paved the way for many other contemporary anthropological works not only on childbirth, but reproduction in general. These ethnographic findings have also underlined how birth outcomes in varying ethnographic

[3] My use of the term "North America" to describe the birth culture I interact with in this research is meant to reflect the normative dominant cultural norms and treatments of birth in primarily Canada and the United States, although I fully recognize the intricacy of local cultures as well as other North American countries which are not studied in this project.

contexts differ based on these cultural conceptions of the birth event (Sargeant and Bascope 1996). Davis-Floyd is one anthropologist of birth who also offers prominent works which have covered a variety of topics; cyborg reproduction and birth (Davis-Floyd and Dumit 1998), paradigms of childbirth (Davis Floyd 2001), birth models (Davis-Floyd et al. 2009), and more recently her research on birthing practices during the COVID-19 pandemic (Davis-Floyd et al 2020). Davis-Floyd's work provides us with a view into the ways cultural values around reproduction and birth are constructed, internalized and/or resisted and shows how the system is fashioned and contested in light of political, social and economic interactions (Van Hollen, 1994). Ginsburg and Rapp (1991) are other prominent scholars who in addition to seeing reproduction as a cultural event see it as a political one, which synthesizes the local and the global. My research also takes up the study of birth as a political event by exploring the impacts of the global (a pandemic) on the local (women's experiences of childbirth). They emphasize the importance of reproduction and recommend it be centered in anthropological inquiry, which this project does in the cultural and political context of the COVID-19 pandemic.

Aside from the subject of my research, the entry point in my approach is also derived from notable scholars in the field of an 'anthropology of the good' (Robbins 2013). Robbins argues for a shift away from the anthropology of suffering and instead suggests emphasis on topics including value, morality, well-being, imagination, empathy, care, hope, time, and change which he believes are capable of taking on a distinctive critical force of an earlier anthropology without the associated weaknesses. He says,

> "The point of developing this new kind of anthropology would not be to displace the anthropology of suffering, which will continue for the foreseeable future to address problems we need to face. It would be to help realize in a distinctively anthropological way the promise suffering slot anthropology always at least implicitly makes: that there must be better ways to live than the ones it documents." (Robbins 2013,458).

Taking up this call, we already have endless descriptions of the suffering of women at the hand of overly medicalized systems and my research builds on what has been done and

offers ‘better ways’ to do birth. Osterhoudt (2021) follows the same trend with her suggestion for “bright spot ethnography” looking for ‘things that work’ during a crisis instead of emphasizing failures which she argues can broaden the analytical potential of particular topics or fields of study.

My entry point to the body of literature first confirms research in the study of birth as both a cultural and political event and answering calls of scholars such as Robbins and Osterhoudt. My individual contribution is by seeing the issue through my unique autoethnographic lens.

1.2 Overview of the Research and Thesis Structure

My master’s thesis research is an anthropological investigation of expectant women’s experiences of childbirth under COVID-19 restrictions in Greater Montreal and Ontario. Using my perspective as a pregnant woman, trained birth doula and anthropologist, this project explores how heterosexual women navigate complexities of the birth experience considering the challenges that a global pandemic brings. Broadly, my research is concerned with how women faced birth and handled their transition to parenthood considering uncertain and changing conditions. What can we learn from a pandemic birth culture that may inform us of best birthing practices in the future?

Drawing on autoethnographic reflections, nine semi-structured ethnographic interviews conducted over Zoom, and a WhatsApp group chat, I found that what took place during the peak pandemic year (2020-2021) was an intensification of the typical medicalized North American birth which is based on a culture of fear. I document here the nuance in each woman’s experiences, including my own, to show the confusion and inconsistency we experienced as we tried to navigate our births and transition to parenthood. The interviews underscored an increased reliance on online supports. Although the online world was useful in finding alternatives to gaps in support left by the pandemic, part of my argument in the thesis is that it added to the mental load of some ‘COVID cautious’ women as they tried to locate supports that were comfortable and safe. Finally, the thesis outlines positive aspects of giving birth during a pandemic in addition to the negatives to get a more complete picture of what continued to work well despite the standstill in other areas of life.

The ongoing COVID-19 pandemic has put life as we know it to a stand still, political upheaval, severe social and economic disruption, resulting in many deaths worldwide: this is one of the deadliest crises to have hit humanity in decades. Pregnancy and birth are already known to be stressful and uncertain during normal times, so how was I and other women living in provinces with the highest COVID case counts in Canada expected to cope under the pressure? Birth as a basic human event, cannot be postponed or cancelled like so many other aspects of our lives, so studying how birth continued to happen despite the unprecedented circumstances is important to say the least. My contribution to the body of literature is significant precisely because it looks at the global impact on the intimate lives of women trying to navigate their reproductive experiences during a global pandemic.

The balanced approach utilized in this study, one that considers what works during the pandemic in addition to critiquing systemic shortcomings, allows us to see if and how culture changes under pressure and offers potential avenues for future improvement. How do women like me cope and bring new life to the world when life as we know it came to a standstill? Through lockdowns and curfews when most of society was worrying about contracting a serious respiratory virus, how was life in its inception being treated?

The thesis has three main chapters. Each uses personal analytical reflections from my own experiences during my pregnancy, birth and postpartum to thread together various themes, enhancing the autoethnographic quality of the study.

The first main chapter (Chapter two) situates the pandemic birth as an object of investigation. It asks the question, ‘what is a pandemic birth?’ Seeking to answer it by situating the phenomenon as a direct relative of the ‘typical’ Canadian birth. The chapter outlines the dominant cultural discourses that define the majority of births in Canada and the United States and suggests that a pandemic birth is a simply dialed-up or intensified version involving more fear and more uncertainty amidst changing circumstances. It analyses the confusion and inconsistencies in provincial health measures and their impact on birth for women. This first chapter is characterized by my journey of realization that I internalized ideas of a ‘typical’ North American birth to the point that it blinded me to what a pandemic birth actually was. As you might notice I move between the terms Canada, the

United States (US) and North America in my analysis. While there are grave differences in the health care systems, culturally, discourses around birth (as informed by media) can be thought of as sharing similarities. I use North America when referring to discursive elements of both cultures and specify Canada when referring to specific individual experience.

In the chapter three, I illustrate which supports women expected to have during their pregnancies and how those disappeared in the initial stages of the pandemic. I describe and analyze the innovative alternatives women came up with as a form of unwaged labour as an addition to the invisible load women bear. Using examples of 'COVID cautious' women, I demonstrate how the pandemic further disadvantaged women, making them feel guilty and overwhelmed with "worry work" to get essential support that was inaccessible in person. This reinforces the overall argument that Canadian society is generally not well equipped to help new families on their transition to parenthood.

The unexpected advantages of giving birth during the pandemic is the object of inquiry in chapter four of this thesis. It promotes a balanced view of the events during the pandemic so as not to reduce birth experiences to only negative or exclusively positive aspects. Centering on themes of bonding, connection, and improved access to some supports, I argue that the silver linings point to areas of weakness in North American treatment of pregnant and newly postpartum individuals. This chapter concludes my work with a call for a review of our practices by looking cross-culturally for practices that center women's physical and emotional needs in addition to those of the baby.

Through a variety of creative approaches, this dissertation at its essence is a critique of the dominant birth culture in North America which favors a risk-based and fear driven treatment of birth. This only intensified during the pandemic by limiting support options for women during this phase in the life cycle. It centers my own experience as a young, Canadian, middle-class Muslim woman living in Quebec who also drew on her position as a pregnant anthropologist. I was able to analyze the experiences of other predominantly middle-class Canadian women from a variety of cultural and ethnic backgrounds and what their experiences say about the problematic elements of the systems in which we conceive,

gestate, birth and parent. Taking the pandemic as a petri dish, to see how our birth culture plays out in a new environment showed us the essence of the system- not only the dysfunctional elements but also the things that did work so we know going forward how to support women in their journey not only for the sake of being better prepared for future crises but to improve our system in general, to lower mortality rates and improve outcomes and morale of experience for everyone.

1.3 Pandemic Timeline

To provide some more context and to make reading this work easier when it comes to restrictions and series of events, below I provide a timeline for the unfolding of significant points of the pandemic for readers to have a reference to better orient themselves. Although in many instances I use the past tense when referring to the pandemic throughout this thesis, at the time of writing this, the spread of COVID-19 is still very much present, and its impacts continue to ripple throughout our daily lives. The 'pandemic experiences' I refer to in this research speak to the most intense periods of the pandemic whose timeline I list below and garnered the massive media attention. It was challenging to provide dates for events specifically related to birth, such as points in time when exclusion of support people was no longer permitted or allowed once more due to the great variation and inconsistencies on measures at an institutional level (will be detailed in the next chapter).[4]

- March 11th - COVID-19 declared a pandemic
- March 21st - Gatherings in Quebec banned, new deaths as shutdown begins
- April 17th - Canadian Army called to help at long-term care facilities
- July 18th - Quebec becomes the first province in Canada to require mask-wearing in all indoor public places.
- September 2020-Second wave (Beta variant) begins
- December 2020- COVID-19 vaccinations begin

[4] Timeline points from my own recording of events, and (Government of Canada 2022, CTV News 2022)

    - Canada surpasses 15,000 deaths related to COVID-19

- January 9th 2021: Quebec implements a curfew
- March/April 2021: Third wave (Gamma variant) begins
    - Reopening in Quebec reversed due to third wave
    - Border between Ontario and Quebec closes to all non-essential travel
    - Quebec opens vaccination appointment slots to pregnant people before general public
- May 2021: Curfew ends in Quebec as gradual lifting of restrictions begins
    - June 2021: provincial boarders reopen while limited number of gatherings permitted outdoors
- September 2021-Fourth wave (Delta variant) begins
    - Quebec becomes first province to implement vaccine passport system
- December 2021- Fifth wave (Omicron variant) begins
    - Lockdown and curfew reinstated to control highly contagious variant
- January 2022- Canada surpasses 33,000 deaths related to COVID-19
    - Citizens protest COVID-19 mandates and protective measures in the capital and across the country
- May 14th 2022- Quebec lifts mask mandate for most indoor spaces (except medical settings)

1.4 Methodology

1.4.1 A Pregnant Doula Anthropologist

Once I found out I was pregnant in the Fall of 2020, I could not ignore the very personal turn this project had taken. I decided I was going to use this turn of events to my advantage and allow my experience to inform the research. As a birth doula I already had ‘insider’ knowledge of the birth world, and access to spaces where I learned how birth work was shifting weekly with implementation of provincial COVID-19 measures. Now, as a pregnant woman I also had the perspective of the client and the ideal participant for my

research. I was both ‘insider’ and ‘outsider’ (Narayan 1993). I experienced firsthand the stress and anxiety associated with mentally editing my birth plan with each new restriction, uncertain of what the landscape would look like when I would go into labor. This informed my research, the questions I asked and the connections I made in ways that would not have been the same had I not had my own pandemic birth experience.

The overarching methodology I employ in this project is autoethnography. Autoethnography is a theoretical and methodological approach that involves using personal experience to engage myself, others, cultures, politics, and social research (Denzin 2013). Autoethnography allows the researcher to consult the tension between insider and outsider perspectives, social practice, and social constraint. It uses a researcher’s personal experience to describe and critique cultural beliefs, practices, and experiences, uses deep and careful self-reflection to name and interrogate intersections between self and society, the particular and the general, the personal and the political (Lapadat 2017). Many anthropologists and social scientists have taken up the study of birth through a personal lens (autoethnography) for example Robbie Davis-Floyd who embarks on the anthropological study of birth after having a traumatic and what she concludes, a medically unnecessary cesarean birth (Davis-Floyd and Dumit 1998). Another example is that of Alma Gottlieb (1995) who narrates her journey of pregnancy and childbirth drawing comparisons between her life in the US and fieldwork in the Ivory Coast. She shares the story of how she navigates her pregnancy as well as trying to accomplish a natural birth in a highly technology and intervention-oriented environment, a great contrast from the types of births she witnessed during her fieldwork (Gottlieb 1995). While conception, pregnancy and birth are deeply personal, individual, and local experiences on the surface, as anthropologists have shown through decades of research, the study of these areas are entangled with public and global processes impacting their experience and outcome (Ginsburg and Rapp 1991). In this project, what best describes my use of this tool is how it represents the researcher in the process of ‘figuring out’ what to do, how they live and the meaning of their struggles. This has been particularly meaningful in my methodology in the context of birth during a global crisis.

1.4.2 Why This Field Site?

This research is multi-sited, one site being the everyday life as a pregnant woman in Quebec during the pandemic, whose real experiences are intertwined with a plunge into the virtual world, various virtual events, a WhatsApp group chat and Zoom rooms for a set of semi-structured interviews. The onset of the pandemic in early 2020 saw cancelled flights and countries restricting or halting travel altogether putting a pause on international trade and business. Everything from elementary school classes to baby showers went virtual as the whole country was instructed to stay home except for essential reasons. This shift required anthropologists to quickly adapt their methodologies and research techniques to the virtual world engaging in "digital ethnography" or "cyber anthropology" (Weber and Bookstein 2017). This field site has many advantages and conveniences, as well as limitations which I will outline below in the context of my project.

Following public health guidelines and provincial law, I found myself isolated at home with my three person 'bubble' for the better part of a year and my whole pregnancy. I attended classes online, held virtual tutorials for first- and second-year undergraduate students and planned how I would do my research exclusively on virtual platforms. Outside of work, I attended virtual doula meet ups, took classes geared towards expecting families, facetimed with my family in Ontario, and texted on WhatsApp with a group of friends in Montreal and Toronto (who I had not seen outside of the occasional masked porch visit or distanced walks in the park). The only time I went out was for daily walks and prenatal appointments where with my notebook and pen in hand I made observations about my experience.

The shift to online everything was easy to adapt to as it was a shift many institutions and organizations made to keep activities going. Online platforms have many advantages and especially in my case on a practical level; I would not have been able to do this program at Western had it not been virtual. Being pregnant and immunocompromised, working from home at my desk was the safest place for me to be. After the birth of my son, that same place was the most convenient, allowing me to care for him in the way I wanted while doing my research whenever he slept.

Pre-COVID-19, my pregnancy and birth would have interrupted my studies, however with everything being online, and the nature of my research this meant that my experience enriched rather than inhibited my project. This virtual field site perhaps made my ideal participants more accessible to me, as others who had recently given birth were not able to meet with strangers and bring their newborns with them. In the same way it was convenient for me, it made it easier to interview others who had also just given birth and would have made it difficult to meet in person, minimizing interruption to delicate sleeping or feeding schedules (Which I am also still trying to figure it out). Being able to connect with people in other cities and provinces that I did not live in was an advantage of this moment to conduct research.

While in my case the advantages outweighed the disadvantages; virtual research does have its limitations. This includes digital eye strain, exhaustion from sitting in one position for extended periods of time (especially while pregnant), what came to be called "Zoom fatigue", and a feeling of loneliness, a thirst for in person connection that cannot be quenched through a WIFI connection. It also exacerbates access privilege as the types of women I spoke to were those who could afford the time, had internet access, and had a safe home environment from which to speak to me. I recognize this as a limitation of this research in who I was able to reach and represent. A more in-depth future study could be designed to account for the diversity of experiences with a focus on those groups typically marginalized in health care.

1.4.3 Recruitment & Sampling

I made all preparations for data collection before my due date in May. Once I gave birth and after a short maternity leave, I had the appropriate supports to begin the data collection phase of my project. The "asynchronous focus group" was a WhatsApp group chat that pre-existed the project and did not require any special recruitment or sampling. I simply sought group members' permission and exported the chat transcripts into my files for analysis. To solicit interviews, I began posting materials on various social media platforms with the help of my supervisor and advisor. I also shared it with some doula colleges and friends to help spread the word. Soon I began receiving responses to my questionnaire where I was able to

see respondents' experience with birth, birth setting, age category, and other details that were useful in determining eligibility for the study. I soon began to get more responses and realized it would be much more than I could interview for the scope of this project.

I realized early on some limitations with the recruitment procedure, many of the participants who I interviewed had found out about my study from my supervisor's Instagram page dedicated to infertility. This of course influenced the typical age category and unique experience of infertility and individuals who went through In-vitro fertilization (IVF). Another limitation in the recruitment phase was my inability to have recruitment materials reach women who could be newcomers to Ontario or Quebec or others with little to no support, or where language could have been a barrier.

Seven out of nine interviewees were white women who were age 30+ and middle to upper socio-economic status (were on paid maternity leave, could afford day care, had good occupations (university professors, occupational therapists', teachers etc.) One woman out of the nine I was able to speak with identified as a visible minority, one as Indigenous and two as persons with visible or invisible disabilities. Although I was hoping for more diversity in experiences, this is who I got and could be telling in itself about the types of women who are available and willing to participate in such a project. All the women I interviewed lived and gave birth in Ontario even though I had hoped to have a similar number of Ontario to Quebec interviewees. I prepared Excel sheets to keep track of responses from the questionnaire and highlighted those I would be interested in speaking to hear the stories of a diverse group of women. I sent out many emails, some I never got responses to, and others did not show up for the interviews at the set time, so nine was the number I was able to do within my time frame. This is the uneasy business of sampling. There could be factors such as privilege, socially and economically marginalized individuals could have less support, time, and financial resources to be able to do an interview, or simply were no longer interested. Although I experienced uneasiness with my sample, in the end, this is what I had to work with.

1.4.4 Asynchronous Focus Group/ WhatsApp Group Chat

The WhatsApp group titled "BIZZZMFF"[5] originally created in 2017, is a group of eight Muslim women from diverse educational and ethnic backgrounds using the group to connect, ask and share advice pertaining to their lives as women, wives, and mothers. Two out of the eight women had just given birth shortly before the pandemic was declared and experienced their immediate postpartum months during the first lockdown. The other six (including myself) announced their pregnancies in the later months of 2020. Our due dates were spaced a month apart from January to June 2021.

This group acted as a real- time documentation of experiences of pregnancy, birth and postpartum during the changing restrictions from a diverse group of women. These naturally occurring conversations were undirected and happened at times which suited participants best. The instant nature of the WhatsApp platform allowed me to understand the experiences and document interactions between myself and other participants. The fact that the participants are known to each other enhances the richness and depth of data that was collected as important contextual information is already known to the researcher. Each participant has different experiences of birth during various points of the ongoing pandemic and this focus group sheds light on how they have been impacted by changing restrictions unique to their cities and situations and how they have navigated such restrictions as well as providing support and advice to others.

The women in this group all consented to participating in the research and filled out my recruitment questionnaire. Two of the women indicated they identified as people of colour, five as visible minorities, five as members of marginalized religious groups and three as a member of marginalized ethnic groups. Six are between the ages of 30-39 and one between 18-29 (excluding myself). All but one experienced their pregnancies and births in Quebec with the one who gave birth in Ontario. All had hospital-based live births with family doctors or obstetricians as care providers. Five had given birth before and three had

[5] This is an acronym for all the names of the women in the group compiled by one of the members. Any time a new member is added (which happened after data collection was completed for this project) the letter is simply incorporated to the name.

their first birth experience. Although the group is rich with data, I did not get to sit down and ask questions to each participant in the way that I did with interviewees thus there are gaps in my knowledge about things such as fertility issues experienced, losses, and details of 'figuring out' birth support. The data collected from this group was not generally used to provide direct quotes but rather guided my own background knowledge about the topics and experiences detailed in this study.

1.4.5 Semi-Structured Zoom Interviews

From September 21st to October 25th, I conducted nine interviews with women living across Ontario. These women came from varied educational and occupational backgrounds, experiences with infertility, IVF, pregnancy losses and births with different types of prenatal care and two types of birth settings (hospital and birthing centers).

Participants were selected based on their recruitment questionnaires and contacted by emails they provided. They were given the letter of information and consent in an email to review before the meeting and any questions or concerns were discussed prior to recording their verbal consent. Participants were also given the option to use a pseudonym, so many of the names in this study are pseudonymized. Interviews lasted anywhere from 40 minutes to an hour and a half depending on how much time participants had and what they wanted to share about their experiences. Many interviewees did the interview with their babies around, casually breastfeeding, playing with them, or holding and rocking them through a nap. I encouraged them to tend to their children as they needed, noting that I have a baby as well who could need me at any point during our session. I created an interview guide which included broad questions about pregnancy, birth, and the postpartum experience during the pandemic, but I adjusted questions based on the flow of the interview. I began each interview with a brief introduction before asking the participants to share with me their birth story. I did this to get a general understanding of their experience before revisiting points I was interested in developing.

1.4.6 Interview Participant Descriptions

All the participants had husbands who accompanied them as the primary support person during their labour and birth. None of the participants hired birth doulas although some indicated they might have been it not for the pandemic and associated restrictions. Every birth experience is unique, and I certainly heard a wide variety of stories, from precipitous labors in a bathtub at a birthing center to traumatic cesarean births (C-section) after hours of labor. I heard nine unique birth experiences.

Of the nine interviewees five were first-time birthers and four had given birth before. four of the women had struggled with infertility and had gotten pregnant with IVF. Five participants had midwives as their primary prenatal care providers and four had family doctors or obstetricians. Some of these participants had to have their care passed on to obstetrics due to complications but returned promptly to midwifery care immediately after the birth. Seven births had taken place at hospital and two had occurred at a birth center. I had no response from anyone who had given birth at home. Five women had to be induced between 38-41 weeks (about nine and a half months) for various reasons and four of these ended in C-sections. One participant said she suspected she had contracted COVID-19 in January 2020 before tests were available and one participant shared that she had contracted the virus two weeks before her due date. No other participant shared that they got COVID-19, but it was assumed that they had never contracted it. Although participants were not asked about their vaccination status, many mentioned they had gotten the shots during or after their pregnancies.

After a participant shared their birth story, I began to ask clarification questions about the general context before asking questions relating to their birth setting, experience preparing for the birth, anything negative and positive about their experience giving birth during that surprised them and any advice they would give their past self or another woman who was going to give birth during the pandemic among other discussions. Comparisons between previous birth experiences and this one often came up before I had the chance to ask, and discussion of various supports and services were discussed at length with each participant.

Many quotations taken from interviews used in the study were altered to remove identifiable information as well as to make them more grammatically sound and clear whilst maintaining the integrity of what was said.

1.4.7 The Role of Different Data Sets in My Analysis

As moved through the research process and my pregnancy, I came to understand myself as a knowledge broker interacting with the different communities and platforms, I found myself a part of or interacting with during and after my pregnancy and research period. Being a newly trained doula and having had the chance to support a birth in person (and a couple virtually) I could use the knowledge I was gaining in those spaces available to me to understand one side of the pandemic birth experience in Montreal. On the other side, being a participant in the WhatsApp group chat, I could share updated information about how the hospital birth experience was looking like in the different hospitals me and my friends were going to give birth at as well as discuss other aspects of birth sharing insights gained from my perspective as a doula when appropriate.

The different data threads that have turned this project into what it is necessitates an explanation. I used my various data sets (being a doula, conducting online ethnography and interviews, participating in a WhatsApp group as well as my own ‘pandemic’ pregnancy, birth, and postpartum experiences) in different ways. Although the bulk of quotes and experiences shared in this research derive from my interviews and personal encounters, the role of the group chat and role as a doula remain central to the findings described throughout the chapters. These two communities in particular served as the bulk of my understanding about birth which allowed me to approach this subject in the first place. As a doula, understanding how to support an expectant family, communicate effectively in difficult situations especially during a pandemic and being empathetic and supportive when things do not go the way someone intended have served me in this project but also beyond. Having a group chat, which offers an intimate view into the lives of fellow mothers and sisters is also invaluable to reaching many conclusions described in this research. My position as an anthropologist allows me to braid together my own birth experiences as a first-time mother, a doula and a member of a community of women to paint a picture of

what birth during a pandemic involved from various angles, offering a unique and encompassing original work.

1.4.8 Note on Use of Terms

Although the trend in recent research related to birth and women has favored gender neutral language, all the participants in this research identified as cis-gender women therefore seeking to represent them for what they are I mostly use “women” and “mothers” whilst occasionally using gender-neutral language.

Again, I use “North America” to encompass both the United States and Canada since the media discourses are identical and other cultural elements are very similar when it comes to experience of pregnancy, birth and postpartum. Although there exist major differences in access to healthcare, the level of integration of midwifery in the broader system and neo-natal and maternal health outcomes.

1.5 Conclusion

The COVID-19 pandemic continues to expose cracks and inequalities in the Canadian healthcare system, especially in caring for expectant families as they have seen many of their rights during birth overridden. By giving a voice to women and placing their narratives at the center of this research, we facilitate the space to overcome potentially negative birth experiences and long-term consequences of such events. My hope is that this research, and other pandemic-based humanistic studies will help inform institutional improvements to advance more holistic modes of care in the interest of expectant individuals and their children. While COVID-19 is not by any means “over” as I write this, we can work to make this time valuable in generating insights to help develop strategies to better support women during a crisis and enhance their experiences during non-pandemic times.

2 Chapter Two: What is a Pandemic Birth?

I have always been intrigued by the process of human reproduction and in particular pregnancy and birth. After my undergraduate degree, I considered becoming a midwife, but before committing to another four years of school, I decided to first test the waters with a birth doula training in June 2020. A few months later I was offered the opportunity to do my master's (virtually) where I combined my love of anthropology and interest in birth to study its manifestation during a pandemic with my new perspective as a doula. Little did I know the project was about to become much more personal after I discovered I was pregnant just a few days before the start of the fall term.

For nine months I was engaged in an embodied experience supporting the growth and development of my baby. On an intellectual level my understanding of birth grew too. I read journal articles, book chapters, newspaper articles, scrolled through endless Instagram, and Facebook posts, attended virtual events, and spoke with other women who had experienced birth during the pandemic and otherwise. I went to prenatal appointments with my notebook and pen in hand, jotting down my observations of the care I was receiving and anything else COVID-19 related. I experienced pregnancy through different waves of COVID-19 infections, through lockdowns, curfews and the closing of provincial borders that separated me from my family. As months of imposed and voluntary isolations went by, I began to feel overwhelmed as my due date loomed. The pandemic situation around the time of my birth was still unclear. There were so many unknowns that I could not plan for despite all my research. Would my parents be able to come for the birth? Would the doula I hired be allowed to support me in person? Would we have to drive to the hospital during curfew hours? Would I be OK laboring with a mask on? Or the worst fear of all, would any one of us contract the virus during our hospital stay?

When I was exactly 41 weeks pregnant, I went in for a routine test which found that I had very low levels of amniotic fluid, and it was recommended that I be induced. After consenting, my pandemic birth experience was finally beginning. Everything I had read and prepared for led me to this point and yet, after some separation from my husband in triage, and an obtrusive swab up my nose, anything pandemic related faded away from my

attention. I was working hard through labour, birthing my baby, and recovering. All my worries and concerns about air quality, exposure to infected staff or anything pandemic related at all was just not salient in the way I had expected. I was too busy giving birth to think about the novel coronavirus until I put my mask back on three days later to go home with our new baby boy. I was surprised that my experience seemed like a relatively 'typical' hospital birth experience.

So, what was I doing studying pandemic births when there was nothing too 'covid-y' about it after all?

2.1 Introduction

This chapter walks you through my quest to 'figure out', what is a pandemic birth. After giving birth myself, as expressed above, I was surprised at how uneventful it was in terms of COVID-19 protocols impacting the physical experience of labour and delivery. I was conflicted about what this meant for my research, initially blaming fear inspiring media discourse for warping my expectations. I anticipated it would be worse because I was repeatedly told it was going to be. It was not until the later stages of my project when I realized the masks, COVID-19 testing, and protocols were distracting me from understanding the reality of what was happening. I had difficulties describing what a pandemic birth was because I had internalized the generally biomedical and technocratic routines and practices of a 'typical' North American birth. I was so engulfed in the birth world that I could not see what was right in front of me, and worse, happening to me.

In this chapter I suggest that pandemic births are no different than the typical North American hospital births except that their usual features are simply augmented. Discourses of risk, uncertainty, fear, and anxiety already make up the mainstream understanding of what birth involves (Cummins 2020, Luce et al. 2016). This makes it hard for women including myself, to see the effects of the pandemic on their own experiences. We are already generally accustomed to the cascade of interventions, unnecessary inductions and high rates of cesarean sections that makes it difficult to discern how the pandemic simply enshrined these practices in most cases.

To unpack this complex phenomenon, I first elaborate on the broader cultural context of birth in North America on macro and micro levels. This includes a brief discussion of dominant discourses about pregnancy and birth and how pandemic birth discourse echoes these patterns. The next section describes women's views on how the pandemic impacted their births followed by a discussion of inconsistencies in public health guidelines, hospital protocols and other measures on provincial, municipal, and institutional levels across Quebec and Ontario. This chapter illustrates the varying degrees of influence these protocols had on diverse experiences which make it challenging to see pandemic birth experiences for what they are. COVID-19 births point to the underlying systemic and cultural shortcomings when it comes to North American pre- and post- natal care.

2.2 North American Birth Culture

The dominant North American treatment of pregnancy and birth today is characterized by a medicalized approach to care with most births taking place in a hospital setting. The rapid development of biomedicine at the start of the 20th century saw birth, which traditionally was the exclusive domain of women cared for by midwives in home settings, rapidly become a male dominated obstetrical practice in medical institutions (Davis-Floyd and Sargent 1997). The cultural shift was so dramatic that midwifery practices were banned in most parts of North America, some even until today. It was not until 1994 when midwifery in Canada was reinstated as legal in most provinces and midwives could practice autonomously whilst being well integrated into the health care system (Daviss 2016). The growing orientation towards science, technological development, economic profit, and patriarchally governed institutions reflects the core value system of society, rather than evidence-based practice as Anthropologist Robbie Davis-Floyd argues, "The western medical system is less grounded in science than in its wider cultural context; like all health care systems, it embodies the biases and beliefs of the society that created it" (2001, S5).

In her study of North American birth, Robbie Davis-Floyd (2001) describes three paradigms of health care; The technocratic, humanistic, and holistic, which to varying degrees influence contemporary childbirth in the west. The dominant approach of the typical hospital birth is primarily characterized by the technocratic paradigm, whose key

tenets treat the body as a machine, practice alienation of practitioner from the patient, having a hierarchical organization and standardization of care, as well as diagnosis and treatment coming from the outside-in. This biomedical approach to care sees the mechanical and dysfunctional birthing body as constantly in need of technological surveillance and intervention and in practice this model can cause harm to both mother and baby (Davis-Floyd et al. 2020). In North America, this harm disproportionately impacts racialized people such as black and indigenous women which also points to the systemic racism plaguing these institutions (Davis, 2019). In reaction to these excesses in the health care system, there is a growing trend from within to reform and humanize the technocratic experience, making it more relational, partner oriented and compassionate which is characteristic of the latter two, humanistic and holistic paradigms (Davis-Floyd, 2001).

Whilst most births take place in hospital settings with doctors, there is a growing popularity in midwifery care supporting out-of-hospital births (OOH). Midwives in Ontario and Quebec can care for women birthing in hospitals, birth centers, and home settings. The midwifery system in Ontario for example, has been described by foremost birth anthropologists as “a birth model that works” because of the unique integration they have in the health care system which facilitates their philosophical goals relatively successfully (Davis-Floyd et al 2009). Unlike in obstetrics, midwives lean towards the humanistic and holistic paradigms which cover a rich variety of approaches and is based on principles of connection, integration, oneness of body, mind and spirit and often treats the body as an energy system (Davis-Floyd 2001). Davis-Floyd argues there is room to incorporate elements from all three paradigms to revolutionize our approach to childbirth in North America (Davis-Floyd 2001).

2.3 Birth Discourse in Media

Women’s perceptions of birth in North America are mainly shaped by dominant discourses of risk and uncertainty disseminated through media representation (Vitek and Ward 2019). The absence of birth from the average daily life in western culture has left a gap in basic knowledge and first-hand experience with childbirth, making media representations the only opportunity to see one (Luce et al. 2016). North American discourse around birth is characterized by risk, blame and responsibility which are disseminated through media

outlets and have been found to influence women's choices when selecting a birth setting (Coxon et al. 2014). An absence of natural progression, uneventful labour and deliveries means women may be more likely to choose a medicalized birth at a hospital since they have the idea that it is safer (Coxon et al. 2014). In their study of how discourses of risk, blame and responsibility influence birthplace decisions for women in England, Coxon et al. use sociocultural theories of risk to focus their analysis and argue that planning place of birth is mediated by cultural and historical associations between birth and safety, and is further influenced by prominent contemporary narratives of risk, blame and the responsibility. They conclude that even with high-level support for 'alternative' settings for birth, these discourses constrain women's decisions, and limit opportunities for planning birth in settings other than in hospital. They contend that for any shift to occur alternative settings would need to be positioned as a culturally normative and acceptable practice, suggesting the role of the media to be important in this regard (Coxon et al. 2014, 64). Others like Luce et al. (2016) describe the media influences on how women engage with childbirth and that dramatic television portrayals of birth may perpetuate the medicalization of childbirth. This study explores how dominant discourses are portrayed on television shows, news reports and books but have also made their way into new forms of media on the internet and social media platforms such as YouTube, Instagram, and Facebook. Although these are spaces used for reproducing and reinforcing dominant discourses, they are increasingly becoming spaces for interacting with and challenging them. Thus, suggesting that midwives need to engage with television producers to improve the representation of midwifery and maternity in the media (Luce et al. 2016). It is important to understand how dominant birth narratives have shifted during the global pandemic and how they impact women's choices and experiences of birth.

2.4 A Picture of Birth During the COVID-19 Pandemic

In March 2020, when fear of the virus was at its peak and most of the world was under lockdown, reports of women having to labour and give birth alone in hospitals surfaced, alarming many expectant individuals as well as birth workers and activists (Aquadro 2020). Not only were these people not allowed to have even one support person accompany them, in some hospitals parents who tested positive for the coronavirus or presented symptoms

were separated from their newborns and skin to skin, breastfeeding and rooming-in were often prohibited (Davis-Floyd et al. 2020).[1] Hearing of this simultaneously horrified me and drew me into studying birth during the pandemic. I suppose it was out of these stories that the phenomenon of the 'pandemic birth' emerged. Although on the surface, birth manifests differently from woman to woman in various places and phases of the pandemic, this section will review some of the common characteristics of birth during the COVID-19 pandemic connecting to its North American roots.

The pandemic has exposed cracks in the health care system which have manifested in prenatal care and birth as well. Severe staff shortages, lack of adequate supplies of personal protective equipment and rapidly changing measures and protocols through waves of the pandemic are all unprecedented pressures which have impacted the experience of birth. Expectant women have faced major changes to their birth experiences considering these difficult circumstances including alterations to their birth plans, limited in-person support, no visitors, limitations to pain management strategies, wearing a mask, having to be tested, and/or changing health care providers or birth settings (Gildner and Thayer 2020). Birth workers such as doulas had to adapt their hands on services and find creative new ways of supporting their clients like using the virtual realm (Castenada and Searcy 2020). Growing pressures on the health care system ignited longstanding debates on the safety of OOH births and hospital births alike. A study by Gildner and Thayer (2020) found many women have been motivated to give birth OOH for fear of exposure to the virus. On the other hand, they found many women have also shifted their plans in favor of birthing in hospital fearing possible complications were they to contract the virus during labour and to guarantee themselves a spot at a hospital in the event an emergency transfer could be needed. The point I am trying to reach is what Gildner and Thayer (2020) suggest, the main motivation for these choices seems to be fear driven, whichever direction it pushes women in. While on the surface pandemic births seem to be characterized by changes to the typical labour and delivery experience mentioned above, we can say some women have been driven into opposite directions out of their immediate fear of the virus and underlying fear of birth. These are findings confirmed by Statistics Canada. Preliminary data has shown that although the *number* of non-hospital births in 2020 remained lower than numbers from 2014 to 2017, the *proportion* of non-hospital births in 2020 (2.1%) was the

highest it has been in more than a decade. This spike was most notable in Ontario (3,187 in 2019 to 3,861 in 2020) (Government of Canada 2021). My research focuses on the nuance in these diverse experiences and how they point to the problematic nature of our basic treatment of birth on a normal day and especially during a pandemic.

Discourse around birth during the COVID-19 pandemic echo dominant North American narratives. During this crisis, there has been a reversion in obstetrical practice to a more technocratic treatment of birth (Davis Floyd et al 2020). A Canadian study conducted by medical anthropologists have demonstrated the heavy use of biomedical interventions during perinatal care such as women being offered and accepting elective inductions out of fear of potential institutional collapse (Rice and Williams 2022). Emergent research from Europe has also shown significant increases in labour inductions, instrumental deliveries, NICU transfers in addition to those who delivered during the first wave of the pandemic being more likely to experience adverse effects postpartum (Wagner et al. 2022).

If pre-COVID-19, birth was treated as a potentially dangerous and risky event, then the threat of a novel respiratory virus shutting down society enhances a fear driven treatment of birth. These threats have been portrayed in the media which reinforce fear-based choices, something I experienced first-hand. Here are a few examples of common headlines from major Canadian news outlets a pregnant woman like me may have encountered; “COVID-19 during pregnancy means 10 times higher risk of ICU admission, Canadian data suggests” (Pelley 2021) or “COVID-19 fears spark increased interest in home births, midwives say” (Perkel 2020). Repeated exposure to this content, portraying birth during a pandemic as a stressful, risky, and fearful experience even while I was critically engaging with them, I could not help but feel like I internalized them and allowed them to shape my expectations for what birth during the COVID-19 pandemic would really be like. As much as I wanted my version of a ‘natural’ hospital birth with no interventions, it was hard to unlearn narratives of risk and fear when thinking about childbirth which, as I came to realize later, was precisely why it was difficult for me to see a pandemic birth as simply an amplified version of the common North American birth.

During my data collection, I heard from women like Zahra whose experience of birth during COVID reflected dominant discourses. Zahra, a Muslim woman in her thirties gave birth for the first time in a Toronto Area hospital and felt like giving birth during COVID-19 was terrible, “I think the pandemic sucks overall but giving birth in a pandemic is just really not fun, I think it's one of the worst things of this pandemic.” She compares her experience to a friend who had to give birth alone via C-section in April 2020 who ‘had it worse’ saying, “when I hear about the experience of other women around me, I think I was one of the lucky ones to have had the experience that I did.” Zahra perceives her pandemic birth as a terrible and a traumatic experience, yet when she compares her experience to her friend's, she expresses gratitude and relief at how her own birth went. This points to the possibility of internalization of birth as a fearful and typically traumatic experience.

Repeated exposure to such discourse on pregnancy and birth during COVID-19, overwhelmingly associated with fear and negativity gave me the impression that giving birth during the pandemic would be a nightmare and require lots of preparation, and intense support for it to go as I had imagined it. However, after giving birth myself, despite the medicalized nature of how it unfolded, I was initially taken aback at how ‘routine’ it was. I did not perceive it as being like the horror stories I had heard and despite being extremely ‘COVID cautious’ throughout my pregnancy, the fact that I was not even paying attention to my mask or giving the virus a second thought surprised me. I was confused until I began speaking to more interview participants when it seemed their experiences confirmed mine. Klara is one such woman, a second-time mom in her 30s who gave birth in hospital (was transferred from midwifery care due to complications) She shared,

> “It's strange if you didn't bring up COVID. There was very little talk about COVID in lots of ways…. I do not remember feeling, by the time I was in the hospital and in my room, like it made any difference that COVID was going on.”

Mary is another woman who gave birth to her second child in May 2021 at a birthing center in Ontario and shared similar sentiments, “it’s looked pretty much the same except for the addition of masks, it was everything before and everything that's has come since that has been so different.” Both participants had pre-COVID-19 birth experiences to compare their

recent experience with which led me to think that the pandemic indeed did not have much to do with the physical experience of the intra-partum period. However, as the interviews went on, when I spoke with Hannah and others my initial hypothesis started falling apart. Hannah, a first-time mother in her 30s whose fertility treatments were interrupted by the pandemic, explains that when she was laboring at an Ontario hospital and became fully dilated, there were not enough staff and medical personnel present to receive her baby. She relates,

> "They said don't push because we're short staffed, because the nursing staff is just not adequate here. We don't have enough people around to have you deliver this baby right now, so don't push, keep the baby in."

Hannah was left for a couple of hours before the appropriate staff trickled in and she had the physical urge to start pushing.[6] This demonstrates an example contrary to mine, Klara and Mary's experiences where the actual physiological dimension of her labor and delivery was directly impacted by staff shortages likely resulting from the pressures on medical institutions caused by the pandemic.

These contradictory stories challenged my understanding of a "normal" or "routine" birth experience versus a COVID-19 birth experience. What further complicated this process was hearing from women who were more satisfied with their birth during the pandemic than they were with a previous birth experience, contradicting dominant discourses of a pandemic birth. Annette for example, who was under the care of midwives at a birth center in Toronto, had a frightening experience after an emergency transfer to hospital with her first child. However, her pandemic experience in April 2020 was what she described as "the birth of her dreams"; A fast labour, giving birth unmedicated in a tub at a birthing center with her husband by her side. Annette explains the pandemic factors that allowed for this experience to happen, such as having extra help at home from her sister who was stuck in Canada because of lockdown as well as increased access to virtual resources which she used to physically prepare her body for the birth she wanted. Giving birth during the

---

[6] The epidural is known to delay the physical sensation of pushing especially for first time birthers

pandemic made her feel brave and resilient, choosing a home birth as a backup option which she would not have done otherwise (See chapter four for more on pandemic "silver linings"). Hearing this range of experiences made it difficult to paint childbirth during COVID-19 with one brush. To add more complexity to the picture, the next section highlights the confusion and inconsistencies of safety measures and protocols at various levels of government and institutions whose uneven application shaped birth during the pandemic. This accounts in part for birther's diverse experiences, but also adds increased uncertainty as a defining characteristic of a pandemic birth which I argue is a dialed-up version of an overly medicalized birth in North America.

2.5 Confusion and Inconsistencies of COVID-19 Measures

My research found that the safety measures, or protocols put in place on various levels of society also had a profound impact on birth during the COVID-19 pandemic. Rapidly changing rules and regulations on the federal, provincial, municipal, and institutional levels shaped reproductive processes, from infertility treatments to prenatal care, childbirth, and postpartum. Due to the novelty of the virus, and the scientific community trying to understand it and its variants, this has left room for differences in the treatment of birth across the country. These differences vary not only from one province to another but even from one hospital administration to another, be they two hospitals across the street from each other, as I found in my own city. Inconsistencies here refer to different protocols- mostly in hospital experiences- regarding COVID-19 screening processes, (being tested or not), inconsistencies in communications between primary health care providers, provincial mandates, and other institutional policies. Variability also depended on who was on staff any particular day, as one participant working on the front lines shared. This irregularity in the treatment of childbirth during a pandemic has led to confusion and uncertainty in what a pregnant individual could expect and, in many cases, negatively affected their experiences. In this section I will explain how the changing circumstances surrounding pandemic births were made more uncertain because of the inconsistencies.

The difficulty of accessing up to date information about protocols at the time women neared their due dates is one area where inconsistencies were experienced. Birthers were obligated to find information on their own using a combination of sources including

Facebook and/or WhatsApp groups, calling their hospital directly, hospital websites, Instagram accounts and often cited that asking their primary health care provider was not helpful. My own care provider who was expected to attend my birth could not tell me what pain relief options (like noxious oxide, or the bathtub) were available at the hospital she worked at or inform me of any other restrictions that would impact my birth plan and birth experience. Many women I spoke to have the same troubles, not knowing who to go to for the most accurate and up to date information complaining that hospital websites were rarely posting updates. One participant in the WhatsApp group shared her frustrations and worries with hospital procedures for testing which took too long and could impact the options she had for achieving an unmedicated birth,

> "What sucks is that if I go into labour at night, COVID tests are not analyzed until the next morning, so I won't get my results until like after 8am the next day. Which means I will have to be wearing a mask at all times and I cannot use the water bath."

What is particularly frustrating and insensitive about this policy- receiving a negative test result before being able to remove the mask during labour or utilize the water bath is that some births are very short and in many instances a baby would be born before results would be analyzed, as was the case for this mother. This begs the question, why were test results for women in labour not a priority, or even necessary in some hospitals while not in others, what is the best practice? Zahra is another woman, who delivered her baby in October 2020, explaining her experiences with the inconsistencies,

> "At that time, in fall of 2020 things were just very, very uncertain. Things were changing so quickly, and there were new laws in place, and I think they would extend the lockdown every certain number of weeks so just the uncertainty of it all, and again the fact that things were a mess. I don't remember exactly what questions I was asking, but I would try and ask questions to various offices or my gynecologist and my family doctor and they just wouldn't have answers, or they would be inconsistent, there are a lot of inconsistencies"

Zahra's experience also illustrates inconsistencies on a municipal/regional level. Two weeks before her due date, Zahra began feeling unwell and had every symptom of what she thought was strep throat, unfortunately she ended up testing positive for the coronavirus as her due date loomed. It was stressful to deal with the thought that at any moment she could go into labour and must give birth alone, she received regular phone calls from a public health nurse walking her through what she would have to do if she went into labour during her quarantine. Zahra expresses how she felt, "my biggest fear was also possibly having go to the hospital in a cab and giving birth alone, because that's what the public nurse reminded me about two or three times a day for about a week." Thankfully, Zahra did not go into labour and at 41 weeks and two days pregnant she was cleared from COVID-19 and was scheduled for an induction. She had been in communication with her health care provider about her situation and was told that the team at the hospital were informed of her case and the hospital would be expecting her. Though she was given official clearance in a document by the local public health nurse, when she went to the hospital for her induction, she says she was treated very roughly and almost pushed back to the entrance by a nurse at reception who was "freaking out" about her having just recovered from the virus. Zahra explains how unpleasant this was for her, though the rest of her experience was "smooth sailing." This is one example that shows inconsistencies between organizations in the same area who would be expected to work together on issues related to COVID-19 infections.

In the months I was closely following the situation of COVID-19 and birth, I also noticed differences between hospitals in screening procedures. For my own birth I was made to be tested for the coronavirus despite being asymptomatic, but my husband was not, in another hospital in the Greater Montreal Area a friend and WhatsApp group participant was tested in addition to her husband (also asymptomatic). While I was interviewing women in the Greater Toronto Area, none of them or their support people were tested at all, if they were not displaying symptoms. At one point I even stopped asking participants if they had been tested thinking it was not important, until I spoke with Steph, a mother of three living in a small town in Northern Ontario.

Steph's pandemic birth experience was her first surrogacy journey which she described as traumatic because of the inconsistency surrounding the COVID-19 testing. Steph was being

followed by a midwife and planned to be induced at a local hospital out of precaution since her baby was measuring big. She describes her experience initially as very confusing when it came to understanding who would be allowed to accompany her and the baby and who would need to get tested and when. She explains that the intended parents were tested after arriving from their travels to attend the induction (which was twice delayed due to intensive cleaning protocols between induction patients). They were told at reception that her husband would have to be tested but she would not, however no one ever came to perform it. After an unexpectedly long labour, and presumed dystocia[7], a C-section was called to get the baby out safely. Once in the operating room (OR), someone asked if everyone had their COVID-19 tests done, to which one of the care providers replies that Steph and her husband had refused – which Steph describes as inaccurate since in the ten hours they had been at the hospital no one came to test them. This confusion with the COVID-19 test ruined the rest of Steph's experience at the hospital, she says, "I feel like that whole issue about the COVID test stirred up so much of the drama and the tension in the OR." After an extremely unpleasant experience in the OR, Steph was threatened that she would be isolated for ten days, and her husband would have to leave if they did not agree to take a test. She was refused to spend time with the baby until 12 hours later when her test result came negative (she was asymptomatic the whole time).

The disorganization and confusion they experienced with this one measure that was meant to protect everyone, instead caused harm to the most vulnerable person, the birther herself. Steph, who was five months postpartum at the time of our interview shares, "I gave birth in May, and I still have extreme pain in my stomach, and they missed part of the placenta which they found eight weeks later, I had retained placenta." Steph attributes this to the tension in the OR causing doctors not to clean her uterus out adequately. She had not been contacted by any health care provider about treating her situation despite her efforts and was still in pain when we spoke.

---

[7] a slow or difficult labour and/or birth

This makes me question what rights a birthing person has and are actually respected and protected at institutional levels in these regions and how COVID-19 has exposed these issues in the health care system, especially for someone like Steph who was in a sensitive position. Of course, one reason that could explain these inconsistencies can be staff shortages due to the increasing burden on hospitals and Steph's birth story points to the very real impact of COVID-19 protocols on a birth experience. To drive the point of this chapter home I re-evaluate my own experiences on what I uncovered a pandemic birth is.

2.6 Re-Evaluating My COVID-19 Birth Experience

After realizing that perhaps the reason why I thought my experience was so "routine" and not impacted by COVID-19 very much was due to my own internalization of birth as a highly medicalized and uncertain time, I began to see my experiences in a different light. When I was 41 weeks and one day pregnant, I was sent to the hospital to have some routine testing done to ensure my baby was doing well. I had been there for several hours waiting alone. I was a hungry, masked, and heavily pregnant woman expecting to be told everything was alright, to go home and await a natural initiation of labour, fully confident in my plan for as 'natural' as a hospital birth could be. To my disbelief, I was shown on ultrasound that the fluid levels in my baby's amniotic sac were too low and I was told I would have to be induced. My heart dropped and I knew I had to advocate for myself since no one else was there to support me. I nervously called my husband and doula to see what the evidence suggested and what options I had to proceed. I remember feeling so stressed and helpless while trying my best to make an informed decision when I heard the staff on the other side of the curtain say, "the patient has consented to be induced.." before they had even spoken with me! From that point until my son was born, I experienced an unexpected hemorrhage, was told I should not eat, was not allowed to wear the clothes I was comfortable in, I consented to the full cascade of interventions and finally an epidural when other preferred options for pain relief were not available due to the pandemic. I was not supported in the pushing method or birthing positions I wanted to try and to top it all off my placenta was thrown out after I had explicitly said I wanted to keep it for a while. With all of this, I still felt like the coronavirus did not play a big part in my birth? This is the point I realized I was so desensitized to the highly medicalized nature of birth in North

America. Maybe the surface things like wearing the mask and being tested for the virus or the unit being short-staffed did not impact me in the way I expected it to after hearing horror stories from my participants and the media, but my birth experience was a pandemic birth nonetheless, more fear, more uncertainty and more North American than ever.

2.7 Conclusion

This chapter has described the complexity of a pandemic birth to provide the necessary background for the coming chapters. First, a pandemic birth requires a broader perspective that stretches from pre-conception and continues through pregnancy and delivery ending with the transition to parenthood well into the postpartum period—these can't be disentangled. Pandemic birth was found to be an extension of North American birth, highly medicalized and technocratic, dominated by discourses of fear, risk, and uncertainty. These recurring themes were amplified during the pandemic as we saw when studying the inconsistencies and confusion caused by changing protocols. I found through my research and personal experience that while it is possible to engage critically with and challenge these discourses, I am not immune to the effects they have on my perception of birth. Influenced by the media and stories I had heard, I expected birth during the pandemic to be much worse than I initially felt my own experience was. However, it was only after a deeper analysis of my autoethnographic and interview data that I realized I had internalized the essence of North American birth. What I initially thought was a relatively routine experience turned out to be a truly North American one. When I revisited my experience, I realized it was fear driven, giving in to unwanted interventions, plagued with anxiety at the uncertainty of circumstances around my own birth.

3 Chapter Three: ‘Building A Village’ During A Pandemic: Increasing the Invisible Load & The COVID Cautious

After witnessing many of my friends start their families before me, I saw how special it was to have other pregnant friends during your own pregnancy, someone who understood your feelings first- hand- and shared the ups and downs of a nine-month anticipation. During the second wave of the pandemic after becoming pregnant myself, I discovered that five out of seven of my friends in our WhatsApp group were also expecting, with due dates exactly a month apart. It felt surreal that we were all experiencing the same thing at the same crazy time, but I was deeply disappointed that we would experience most of our pregnancies in isolation from each other, despite living in the same city and having interconnected lives. So how did we manage to still act as each other’s ‘village’ despite the curfews, lockdowns and other restrictions straining Quebec society? We had to be creative, combining online and offline modes to stay connected in ways that were comfortable for everyone; An active WhatsApp group, distanced porch visits, meal trains, virtual prayer sessions, baby showers, gender reveals and hangouts on Zoom, all safe spaces to ask questions and discuss anything from heartburn to breastfeeding and beyond. My sisters were there for me and each other in so many ways at the press of a (few) buttons that made my pandemic pregnancy less lonely. Although these activities were essential to my support network and relieved me in so many ways, behind the screen was a mother whose invisible load weighed heavier than it would have been in ‘normal’ times...

3.1 Introduction

Long before the pandemic, research has shown that most household responsibilities fall on the shoulders of women and mothers who bear the brunt of emotional and cognitive labour compared to their male counterparts. What has been called by many names, including ‘the invisible load’, ‘worry work’, or ‘the mental load’ is essential labour to keeping households afloat and has attracted more attention in the wake of the pandemic (Hogenboom 2021, O’Reilly 2020). When discussing the impact of COVID-19 on women, the United Nations Secretary General comments, “the pandemic is deepening pre-existing inequalities, exposing vulnerabilities in social, political and economic systems which are in turn amplifying the impacts of the pandemic” (United Nations 2020). The pandemic exposed

the extent of the invisible work women do and how central it is to societal reproduction (O'Reilly 2020). In this chapter, I ask, how do middle-class women in this study manage to build their support networks when most anticipated support systems disappeared? Did this create an increase in the mental/invisible load they carry as partners and mothers?

Unpacking my own experience being 'COVID cautious' as well as those I interviewed, I argue that while 'virtual village-building' during the pandemic offered these women a way to safely connect with others to aid their transition to parenthood, it also hid within it a large amount of extra mental and cognitive labor with higher stakes (risk of severe consequences) for mothers trying to keep their families safe from the virus. In other words, the ways these women filled the gaps in support left by the pandemic while facilitated by the online world, simultaneously created new problems on which they had to expend additional labour.

To achieve this, I first describe 'the village' typical in North America as it was prior to the pandemic and which supportive elements women imagined they would benefit from before they disappeared. As a result of these changes to the culture of support, women were burdened with the task of rallying the necessary support to make it through these intense phases from conception to postpartum. Describing creative alternatives combining virtual and others means, I use various examples to explain the nuance of how the virtual realm simultaneously facilitates and isolates women in their search for help and support. In other words, COVID-19 made entrance to parenthood more intense and involved more invisible work in navigating the novel problems that surfaced as a result.

3.2 Who Makes Up "The Village" In North America?

The popular idiom "it takes a village to raise a child" references the fact that women and mothers, for the better part of human history have lived in close proximity to relatives, neighbors, friends and peers who with their own experiences provided knowledge, wisdom and helping hands especially when it came to reproduction and child rearing stages. While this may still be the case in the literal sense for some parents, for the most part, especially since the beginning of industrialization, social and economic factors have shifted women's access to these traditional supports. More mobility in one lifetime meant women are no

longer guaranteed to be living in arrangements where they can simply expect others to offer information and support. To deal with isolation and loneliness that has resulted in lacking access to these traditional supports, women have had to seek out new ways of 'building their village'. In recent decades, this void has been filled using technological means. Amy Smolinski, a researcher exploring military mothers and breastfeeding says, "humans are social creatures and we have developed technological means to meet our need for social interaction, validation and support" (2016, 64).

It is already known that the virtual world has created a shift in parenting culture in North America and beyond through diverse opportunities and spaces to connect, express and explore issues relevant to parenthood (Arnold and Martin 2016). Studies on digital motherhood show the importance of social media for mothers who use these platforms to connect with other mothers and communicate with networks of family and friends, using it to perform their role and draw closer to them in "social nesting patterns" (Bartholomew et al. 2012). One online space that has garnered the attention of many scholars is the "mamasphere" where a genre of blog writing, or "mommyblogs" have allowed mothers to build a sense of community through interacting with a network of first-person accounts of people sharing their diverse and intimate experiences of motherhood (Friedman 2013). These spaces allow mothers to vent frustrations, appreciate joyful moments, ask questions, and participate with others in constructing their own identities as mothers. The pandemic accelerated the trajectory of these cultural trends in the wake of the disappearance of traditional supports for new families. Another understudied platform that is used widely by women especially during the pandemic is that of closed or private online mother's groups on sites such as Facebook. One study conducted by Gleeson et al. (2022) explored the experiences of participation and support for members within a closed online mothers' group and found that it enabled a group of childbearing women to overcome isolation and form sustained, evolving and supportive friendships within a small, private, and trusted group. The technology allowed women to engage and share at a level much deeper than what they would in "real life" which was enhanced in a closed online mothers' group due to a smaller, private audience of trusted friends (Gleeson et al. 2022).

My study builds on existing research and offers a new take on an argument made by Leah Veazey, who in her study of the "digital diaspora" aims to alter discourses surrounding migrant mothers depicted as passive victims (2016). In this chapter, I suggest that the women I interviewed during the pandemic, like migrant mothers, are not passive victims of the isolating pandemic culture but rather are active agents in seeking support which suits their needs and values relying more heavily on the internet than previously. Like Veazey, who says, "maintaining online mothering networks online are practices that encourage women to expend significant emotional and creative labour on mothering that is not expected of fathers" (2016, 85), I also suggest that this online village-building is a form of unwaged labour adding to the invisible load intensified by the pandemic.

3.3 Imagined Villages

As a first-time mother to-be, I had expectations of how my pregnancy, birth and postpartum period would likely unfold, especially after learning so much while training to become a birth doula. Aside from the fact that there were many supports we could not benefit from because they became illegal, my husband and I also had to make difficult choices when calculating the possible risk of contracting the virus (even when it was permissible again) resulting in having to let go of expectations for support. In order to unpack the process of building supportive networks during the unique circumstances, we must first grasp what these women's expectations for support looked like and how this was disrupted due to COVID-19. The aim here is not to provide an exhaustive list of support but rather identify some key gaps in these women's lives so we understand how they were filled.

Based on my own and interview participants' experiences, the imagined or ideal village of most pregnant women included three main categories: other pregnant friends, family and some community and professional supports. At least four participants noted how important having other pregnant friends during the pandemic was to them. Gillian, a first-time mom in her forties says, "talking to women who had given birth, but not during the pandemic was definitely not as valuable as talking to women who'd given birth during the pandemic." She explained that when friends who had been pregnant before would share their experiences, Gillian would evaluate their support as not overly useful because of the

restrictive measures differentiating their experiences. Her example shows that while pre-COVID-19 any friends that had experienced pregnancy before could be a part of one's close 'village,' during the COVID-19 era things were different, and friend's advice was not as helpful as intended. Hannah, who had a hospital birth in July 2021 also felt she could not get sufficient support from friends who did not experience a pandemic pregnancy,

> "I'm an older mum than most of my friends so their kids are grown up and while they were definitely supportive in an emotional way it's not the same as somebody going through the same thing, it's not the same as a pregnant friend,"

Having family around to offer physical, emotional, and social support was another part of the imagined village. Hannah explains, "it if it had not been a pandemic my parents would have traveled from where they live to be there immediately and be supports for us in our home for probably a month or six weeks," something she explains was common in her family as they had done for her sister when she had children. Just like Hannah, I also expected my parents to come and support me in the early postpartum days, however, due to restrictions on "essential-only travel" at the Quebec-Ontario provincial border in addition to a curfew this was delayed a couple months until after I gave birth.

Community organizations such as mom and baby groups, which is a common place for these women to meet other moms and babies and do activities together, was another thing women had originally expected would be a part of their postpartum support. Gillian, who struggled with infertility for many years and conceived via IVF explains that since her own friends were no longer having children, she recognized the need to participate in community groups to meet other moms and their babies, she says, "I always pictured going to 'baby and me' classes just to get out and there aren't those now, and even if there were I wouldn't feel comfortable going to them." Gillian points to one of the issues complicating her quest to find safe support during the pandemic, where mothers who were very concerned or worried about getting the coronavirus had to consider the potential risks before attending an event or accepting a form of support.

Another service some participants had imagined they would employ were birth or postpartum doulas. A couple of participants like Hannah and Gillian had already thought

about or even chosen doulas they wanted to attend their births but were faced with the impossible choice- selecting either their husband or their doula when hospitals placed restrictions on the number of birth partners allowed to accompany the birther. Others like Mary, a mother of two in her thirties, had a postpartum doula who provided emotional support virtually. Mary would have liked her doula to play a more hands-on role helping her at home were it not for her desire to reduce risk of contracting COVID-19 by having more in person contacts. These were just some of the supports which were no longer available in conventional ways during the pandemic and these women had to get creative to arrange alternative supports.

3.4 Village-Building During a Pandemic

In this section, I describe the alternative supports mothers detailed in interviews as well as the WhatsApp group chat during the pandemic, followed by a discussion of how some of these supports had unwanted side effects which increased the mental workload for these women. When pre and postnatal care adapted to protect patients and care providers and other supports disappeared due to governmental measures, women had to find other ways to get the essential support they needed to endure the compounding challenges. Some of these supports came about by chance, based on the circumstances, such as a partner beginning work from home who became an extra pair of hands to help with the needs of the new mom and baby as well as tasks around the home or caring for older children.[8] Friends and family could offer support by making porch visits (to respect physical distancing measures) and could drop off or order meals for the family. Others who missed out on the socio-cultural experience of pregnancy used platforms such as Facetime, Zoom or WhatsApp to connect with family and host virtual gender reveals, baby showers and virtual visits or casual hang outs. A personal example of this is when my friends from the "BIZZZMFF" WhatsApp group, organized a prayer session and 'Blessing way', a mother-centric alternative to the common baby shower, where my closest female friends and family were present to bless me and my growing baby and share advice for my journey of

[8] My supervisor suggests that this is also a form of additional unwaged labour as a partner who is expected to be present at their own occupation is also playing their role as co-parent and partner on the clock.

motherhood. Some of these alternatives utilized exclusively online platforms, yet others involved a combination of online and in-person which required navigating in-person safety. This model was used around the country with some participants in the WhatsApp group sharing stories of family members hosting “drive-by baby showers” where friends and families would take turns driving by and ‘visit ‘the expectant couple at a distance and to share gifts. Another touching example that came out of this group was one participant informing us of a friend in the city who had to go in alone for a caesarean birth due to her hospital restricting attendance of a support person. She had minimal support at home, so we planned a postpartum meal train, texting to check in on her and sending advice on how to recover quickly from a C-section from those in the group who had experienced one.

Women also used a variety of mobile applications and social media platforms such as Peanut, Instagram, Reddit, Facebook, WhatsApp and YouTube to name a few, which were used to collect up-to date information about their pregnancy during the pandemic, learn from experiences of others, offering spaces to ask questions about common queries related to pregnancy, birth, infant feeding etc., benefit from free resources as well organizing in-person meet ups with other moms in their neighborhood. Other virtual mediums were also used to facilitate appointments with professionals such as doulas, lactation consultants, pelvic physiotherapists, and therapists. While discussing the new mediums of support can be detailed in a whole project on its own, The purpose of this chapter is to explain the cognitive and mental labour mainly women expended to get this support.

3.5 The Limits of Pandemic Village-Building

While we can celebrate the positive ways the online world facilitated community building, the innovative ways women supported one another and the connections they made which they would not have otherwise, we must also recognize the underlying problems that doing this work during the pandemic involved.

During the pandemic, my husband and I were more conservative when it came to going out and meeting with others, especially considering I was pregnant and the unknown impacts contracting the virus could have on me and our developing fetus. It was often a stressful experience to navigate our own values while trying to juggle our physical and mental

health and our relationships with friends and family who were less strict. Each time there was an opportunity to go out or meet up with someone, we had to make several considerations; How necessary is this outing? Will distancing be possible? Do they have any kids in school or day care? Are they vaccinated? Of course, it was really challenging to make these calls, so I could empathize with women I interviewed who struggled to build a support system that felt safe and often doubted the choices they made and boundaries they set resulting in feelings of self-doubt, guilt, and isolation. While many women relied more heavily on the virtual world to build community as an alternative to in-person relations, I argue also suffered more as a result by increasing their invisible load of having to think about getting support that was safe.

The examples I explain below are women who I and others called, “COVID cautious”. These are women who in valuing the safety and protection of themselves or family from the virus, set strict boundaries when it came to contact with anyone living at another address. Through my interviews, discussions and interactions with friends in the WhatsApp group and personal experience navigating life during the pandemic, it became apparent just how broad range of practices of caution towards the virus was for individuals and their families. In trying to gage how “COVID cautious” a participant was in order to better understand their circumstances during the pandemic and what motivated certain decisions related to their birth plan and post-partum care, I found the use of a scale helpful and asked where they thought they sat on a scale of 1 to 10 in terms of how worried or concerned they were about contracting the virus and how that may have practically influenced their daily life and planning for birth and post-partum. A ten for example would be someone who is terrified of contracting the virus and lives a completely isolated life taking zero risk in going out or having any contact with anyone for fear of contracting the virus.

Every family assesses risk differently, and expectant families have an additional factor of protecting new life to consider. Some participants explained that there were even differences between themselves and their partners regarding the level of caution and detailed the reasons. In general, I found some families took precautions and set up strict boundaries around mask wearing, meeting friends or family or even going grocery shopping even when provincial laws were more lenient as to allow gatherings. I must point

here that certain individuals and families were privileged enough to be able to isolate themselves, when they or a partner had a job in which they could work from home or benefitting from a paid maternity leave or even having the means to afford services making their level of isolation and caution possible.

Our first example is that of Hannah, who rates her and her husband at an eight out of ten on my 'COVID cautious' scale. Hannah explains,

> "My husband and I have really been hermits this entire time because for the entire pandemic we've been focusing on getting pregnant, staying pregnant and then having a healthy baby, and so it doesn't matter what the restrictions are we don't go to the grocery store, we don't go out, we don't see people."

The only people who had met her three-month-old baby at the time of our interview were her own parents and her husband's parents who were all vaccinated and had to wash their hands before handling the newborn. Although they were doing this to protect their family, Hannah told me how difficult it was to make these decisions, "I said to my best friend yesterday, who still hasn't met the baby, every choice feels bad, there's no choice that I can just easily pick. There's always going to be a big downside." It is these downsides of making a choice, while trying to find support as a new parent during the pandemic that I want to discuss, it is the mental work of thinking through each choice and the possible disadvantages that is so burdensome. These choices are more burdensome because the stakes are higher and more costly. Hannah shares that she wished she had more support in her breastfeeding journey which ceased sooner than she wanted because of a lack of appropriate support. The alternative means of support (such as virtual lactation consultations) were simply not helpful as Hannah expressed how difficult it was to breastfeed on Zoom. Hannah described her desire to have breastfed longer so her baby could get any antibodies she developed after being vaccinated while pregnant. There was a lot of mom guilt wrapped up in this experience that COVID-19 brought about because Hannah felt like she did not protect her baby as well as she should have from the virus than if she was able to pass on immunity to her daughter via her milk. Hannah's experience shows us that alternative means of getting support did not work out for everyone in the

same way, we see how women who were COVID cautious felt about making choices they believed were essential to protecting the health of their families and the extra labour involved in making such decisions. The higher stakes in navigating support for Hannah was that her daughter did not get breastfed longer which could have long-term impacts on her health.

The next example comes from my interview with Mary, a 'COVID cautious' mother of two living in southeastern Ontario, who describes her loaded experience in navigating the issue of support and community building during the pandemic. Mary shares her triumphs with finding support online as she leaned away from in-person support to protect her family, citing the wide reach the virtual world has afforded her, "I joined those online communities to try and find community and making connections that I otherwise wouldn't have." She shares the example of finding a friend in a Facebook group who just moved to her area with whom she had many mutual contacts, and the support she found on breastfeeding friendly groups on Facebook and Instagram accounts connecting with people who she can message, "who are also up at 2am nursing." While Mary was very optimistic about the wide reach online community building afforded her (also a form of work), she also expresses the disadvantages of some applications which were meant to facilitate meeting community and building relationships, like Peanut, which made her feel even more lonely. She admits,

> "Watching people go and do all of these things that I desperately wish I could do, but can't because I'm not comfortable with that in terms of safety and my kids, feels even more lonely ...because all of the sacrifices that we're making to try and keep the kiddos away from people who aren't vaccinated and keep them safe because we've made it this far, it feels even more lonely because the rest of the world is moving on."

It takes a tremendous amount of time and energy to find the right space for support and dealing with accompanying feelings of isolation. She was so happy when she read posts in Facebook groups from other moms who were cautious and would feel some mutual solidarity. Mary was well aware of the downsides and expended great amounts of mental labour working through the advantages and disadvantages of this support.

To unpack the complicated situation she found herself in, Mary relied on the online world to get support to keep her afloat but says the “catch 22” is not wanting to be on her phone so much in front of her kids, even though it’s the only safe way. This is an example of the mental load where the mother is worrying about the impact of her essential task of community building on her children’s health. When Mary also described the research, she had done on the impact of screen time for children, it became apparent to me just how much effort and extra time she expended to justify her extra screen use.

Mary was aware of the gendered dimensions of this issue, “lots of people talk about mom guilt and I very much fell prey to that in a way that I don't think my husband does because he doesn’t have to worry about [inaudible]”. Mary followed up by saying how hard she tries to let go of the mom guilt, because “The best thing for our kids is for us to be okay and for me to be okay, I need community and I need people and the only way to do that really, right now is on my phone.” Mary then turned her attention to the smiling, babbling 5-month-old baby on her lap saying, “you guys are resilient right?”

On top of her daily responsibilities caring for her family, building her online community, dealing with feeling isolated and lonely, thinking about the research on the potential impact of screens on her children, Mary also negotiates her dependence on family with the threat that COVID-19 brings. During our interview she explained her math on the expected vaccine rollout timings for infants and calculated that with spacing between doses, her daughter would be a year old before she could be vaccinated, and Mary would be comfortable with her meeting anyone outside the family in person. “Even though it's maybe not the safest thing to do”, Mary admitted that her parents were the exception to their rule, because of their real need for in person support.

Mary was well aware of the higher stakes or costs of being COVID cautious and all of the extra work that came with this. She explains that she went and bought some rapid COVID tests because it is the only way she would feel comfortable having anyone else come into her house, knowing that this was costing her at a time when they were not readily available. On top of the mom guilt, another aspect of emotional labour this complex situation brings is thinking about what others are going to think when a boundary is set. She explains,

“there’s a cost to saying yes to things because there’s risks and there’s a cost to saying no to things too and every time I say no, it feels like the people who I’m saying no to assume that I’m judging them”. All of this is “worry work” added to Mary’s invisible load during the pandemic.

3.6 Mindless Scrolling

I have been a parent for one year. I got pregnant, gave birth and have been caring for my son for 17 months through the ups and downs of the ongoing pandemic. During the long and cold Montreal winters, I experienced some really low lows. Although I am privileged to have a supportive husband and live with family who are available to help and provide support, I still felt like I was struggling and would often turn to social media platforms for information, to connect with friends, relatives, or even just as an escape from the challenges of the daily grind as a stay-at-home mom and all the work that comes with that role. I felt guilty whenever I was on my phone in front of my son, not wanting him to see me glued to a screen and wanting to constantly be engaged with him. I questioned the usefulness of these applications in my life and debated with myself everyday if I should delete them and question if I would be better off without them. It was not until I spoke with Mary and what she said that struck me differently, I could feel with Mary and her explanation validated guilty feelings. In her eyes, this screen time is necessary work to keep oneself feeling supported while navigating parenthood during the isolation of the pandemic, the screen time was just essential means to building a village. But of course, at a price, I have felt the stress involved in drawing, negotiating, and upholding boundaries to protect my family in the best way I knew during the initial waves of the pandemic. But reflecting on all the loneliness, self-doubt, extra time spent researching, and just mental overwhelm and anxiety in negotiating these boundaries, did I make the rights calls? Is my mindless scrolling really valuable?

3.7 Making the Invisible Visible

This complex situation we find ourselves in, as my examples show, is as follows; some women are faced with circumstances that are frightening and outside of their control forcing them to make difficult choices to protect themselves and their families, sometimes

taking precautions above what governmental restrictions require. This results in a situation where they need to expend significant time and energy gathering support through the 'safest' medium; the virtual world, in order to get through it. The same act of community building online, makes women like Mary (and admittedly, me) feel guilty in addition to other side effects described above, for spending so much time on their devices. In other words, we felt guilty and lonely for putting in extra work to find the needed support from the only medium we saw as safe.

The mental load has been defined as,

> "The combination of the cognitive labor of family life – the thinking, planning, scheduling and organizing of family members – and the emotional labor associated with this work, including the feelings of caring and being responsible for family members but also the emotional impact of this work" (Dean et al. 2022, 18).

Not only were most women wearing even more hats during lockdowns and work-from home mandates in addition to the routine roles before the pandemic, but COVID cautious women also had to decide which family members were 'safe' or necessary to be in contact with, spend time online building supportive relationships that had shared values, and deal with the emotional impacts of these decisions, such as 'mom guilt'. As we saw above, the stakes are raised for this kind of work because of the unknowns the virus brought, arguably increasing the pressure on women who were making these choices.

My findings echo what others in the health sciences are uncovering with respect to the gendered online behavior of new parents. In their recent study of new parents in Southwestern Ontario, Hiebert et al (2021) found that fathers tended to have a "'Let me know when I'm needed'" approach that led to the avoidance of health information seeking and in turn cast mothers as lay information mediaries. They added that the gendered nature of online content reinforced these dynamics with most sites being written for female/hetero audiences. They conclude that,

> "Digital technology tailored to new and expecting parents actively reinforced gender norms regarding health information seeking, which creates undue burden on

> new mothers to become the sole health information seeker and interpreter for their family" (Hiebert et al. 2021,7).

COVID-19 simply exacerbated these existing dynamics as new mothers relied more heavily on digital platforms for information and support.

3.8 Conclusion

So many things have happened during the pandemic that we can almost refer to this crisis as a magnifying glass, bringing minute attention to cultural processes that are not working in favor of those who do the brunt of the work, motherhood is no exception. My research is not the only one which has begun to extract lessons in gender inequality resulting from the pandemic. (Nguyen et al. 2022, Corno et al. 2022, Liese et al. 2021).

Knowing that the topic of village and community building could be its own individual research project, this chapter scratched the surface to bring to our attention the impacts the pandemic has had on some new parents in their pursuit of support during tumultuous times. Using autoethnographic reflections and shared experiences from my interviewees, I found that COVID cautious women bore the extra labour of navigating village-building considering the constant threat of the virus on their efforts. I showed how women are doing this mental and emotional labour, triangulating the best way to be a parent when COVID-19 came and made that a much more complicated endeavor. The emotional labour of letting go of who they expected to be a part of their village and coming up with creative new ways to find support using online and other means had greater consequences making the burden even heavier. This work is invisible, boundaryless and enduring (Dean et al. 2022).

In coming to terms with my own journey of finding my village as a COVID cautious mom (once upon a time) I was able to interpret my longer screen use as a valuable form of work necessary to my parenting journey, even though I still feel guilt and debate whether it truly helps or hinders me. This leaves room for future research to explore these nuances in the parenting experience in Canada.

This research sheds a light onto a set of tasks and work women do that goes unseen. Recognition of this unwaged labour needs to be added to the list of necessary

household tasks and fairly distributed in the division of caregiving labour. It also points to more unknown burdens the pandemic disproportionately placed on many women. Looking at how the women I spoke with found support in extreme circumstances, helps us to understand the importance of the virtual world and its potential to provide this support and perhaps understand where to invest resources to support women in this new digital parenting era.

I wish to end this chapter with a piece of advice Mary shared highlighting the importance of finding a community that suits your needs:

> "Find your community, so whether that parents or a doula or a postpartum doula or someone online, figure out who you're going to talk to because none of us are supposed to do this alone, and you don't have to do this alone support looks different right now than it used to, but that doesn't mean it isn't there."

4 Chapter Four: Silver Linings of Giving Birth During the Pandemic

4.1 Mary's Hesitation

"We're complex human beings who can feel two things at the same time. We're allowed to mourn the loss at the same time as we celebrate the joy" explained Mary, a second time mom who gave birth in May 2021. After trying to describe her hesitation in using the term "silver lining" to describe the positive aspects or things that "weren't so bad" about giving birth during a pandemic she continued, "I find the silver lining for me, often means trying to ignore the fact that there's a piece of that that still hurts, which is why I'm trying not to use that word. I can be upset that pregnancy didn't look the way I thought it would and at the same time be so incredibly happy."

After months of analyzing interview transcripts and studying how the pandemic context both helped and hindered birth in various ways, I tried to make sense of Mary's hesitation considering the rest of my data. What does her hesitation say about the expectations on birthing people in Canada? How are these expectations affected by the coronavirus? Mary's hesitation can be interpreted in so many ways but in this chapter, I will continue to focus on understanding aspects of Canadian birth culture through the lens of the pandemic. Pandemic births cannot be labeled as 'bad' or 'good' for birthers and their families but following Mary's suggestion, pandemic births can be both happy and sad, stressful, and joyful, miserable, and comfortable and everything in between. In this chapter, I put Mary's hesitation in conversation with existing literature on crises and "bright spots" to understand how birth continued to function despite a global pandemic.

Contrary to cultural scripts on birth and the pandemic, this chapter examines how restrictions and unprecedented conditions were received *positively* by the women I spoke with in many ways. Utilizing Sarah Osterhoudt's (2021) "bright spot ethnography" as an inspiration, this chapter describes what worked during the crisis instead of emphasizing what went awry. After introducing Osterhoudt's concept, I outline some of the silver linings I heard in interviews followed by my own reflections. It is description heavy as I want to detail the positive things participants shared with me. Their silver linings serve

both to summarize positive takeaways and point to systemic limitations. In essence, I argue that the silver linings of birthing during a pandemic reveal both the positive conditions for birth for certain women as well as the shortcomings o\f contemporary birth culture in North America.

4.2 'Bright Spots' and 'Silver linings'

In working through positive elements of birth during the pandemic, or "things that work" during the latest all-encompassing crisis to impact human society, I found Sarah Osterhoudt's, "Bright Spot Ethnography" (2021) to be particularly useful. Based on the model "bright spot ecology" in the natural sciences, she applies this concept to cultural anthropology which approaches the study of "things that work" in a place otherwise characterized by crisis. Leaning slightly away from our discipline's tendency to focus on the "suffering slot" (Robbins 2013) and expanding on anthropology's commitment to emphasizing narratives of struggle and marginalization, the approach suggests that focusing on the complexity of things that need to happen to keep things working in addition to critiquing the systemic failures, has far more analytical potential and ethnographic richness than only critique,

> "For something to go terribly wrong, and to spiral into crisis, often only one "bad" thing needs to happen—a cyclone, a disruptive economic event, a political coup. Yet, for things to continue to work despite the compounding challenges that life often brings, many related things must come together in particular ways all at once—an overall more complex scenario to investigate." (Osterhoudt 2021, 39).

What especially spoke to me in Osterhoudt's writing was her commitment to expanding the potential of ethnography through recognizing that human experiences encompass a wide spectrum of emotional states, from happiness to despair. This was especially applicable to my research findings:

> "Acknowledging what is going well in a place alongside critiques of what is going badly expands our lens of understanding. It broadens the repertoire of questions we

> draw from and challenges us both to empathize with the suffering of others and to celebrate in their joy" (2021, 34).

This chapter acknowledges what went well in addition to highlighting shortcomings of North American birth culture. I celebrate my interlocuters' joy while empathizing in their grief. To lean away from our tendency as anthropologists to focus on what does not work or emphasizing the failure of our birth system to care for women in the best way, this chapter focuses on what my research participants call, "silver linings" or as Osterhoudt terms them, "bright spots" of giving birth during this time. Contrary to the traditional academic approach, Osterhoudt does not aim to "fix" what is going wrong in these areas but rather to *learn* from them. I know that there is not much that can be changed about COVID-19 birth culture in these places, seeing as for the most part restrictions have been lifted, but what there is to be learned for the future is certainly worthwhile.

4.3 Describing Silver Linings: What Worked for Birthing People During the Pandemic

In chapter two I explained that birth cannot be properly understood without also examining what came before (conception and pregnancy) as well as what took place after (postpartum).While the range of unexpected or "bizarre" silver linings related to different aspects of the reproductive journey was broad,[9] and what was a silver lining to one woman could be a major disadvantage for another, the following section describes and analyzes those silver linings shared by eight interview participants as one participant, Steph, said there was nothing positive about her experience during the pandemic. They are organized according to the stage in reproduction they were relevant to: pregnancy, birth and postpartum.

---

[9] One participant explained how the silver lining behind a miscarriage she had a year before the pandemic began. Describing it as "bizarre" she explained that were that pregnancy to have continued she would have given birth during the first lockdown and the peak of uncertainty and isolation, so that was a "not so bad" aspect of that miscarriage. She also explains how her son who was born during the pandemic was the silver lining of the pandemic because of other family losses they experienced, he came as a light and joy for her family in a time of great need.

Mary hesitated in the first place to use the phrase “silver linings” because she did not want the emphasis on the ‘good’ to overlook the ‘bad’ as she felt our culture tends to do with “toxic positivity”[10]. Similarly, with what follows, the point is not to disregard the negative by only sharing the positives but as Mary and Osterhoudt suggest; we can have both, we look at the bad, what was missed, and mourn but also highlight what was good and what worked- because that is part of the range of human experience. While I am not able to describe all the silver linings experienced by each participant, I list and explain the most impactful and commonly shared points.

4.3.1 Pregnancy

Isolation- There were several advantages to being pregnant during an active pandemic as described by women, one of them being the isolation or “social distancing” imposed on much of Canadian society. Mary, who gave birth to her daughter at a birth center explains the positive aspects of being isolated during much of her pregnancy,

> “We had more family time leading up to delivery, because no one was stopping by to visit I could read, I could cuddle with my son, I have lots of time with him to get him ready for baby that I’m not sure I would have had in normal times.”

Having a previous pregnancy to compare her pandemic experience to, Mary wished her family would have come over more to celebrate and share in her pregnancy, especially since this would likely be her last baby. She was grateful that she could spend more time with her older son and prepare him for the arrival of her daughter, which might not have happened were it not for the restrictions.

Another silver lining to being isolated during pregnancy was explained by Louise, who had a cesarean section at a Toronto hospital. She says that being stuck at home during lockdown and not seeing anyone, protected her from seasonal illness “I didn’t get a cold,

---

[10] Toxic positivity is the expression that no matter how difficult a situation is, people should maintain a positive mindset and avoid negative thoughts.

the entire time I was pregnant, because I didn't go anywhere so isolation helps physically, maybe not mentally."

Gillian, a first-time mom who became pregnant during the pandemic after experiencing infertility, felt that isolation was advantageous because it meant that she was less exposed to unwarranted advice, judgments or comments people often feel like pregnant women should receive. Restrictions on the number of people allowed to gather meant there were less opportunities to be judged by people and gave more control to pregnant women to meet who they were comfortable with (choosing their "bubble").[11] Gillian explains,

> "Funny enough I feel like I got less judgment on things, like there's always people who want to judge everything a new mom does, everything a pregnant woman does, doesn't matter what you do there's always somebody telling you that's wrong."

When I probed more, she explained that due to restrictions she and her husband would only meet with people outdoors and with close friends or family who they trusted and would not feel judged by. However, were it not for the pandemic she would have likely attended larger gatherings such as friends' barbecues or even going out more in public with her baby where she would be more susceptible to such comments even from strangers. Gillian expressed her grief over how the pandemic had 'stolen' her social experience of pregnancy such as getting attention at work and other settings that she wanted over the years of her struggle to conceive. However, she noted the positive aspect which was that the same restrictions that limited her seeing people and getting perhaps wanted, positive attention also limited the negative, unwanted attention in the form of judgments and unwarranted comments.

<u>Working from home:</u> Hannah shares how working from home proved to be a silver lining during her pregnancy. She had just started a new job teaching at a university in Ontario

---

[11] The concept of a "bubble" was introduced in Ontario as a way to give people some choice in who they would restrict their contact with without feeling completely isolated as others in Quebec were limited to be in contact only with people living at their address.

and really liked the fact that she was in control of who knew about her pregnancy and when and if they got to find out,

> “The fact that I was able to go to work without anyone knowing I was pregnant was a silver lining as well. It was a new job, so I had concerns about my colleagues' thinking things about me or my life. I was able to interact with my students without them knowing I was pregnant, so they didn't treat me any differently than they would have otherwise.”

Hannah’s experience points to the fact that pregnant women are often treated differently in professional spaces that may be interpreted positively or negatively by some women. Gillian for example was told by her employers to work from home because she was pregnant which she appreciated because it made her feel safer, but also missed having attention to her pregnancy and belly which she had imagined having during the years of infertility. Hannah on the other hand appreciated working from home to avoid any attention to her pregnancy.

4.3.2 Labour and Delivery

Connection with birth partner- Although one big downside of giving birth during the pandemic meant that there were restrictions on the number of support people allowed at a hospital or birth center, one silver lining six out of eight participants shared was that it provided an opportunity to form a stronger connection with their chosen birth partner. In the case of all my participants including myself, it was our husbands. Many people would usually be accompanied by a mother, sister, parent-in-law, friend, or a doula in addition to a significant other. The restriction for these women resulted in a special time to connect and allowed the couple space to make decisions as a team without the influence or pressure of another person who would have attended otherwise. Gillian shares, “they're not many nice things about giving birth in a pandemic, but one of the few silver linings was I didn't have to find a way to diplomatically tell my sister that she couldn't be in the room.” Gillian was clear she did not want her sister to attend her birth, which would have been a difficult conversation had the restriction not been in place. Another benefit this condition brought was that no outside voices were considered but the birthing person and their partner which

many participants such as Louise, appreciated, “My husband and I went in as even more of a united front. Like we are this team now and we need to make these decisions together, I think that has made us even stronger.”

Zahra is another first-time mom who gave birth in October 2020 who shared similar sentiments,

> “I think it helped because I felt like that time was so special it was just the two of us with our baby and we really, really cherished it…if anything, it just brought us closer together and made us stronger”.

More compassion- There were two participants who cited that they were treated with more compassion and understanding during their hospital experience and felt that staff were more willing to compromise on common protocols considering the circumstances. Klara, who gave birth to her second child in July 2020 with midwifery care, explains how she was surprised when the staff at her hospital birth did not impose an intravenous (IV) drip on her. Klara knows hospitals “like a good intervention” and attributes the fact that no one pushed an IV on her or to delay discharge as wanting to keep patients happy.

> “I get a feeling that the agreement to not go with the intravenous might also have been related to what we (health care professionals) can do in terms of patient care. Given this sort of strange situation that keeps patients happy, and the same thing about that early discharge, no one argued with us.”[12]

Zahra initially had an ugly encounter with the admission staff since they expressed hesitation and fear in admitting her for a scheduled induction since she had just recovered from the COVID-19 virus. Zahra says aside from the initial confusion, the rest of her experience with staff was wonderful and she would easily return there for a subsequent birth, “I feel like because of COVID I think it just made everyone so much more

---

[12] I would also argue that this is another example of internalization of overly medicalized treatment of birth which I unpack through my own example in chapter two.

understanding and patient and compassionate. I think it just made everyone a bit more kind to one another, knowing that we're all going through really weird times."

4.3.3 Postpartum

Working from home- While the pandemic may have excluded partners in some stages of parenthood (like attending ultrasound and pre-natal appointments) for some it gave fathers the opportunity to be *more* involved than they would have during other stages. In addition to not having to spend time commuting to and from work, having a partner working at home meant they were more available to help their partner with daily tasks and caring for the new baby. Ash, a first-time mom, and front-line worker shares her experience,

> "Having him at home and being such a big part of my son's life from an early age, like he can put them down he can do whatever, it's amazing, whereas I know a lot of friends their husbands are back at work, and they don't have the same connection with the baby, or that they just don't have that comfort in dealing with them and seeing them freak out. That was positive".

No visitors allowed- Not being allowed to have visitors postpartum had some silver linings that many women cited. These advantages included not having to be presentable, or host guests while dealing with physical and emotional challenges of having just given birth. One such example is that of Zahra, who was initially worried when she knew that no visitors would be allowed in hospital or at home after giving birth. She reflects that considering the challenges she faced before and after the birth this turned out not to be so bad after all,

> "I think having given birth for the first time this was probably the silver lining in many ways. A lot of my close friends are kind of like my family, and I know people would probably want to visit, but the last thing you want to worry about is making yourself presentable."

Zahra was thankful that she did not have to worry about hosting guests while dealing with physical difficulties postpartum, she notes that coming from a South Asian culture where well-meaning friends and family would normally come to visit, she described could be

"overwhelming and smothering at times" even though it comes from a place of love, she was grateful that she had the space to recover on her own terms.

Klara adds that the ability to be selective about who she would welcome to her home postpartum was another advantage. This way she could ensure that only 'helpful' visitors could come, pointing to the real needs that a woman has after giving birth, getting things done and being able to rest and bond with their newborn, "we didn't have any annoying visitors, we really only had helpful visitors who came and loaded and unloaded the dishwasher and did the laundry."

Ash summarizes the sentiment well, especially during the context of COVID-19,

> "Having the baby and then not having that urge of family going crazy and wanting to see you right after was also kind of nice, I felt like it gave you a bit of space, rather than being bombarded again with all these people wanting to breathe all over your kid, on a normal day I feel like you do need to protect your baby a little bit."

Better support access via virtual platforms- Many adjustments and compromises had to be made to pre- and post-natal care in North America, including the switch to offering various supports and services on online platforms. While some participants mentioned how virtual support was not always as helpful or beneficial as in-person and hands-on support, for others it was a key silver lining and something they benefitted from immensely. Louise, who works in education, felt like there were more options available to her since things were more accessible through online platforms especially so soon after her induction and cesarean section, "being able to talk to my therapist within three days of having given birth, for example, as opposed to waiting until I was physically able to go, that's pretty awesome." She also shares her positive experience of being able to do a lactation consultation virtually,

> "I needed to see a lactation consultant, at one point my breasts were just on fire, and I couldn't figure it out and then I couldn't get anywhere and so we did a virtual appointment and that was unheard of beforehand, so that is certainly a general positive."

Annette, who teaches at a university in Ontario, found that during the initial lockdown there was an increase in free access to pregnancy and birth related information and resources online, which would not have been the case otherwise. Having access to free resources on Instagram such as workouts and birth specific exercises made her feel much more prepared for her second child after her first experience resulted in an emergency transfer to the hospital.

Mary is another participant who shares how she felt more supported with greater access through using virtual platforms,

> "As much as I miss the in-person community I do feel like I have ended up with a bigger community, because when everything is virtual you're not just talking to people, you're talking to people across Canada across the world, who are going through similar things that means you find more people who went through the same kind of things that you did which leads to understanding and more support."

Travel restrictions**:** Annette, who is originally from Europe, had her sister visiting before the first lockdown in March 2020 and became stranded in Canada due to cancelled flights several weeks before Annette's due date. While she was initially worried about the possible pressures of this living arrangement for her family, she later described this as a "blessing in disguise." She was grateful for the opportunity to bond with her sister in addition to the fact that she acted as a live-in care giver to help with her son during the last stages of her pregnancy, during her birth and to provide support in her fourth trimester,

> "We had a live in caregiver both five weeks leading up to me giving birth and for another five weeks after I gave birth, which was incredible. She took care of the toddler and kept our backs free so that we could tend to the baby, and she cooked dinner for us half the week, my husband cooked half the week until I was ready to join the household preparations again."

While there are so many more unique experiences and advantages to giving birth during a pandemic, we will take what has been mentioned and understand what this means for North American birth culture.

With everything being said, I have not forgotten the experience of my outlier, Steph. Steph's pandemic birth experience was an outlier in many ways, she was the only indigenous woman and also the only surrogate I spoke with in addition to identifying as a person with a visible or invisible disability. There were many points during our interview where the vulnerability of being a surrogate, being treated differently and perhaps with more caution because it was 'not her baby' and how these factors impacted her experience. Although she had her partner by her side to support and advocate for her, her experience ended in an emergency caesarean section and resulting in her presumed retained placenta- the pain and trauma she experienced.

I am uncomfortable essentializing her experience by attributing it to one factor or another, but share her story here as a way to contrast the findings of the majority of participants to show that a pandemic birth sometimes had no silver linings at all. It is known that the instance of adverse maternal health outcomes is elevated in populations of Indigenous women in Canada as well as birth outcomes being consistently less favorable than non-indigenous populations (Sharma et al. 2016; Government of Canada, 2017). Recent research has also emerged showing how the pandemic has greatly disadvantaged black, indigenous and people of colour (BIPOC) compared to their non-BIPOC counterparts. Although the majority of my participants were able to cite advantages to giving birth during the pandemic, I acknowledge Steph and other women whose experiences did not match those I detail in this research. I share her story here to be transparent about the variety of experiences Canadian women may have had giving birth during COVID-19 who were not in a position to experience the silver linings shared and which my sample was not representative of for reasons described in chapter one.

4.4 Reflections on Silver Linings and My Experiences

I would like to end this chapter with a discussion and personal reflection of what the presented data means to our survey of pandemic birth culture in Quebec and Ontario. When I was wrapping up my interview with Mary in the fall of 2021, I asked if there was anything else she wanted to share before completing the interview, to which she responded, "It's hard to know if everything will ever go back to what it was before, and sometimes I don't think it should go back". In our exchange, she expressed how mothers should be able

to put themselves first and is curious as to how the pandemic and what we discussed could change our birth culture as we know it. Mary makes a call for our birth culture to be more birther centric, citing that most of the attention is usually on the neonate while the new mother's needs, and feelings are sidelined. As we have seen in this chapter, it is difficult for women to express conflicting feelings about their experiences because of a culture that expects her to be grateful that she had a good birth outcome regardless of how the experience was for her. Some women can be subject to unwanted advice and judgements from strangers and are often expected to host visitors right after giving birth among other things. Mary had the feeling that the newly born mother is forgotten as all the attention is focused on the baby after birth, even in a medical context.[13] Just as a silver lining highlights the darkness of the storm cloud, the silver linings outlined in this chapter expose negative elements of North American birth culture and offer alternatives ways in which we can orient to more nurturing and birther-centric practices.

To weave together the various threads of this chapter, I equate the silver linings of pandemic births with Osterhoudt's bright spots as 'things that work' for birth during a pandemic. As both Osterhoudt and Mary suggest, by examining the things that work in addition to being critical we can access a more holistic understanding of a phenomenon through acknowledging the complexity of human life, leading to greater analytical potential. Birthers spoke of the novel opportunities COVID-19 and its accordant restrictions afforded them, such as deeper bonding with those in their inner circles, increased autonomy over decisions in pregnancy, birth and postpartum in addition to improved access to support which I will briefly summarize below.

My data displays how restrictions resulting from the spreading virus offered increased opportunities for intimacy and bonding between partners and immediate family members (children, siblings etc.) of the women I spoke with. Working from home, a halt to travel and prohibitions on having any private gatherings promoted a sense of closeness and

---

[13] Participants referenced the postpartum check-ups often only focused on the baby and the new mother's needs were often overlooked (such as having stiches checked for healing). Steph, being a surrogate, said she never had postpartum care in the absence of the baby which could be another reason why her retained placenta was missed.

bonding between birthers and their inner circles. Either being able to spend more time with children prior to welcoming a new family member, bonding with a stranded relative, or feeling like a united front with an intimate partner in the face of labour and birth, restrictions created new opportunities for birthers to bond with those around them in more profound ways.

Of course, I do not by any means suggest that isolation as we experienced is better for women during their reproductive journeys, but rather point to the positive results of what happened to learn from for the future. We do not have to wait for another global crisis uprooting our cultural norms to give us the chance to reflect critically about the direction of our birth culture and how it often disadvantages women. Rather we can take the lessons learned from this study and others like it to expand our cultural potential for improving women's experiences by creating the space for intimacy and autonomy of their bodies and decisions. As Mary suggests, things should *not* go back to the way they were, but rather include advantages experienced during various waves of the pandemic into an improved birth culture. Although my study did not have the experiences of women in more varied socio-economic situations, there is still much to be learned from those in more privileged circumstances. Cross-cultural comparisons would be useful to see how pregnant and newly postpartum women are treated in ways that may be more sensitive to their unique needs than is the case in some regions in North America. Some recommendations could include offering more flexibility with conditions for work and study from home, extending to partners as well. Other ways include keeping the virtual platforms open as an affordable option for professionals working with pregnant and postpartum individuals, improving access to resources helping women prepare for birth, training staff and people who work with new families to be more compassionate to clients, take into consideration birther's diverse needs especially when they are more evidence-based than existing practices, and incorporating humanistic and holistic paradigms that are culturally sensitive to the diversity of birthers in Canada. Finally, it was apparent from interviews and my own experience that there needs to be cultural scripts (and spaces) that acknowledge the full range of birther's conflicting feelings about their complex experiences- be they grief and happiness, sadness, or joy. Will we see these changes on a micro and macro level? Will these families do things differently for future pregnancies? Will I?

4.5 Postpartum Quarantine

I was scrolling through Instagram one day and came across a post comparing postpartum customs in different parts of the world. It pointed out how in modern America, the focus has usually been on the baby but "rarely includes the other person who was born, the mother." (Fields 2022). It lists a series of fourth trimester customs typical in countries like China, Vietnam, Somalia, and other places, which emphasize the comfort and nurturing of the new mother as she regains her strength while being supported in her new role. "La Cuarentena" is one such custom practiced in Latin America and other countries, a 40-day period of resting and being taken care of by surrounding family. Of course, the irony in the shared roots of the words 'Cuarentena' with 'quarantine' was not lost on me and offered a new perspective on my own pandemic birth. After experiencing most of the advantages mentioned in this chapter first-hand, feeling greater bonding and more agency, allowed all the time I needed to rest and recover from my birth and bond with my new baby without the typical pressures of our culture- what I began to consider was that perhaps we experienced an unintended form of 'La Cuarentena' during our own imposed lockdowns and quarantines of a different nature. I now reflect on that time and although not everyone who I would have wanted to be there supporting me and my new family in those early days were present, perhaps I would not have had that chance to rest and lie-in, in the way I did. This gives me a sense of closure for this chapter of my research- that birth during the pandemic as isolating and scary as it was, offered new families a different way of doing things, indeed showing "what works" in a pandemic and what I argue should continue to be a part of the way we do birth in the future. Learning from diverse customs that offer women a dignified and supportive environment will change my view of birth, while I appreciate having had this experience and being able to using my unique perspective for the better.

4.6 Conclusion

To conclude, this chapter formulated on Mary's hesitation and bright spot and silver lining metaphors have portrayed some advantages of the difficult conditions birth givers faced during the pandemic. These advantages point to the negative aspects of birth culture in

North America. Using my own experiences and those of women I spoke with, we saw how the conditions caused by the coronavirus increased opportunities for these women to bond with their partners and other close family members in addition to strengthening their sense of agency and improved access to supports through their reproductive journey. I suggest that we have much to learn about what took place, and how to incorporate flexibility in the range of options available to pregnant, birthing, and postpartum women for them to not only survive but thrive. Studying and composing appropriate applications for pregnancy, birth and postpartum customs cross-culturally would be useful in reorienting North American practices to be birther-centric. The data I collected could also be used to inform a discourse analysis of how women's discourse reflects dominant, internalized ideas of their birth experiences reflecting how our culture is not very birther-centric. Other potential areas for research could employ the 'bright spots' approach to other areas of human reproduction to get a holistic picture, more collaboration to uncover what is working in addition to critiquing what is not.

After experiencing some of the best opportunities and greatest joys during the pandemic, as well as some of the lowest lows. I acknowledge how the variety of feelings has broadened my ability to see the whole experience for what it is and its nuance in human life and reproductive experience. The question remains, will these bright sports endure, or will they fade away?

5 Chapter Five: Conclusion

Even before the pandemic or my pregnancy, I knew that there were common cultural events that I did not want to practice whenever I did get pregnant, one of them being the 'baby shower'. An obvious pandemic silver lining for me was that I could not have such a gathering in person during the height of the pandemic. As relieved as I was, I could not deny my family and friends' desire to celebrate my pregnancy in an alternative way. One of these ways that we settled on, was a virtual gender reveal party. Wanting to follow all the public health rules, it was a hybrid event. We technically live at the same address as my brother-in-law and sister-in-law (who are upstairs) and so hosting them on this rare occasion did not break guidelines for gatherings which we had avoided as much as possible. Our family and friends from around the world joined us on Zoom, while my brother-in-law and his family joined us in person in our apartment. Taking precautions, they wore masks, kept their distance, and made the visit short. My sister-in-law decorated our whole apartment in the colour corresponding to the gender of our baby which only she knew. Our laptop was held with everyone waiting to see my reaction on Zoom, I opened the door to a blue balloon forest and blue dessert table. "It's a boy!" We took pictures together to capture the moment and enjoyed our small hybrid gathering which was about to take a U-turn.

The next day, to our horror, my brother-in-law informed us that he had just tested positive for COVID-19! Everyone was nervous, not wanting anyone, especially me to get sick from the one and only time we had shared a space with each other in the many long and lonely months of being so careful. The event and its anxious aftermath are now funny to think about. It is part of my "pandemic birth story" and speaks to what I have shared in this thesis. The isolation of the pandemic was intense, in our case separating us from family living in the same building. Nevertheless, there was the silver lining of not having to do a baby shower and finding creative alternatives that involved others from around the world who would not have otherwise participated in celebrating our baby in the same way. In the days that followed, the anxiety and increased mental load I carried as I sought out more detailed health information in the event, I had contracted the virus (I hadn't) weighed

heavily on me. Having self-described as 'COVID cautious', I began second guessing my choices and the desire for celebration and connection during pregnancy. I will not forget these waves of emotion that this anecdote captures.

5.1 Key Findings

The COVID-19 pandemic has undoubtedly exposed weaknesses in the existing systems and institutions people depend on in all areas of life. Birth is no exception. How new families navigated and continue to navigate uncertainty in their reproductive journeys will continue to be a ripe area of research. Using autoethnographic reflections and drawing on nine semi structured ethnographic interviews conducted over Zoom, I have analyzed some Canadian women's experiences giving birth during the COVID-19 as a window into the often-problematic treatment of birth in parts of our country. My focus here has been on how birthers themselves describe their experiences. Their insights reveal several important findings. First, a pandemic birth is culturally rooted in the North American treatment of birth which is predominantly fear driven. The inconsistent and confusing measures during COVID-19 simply amplified discourses of risk fear and shaped women's experiences and choices. Next, in chapter three I described how women expected to be supported during their pregnancy and beyond and how they took matters in their own hands to find alternatives when supports disappeared. I argued that the time and effort put into finding these alternatives, especially for women who are COVID cautious is a form of labour that increases the invisible load women bear. Finally, in the fourth chapter I focus on the "silver linings" participants highlighted in their experience. Citing several benefits, birthers talked of the novel opportunities the pandemic, and its accordant restrictions afforded them, such as deeper bonding with close family, increased autonomy over decisions in birth and post-partum and more accessible supports. I argue that these silver linings simultaneously outline a dark cloud, highlighting the negative aspects of our birth culture and thus pointing to ways to move forward in improving our culture's treatment of pregnancy, birth and postpartum. By allowing women to feel a range of complex emotions and reactions, we add nuance to experiences and do not reduce them to being black and white where there is a lot of grey.

My conversations with participants and my experience underscore that North American birth culture needs to be more centered around the needs of the birther than it has been previously, taking her needs as equally important as the baby's. We can begin by looking cross-culturally for traditions and practices related to pre- and post-natal care and work to replace the supports and care that have vanished in the post-industrial era.

5.2 Contributions

The following section outlines some of the unique contributions this humble study offers. Throughout the process of writing this thesis, I kept asking myself, so what? What is the point of conducting a study on birth during the pandemic? Other than trying to make sense of my own experiences during a strange and confusing time. The obvious answer is that I am not the only one to have given birth during the pandemic, nor am I the first to have taken up the cultural study of birth. This study has confirmed research which anthropologists studying human reproduction have been doing for decades (Ginsburg and Rapp 1991). The impacts of power, politics, scientific advancement, capitalism on birth and more have already been well documented, all the cross-cultural comparisons and evidence of being able to do this in another way is there. What my project contributes is a marriage of anthropology of birth with bright spot autoethnography during an unprecedented time in unusual circumstances following in the direction of an 'anthropology of the good' (Robbins 2013). Having the opportunity to examine my own and others' experiences of pregnancy and birth during a two year long and counting global pandemic with the aim of finding a better way to do birth for the future is my original contribution to the literature.

The relevance of my work to the greater body of literature is not lost. Confirming findings on the highly medicalized and technocratic treatment of birth in North America is not new but is just the latest work to confirm the direction we are going in. This begs the question, what is the tipping point? My work is unique because of the approach and how it walks readers through processes of internalizing and awakening to the negative aspects of our culture. By looking at what works as an entry point to what is critiqued and to be done better, we see and experience firsthand the potential a culture shift in the right direction would have for birth in the future. Referring back to Robbins (2013,458) "there must be

better ways to live" than the ones anthropologist document and that is what I have done here, showed examples of how elements of our birth culture can and have to "make it work" even better.

Being aware of the mainstream birth culture and treatment of birth in Canada[14] my project in part begs the question- what will be the tipping point? Could the COVID-19 pandemic, be it? What forces are preventing these cultural and ideological shifts about doing birth in a better way that improves outcomes and facilitates empowering and successful birth stories? Based on preliminary data at the start of the pandemic, Statistics Canada documented an increase in non-hospital births. "Although the *number* of non-hospital births in 2020 remained lower than numbers from 2014 to 2017, the *proportion* of non-hospital births in 2020 (2.1%) was the highest it has been in more than a decade" (Government of Canada 2021). This shift indicates that a greater proportion of women were choosing to give birth in the home, a birthing center or other facility during the pandemic. However, this type of trend is not new and has been observed during previous disease outbreaks. According to the Association of Ontario Midwives, there was an increase in demand for midwifery attendance at home births during the severe acute respiratory syndrome (SARS) outbreak in Toronto in 2003 (Government of Canada 2021). This demand has been attributed to the growth of available midwifery services, a desire for low-intervention births and increasing comfort with birth outside the hospital setting. So why are we as a society not facilitating this? Why wait for a great crisis to put back-breaking pressure on an already fragile healthcare system leaving women to fall through the cracks and suffer as we saw during the pandemic?

Research is already being done to examine maternity care preferences for future pregnancies among United States child bearers in the aftermath of the COVID-19

---

[14] This is particularly true for minorities such as Indigenous and black women in Canada and the United States. Both groups experience disproportionate rates of maternal death. Davis (2019) shows how birth workers such as doulas and midwives are critical in mediating obstetric violence and improve the outcomes of birth among black Americans who have consistently had worse outcomes than their white counterparts even when socio economic statuses are equal.

pandemic. A study by Thayer and Gildner (2021) using data collected from an online convenience survey of 980 women living in the United States found that although a majority still preferred hospital births, a total of 58 participants (5.9% of the sample) reported a novel preference for community care during future pregnancies. However, a relatively high percentage (34.5%) of those same participants indicated that they expected limitations in their ability to access these services. These findings highlight how the pandemic has potentially influenced maternity care preferences, with implications for how providers and policy makers should anticipate and respond to future care needs (Gildner and Thayer 2021). While the limitations or barriers to access OOH care in the United States is obvious, what is Canada's excuse? Perhaps more research on how women's preferences change after a crisis in tandem with documentation of investment and lifting of barriers to supporting this increased interest in midwifery care could answer some questions. The evidence for better outcomes is there and the demand is increasing, so the next question is what are the systemic barriers? Why do women go back to birthing in hospital after a crisis passes despite increased demand for midwifery care and better outcomes? Why do we continue to let fear and anxiety be the reigning cultural treatments of prenatal and intrapartum care?

I wanted to conduct this research for myself in part to reflect on these questions. Equally important for me was to make sense of my first pregnancy and birth experience which took place during a historic time. I wanted to do this for women who struggled through isolation and loneliness the pandemic caused to center their experiences and use it as a time to see what cultural shifts serve us well. My autoethnographic reflections revealed to me how cultural processes and ideas of risk are internalized and difficult to unlearn, but they also highlight the positive aspects which point to improvements and areas for change in our birth culture.

5.3 Recommendations

A study inspired by my own journey through my pandemic pregnancy would not be complete without a list of recommendations collected from the women I spoke to and their various experiences. Although it is challenging to make a set of recommendations with the hopes that they will be taken seriously. The following list will be divided into broader

cultural changes and institutional changes. These may be useful to other women who are going through their first birth experience, women experiencing pregnancy, birth or postpartum regardless of whether it is or is not during a crisis or other major disruptive event. I want to develop key learnings that women can take as we were faced with such different circumstances as well as document these suggestions as something to refer to in the future and compare, hoping we will look back, grateful to how things progressed in the birth world offering women a more supportive, memorable, and holistic experience.

Institutional:

1. Implement effective and widespread communication channels for patient prenatal care during crisis and otherwise

2. Widen the category of essential workers during crisis to include birth workers (doulas, lactation consultants, childbirth educators etc.)

3. Create policies to allow doulas into birth rooms without a question- so women don't have to choose between a partner and doula

4. Innovate systemic changes that accommodate the postpartum state- don't make women leave their homes days after birth to weigh their babies. Promote in home care!

5. Make institutional changes to shift to midwifery care for all uncomplicated pregnancies reduce load in hospital during pandemic

6. Improve access to resources and support for people experiencing post-partum depression

7. Provide safer in person supports, more breakout rooms in virtual events to facilitate interactions

Cultural

8. Promote a culture of understanding the complexity of childrearing process- sadness and joy

9. Propagate the evidence on best practices for hospitals to improve outcomes for mothers and their children

10. Promote self-advocacy of birthers and their partners – ask questions don't be afraid to be the squeaky wheel

11. Find your community. Figure out who you're going to talk to, Support looks different right now than it used to, you are not meant to do it alone

5.4 The Beginning of an End

On May 18th, 2021, while I was busy laboring and, on the day, I gave birth to my sweet baby boy, Quebec's premier proudly announced that the end of May would bring his reopening plan, and gradually the curfew and all other health measures in Quebec will slowly be lifted (Olson 2021). Since then, society has slowly weaned itself to life without masks, vaccine passports, and restrictions on gatherings and other areas. More than a year later, life is feeling 'normal' once again and the worries I once had as a newly postpartum mom exposing myself and baby to others have faded away. Of course, there are still COVID-19 breakouts, especially in medical institutions which continue to impact birthing people in hospitals with limits on support people including doulas still being enforced depending on the circumstances. Speaking only for myself, I can say that I still practice caution when handling new babies and give newly postpartum friends all the time and space before visiting whilst gently supporting them from afar. I continue to find comfort in online spaces to seek support, attend seminars, conferences or courses related to women's health- which works better for me as a mom who finds it easier to stay close to my toddler who relies on me in so many ways. Whilst the level of activity on our WhatsApp group is reduced, I am in touch with my group of sisters, as we are back to meeting in person and

coordinating outings and educational gatherings for our big group of growing toddlers. Almost all of us have gotten COVID-19 at some point or another, but we are still very transparent whenever one of our children is sick, staying home to avoid spreading any infections. On a rare occasion, I will resort to a rapid-test kit just to rule the coronavirus out of the picture. Despite continuous waves of COVID-19 infections, life on the surface seems to have returned to normal. It is my hope that the lessons brought to the forefront by the pandemic are not lost upon us as we plunge forward into the future. A future where women's rights and needs from pre-conception to postpartum are considered with utmost importance in regular times and during crisis. It is my hope for more balanced treatment of birth where women's and infant's needs are given equal value and importance to increase morality rates and satisfaction with birth, where there is birth there is life and I want life to begin in the best way possible.

References

Aquadro, Laurel Ingraham. "I Was Forced to Give Birth Alone Because of Coronavirus." *Today's Parent* (blog), April 15, 2020. https://www.todaysparent.com/pregnancy/giving-birth/giving-birth-during-coronavirus/.

Bartholomew, Mitchell K., Sarah J. Schoppe-Sullivan, Michael Glassman, Claire M. Kamp Dush, and Jason M. Sullivan. "New Parents' Facebook Use at the Transition to Parenthood." *Family Relations* 61, no. 3 (July 2012): 455–69. https://doi.org/10.1111/j.1741-3729.2012.00708.x.

Castañeda, Angela N. and Julie Johnson Searcy. "Shifting Landscapes of Belonging: Birth Doulas and Covid-19." *Practicing Anthropology* 42, no. 4 (2020): 5–10.

Colin, Perkel. "COVID-19 Fears Spark Increased Interest in Home Births, Midwives Say | CTV News." Accessed May 5, 2022. https://www.ctvnews.ca/health/covid-19-fears-spark-increased-interest-in-home-births-midwives-say-1.5239352.

Corno, Giulia, Daniela Villani, Francine de Montigny, Tamarha Pierce, Stéphane Bouchard, and Sara Molgora. "The Role of Perceived Social Support on Pregnant Women's Mental Health during the COVID-19 Pandemic." *Journal of Reproductive and Infant Psychology*, February 23, 2022, 1–15. https://doi.org/10.1080/02646838.2022.2042799.

"COVID-19 in Quebec: A Timeline of Key Dates and Events | CTV News." Accessed September 30, 2022. https://montreal.ctvnews.ca/covid-19-in-quebec-a-timeline-of-key-dates-and-events-1.4892912.

Coxon, Kirstie, Jane Sandall, and Naomi J. Fulop. "To What Extent Are Women Free to Choose Where to Give Birth? How Discourses of Risk, Blame and Responsibility Influence Birth Place Decisions." *Health, Risk & Society* 16, no. 1 (January 2, 2014): 51–67. https://doi.org/10.1080/13698575.2013.859231.

Cummins, Molly Wiant. "Miracles and Home Births: The Importance of Media Representations of Birth." *Critical Studies in Media Communication* 37, no. 1 (January 1, 2020): 85–96. https://doi.org/10.1080/15295036.2019.1704037.

Davis, Dana-Ain. "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing." *Medical Anthropology* 38 (December 6, 2018): 1–14. https://doi.org/10.1080/01459740.2018.1549389.

Davis-Floyd, R. "The Technocratic, Humanistic, and Holistic Paradigms of Childbirth." *International Journal of Gynecology & Obstetrics* 75 (November 2001): S5–23. https://doi.org/10.1016/S0020-7292(01)00510-0.

Davis-Floyd, Robbie E., Lesley Barclay, Jan Tritten, and Betty-Anne Daviss. *Birth Models That Work*. University of California Press, 2009.

Davis-Floyd, Robbie, Kim Gutschow, and David A Schwartz. “Pregnancy, Birth and the COVID-19 Pandemic in the United States.” *Medical Anthropology* 39, no. 5 (July 3, 2020): 413–27. https://doi.org/10.1080/01459740.2020.1761804.

Davis-Floyd, Robbie, and Carolyn Fishel Sargent, eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Berkeley: University of California Press, 1997.

Davis-Floyd, Robbie, and Joseph Dumit, eds. *Cyborg Babies: From Techno-Sex to Techno-Tots*. New York: Routledge, 1998.

Daviss, Betty-Anne. “Reforming Birth and (Re)Making Midwifery in North America.” In *Birth By Design*. Routledge, 2001.

Dean, Liz, Brendan Churchill, and Leah Ruppanner. “The Mental Load: Building a Deeper Theoretical Understanding of How Cognitive and Emotional Labor over *Load* Women and Mothers.” *Community, Work & Family* 25, no. 1 (January 1, 2022): 13–29. https://doi.org/10.1080/13668803.2021.2002813.

Denzin, Norman K. *Interpretive Autoethnography*. Second edition. Los Angeles: SAGE Publications, Inc, 2013.

Fields, Amey. “Amey Fields RN, IBCLC +team (@az.Breastfedbabies) • Instagram Photos and Videos,” September 7, 2021. https://www.instagram.com/p/CiNbUHbOqAD/?utm_source=ig_web_copy_link.

Friedman, May. “Mommyblogs and the Changing Face of Motherhood.” Accessed September 26, 2022. https://books-scholarsportal-info.proxy1.lib.uwo.ca/en/read?id=/ebooks/ebooks2/utpress/2013-08-26/1/9781442665231.

Gildner, Theresa E., and Zaneta M. Thayer. “Birth Plan Alterations among American Women in Response to COVID-19.” *Health Expectations* 23, no. 4 (August 2020): 969–71. https://doi.org/10.1111/hex.13077.

Gildner, Theresa E., and Zaneta M. Thayer. “Maternity Care Preferences for Future Pregnancies Among United States Childbearers: The Impacts of COVID-19.” *Frontiers in Sociology* 6 (2021). https://www.frontiersin.org/articles/10.3389/fsoc.2021.611407.

Ginsburg, Faye, and Rayna Rapp. “The Politics of Reproduction.” *Annual Review of Anthropology* 20 (1991): 311–43.

Gleeson, Danielle M., Alison Craswell, and Christian M. Jones. “It Takes a Virtual Village: Childbearing Women’s Experience of a Closed Facebook Support Group for Mothers.” *Women and Birth* 35, no. 2 (March 2022): e172–80. https://doi.org/10.1016/j.wombi.2021.04.011.

Gottlieb, Alma. “The Anthropologist as Mother: Reflections on Childbirth Observed and Childbirth Experienced.” *Anthropology Today* 11, no. 3 (June 1995): 10. https://doi.org/10.2307/2783365.

Government of Canada, Statistics Canada. “Birth Outcomes among First Nations, Inuit and Métis Populations,” November 15, 2017. https://www150.statcan.gc.ca/n1/pub/82-003-x/2017011/article/54886-eng.htm.

Government of Canada, Statistics Canada. “COVID-19 in Canada: A Two-Year Update on Social and Economic Impacts,” March 10, 2022. https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2022001-eng.htm.

Government of Canada, Statistics Canada. “The Daily — Births, 2020,” September 28, 2021. https://www150.statcan.gc.ca/n1/daily-quotidien/210928/dq210928d-eng.htm.

Goyal, Manu, Pratibha Singh, and Nitesh Melana. “Review of Care and Management of Pregnant Women during COVID-19 Pandemic.” *Taiwanese Journal of Obstetrics and Gynecology* 59, no. 6 (November 2020): 791–94. https://doi.org/10.1016/j.tjog.2020.09.001.

Gruber, Kenneth J., Susan H. Cupito, and Christina F. Dobson. “Impact of Doulas on Healthy Birth Outcomes.” *The Journal of Perinatal Education* 22, no. 1 (2013): 49–58. https://doi.org/10.1891/1058-1243.22.1.49.

Hayakawa, Satoshi, Shihoko Komine-Aizawa, and Gil G. Mor. “Covid-19 Pandemic and Pregnancy.” *Journal of Obstetrics and Gynaecology Research* 46, no. 10 (October 2020): 1958–66. https://doi.org/10.1111/jog.14384.

Hiebert, Bradley, Jodi Hall, Lorie Donelle, Danica Facca, Kim Jackson, and Ewelina Stoyanovich. “‘Let Me Know When I’m Needed’: Exploring the Gendered Nature of Digital Technology Use for Health Information Seeking during the Transition to Parenting.” *DIGITAL HEALTH* 7 (January 2021): 205520762110486. https://doi.org/10.1177/20552076211048638.

Hogenboom, Melissa. “The Hidden Load: How ‘thinking of Everything’ Holds Mums Back.” Accessed September 9, 2022. https://www.bbc.com/worklife/article/20210518-the-hidden-load-how-thinking-of-everything-holds-mums-back.

Jordan, Brigitte. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Monographs in Women’s Studies. Montreal; Eden Press Women’s Publications, 1978.

Kaufman, Sharon R., and Lynn M. Morgan. “THE ANTHROPOLOGY OF THE BEGINNINGS AND ENDS OF LIFE.” *Annual Review of Anthropology* 34, no. 1 (October 1, 2005): 317–41. https://doi.org/10.1146/annurev.anthro.34.081804.120452.

König, Anika. “Reproductive Health in the Time of SARS-CoV-2.” *Social Anthropology* 20, no. 1 (2020): 299–300.

Lapadat, Judith C. “Ethics in Autoethnography and Collaborative Autoethnography.” *Qualitative Inquiry* 23, no. 8 (October 2017): 589–603. https://doi.org/10.1177/1077800417704462.

Liese, Kylea L., Robbie Davis-Floyd, Karie Stewart, and Melissa Cheyney. “Obstetric Iatrogenesis in the United States: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse.” *Anthropology & Medicine* 28, no. 2 (April 3, 2021): 188–204. https://doi.org/10.1080/13648470.2021.1938510.

Luce, Ann, Marilyn Cash, Vanora Hundley, Helen Cheyne, Edwin van Teijlingen, and Catherine Angell. “‘Is It Realistic?’ The Portrayal of Pregnancy and Childbirth in the Media.” *BMC Pregnancy and Childbirth* 16, no. 1 (December 2016): 40. https://doi.org/10.1186/s12884-016-0827-x.

Narayan, Kirin. “How Native Is a ‘Native’ Anthropologist?” *American Anthropologist* 95, no. 3 (1993): 671–86. https://doi.org/10.1525/aa.1993.95.3.02a00070.

Nguyen, Tien C., Erin E. Donovan, and Michelle L. Wright. “Doula Support Challenges and Coping Strategies during the COVID-19 Pandemic: Implications for Maternal Health Inequities.” *Health Communication* 37, no. 12 (October 15, 2022): 1496–1502. https://doi.org/10.1080/10410236.2021.2012898.

Olson, Isaac. “Quebec to Lift Curfew, Allow Outdoor Dining as of May 28 in First Steps of Reopening Plan | CBC News.” CBC, May 18, 2021. https://www.cbc.ca/news/canada/montreal/quebec-announcing-lifting-of-covid-measures-1.6030812.

O’Reilly, Andrea. “‘Trying to Function in the Unfunctionable’: Mothers and COVID-19.” *Journal of the Motherhood Initiative for Research and Community Involvement*, July 21, 2020. https://jarm.journals.yorku.ca/index.php/jarm/article/view/40588.

Osterhoudt, Sarah. “Bright Spot Ethnography: On the Analytical Potential of Things That Work.” *The Arrow* 8, no. 1 (2021).

Pelley, Lauren. “COVID-19 during Pregnancy Means 10 Times Higher Risk of ICU Admission, Canadian Data Suggests | CBC News.” CBC, September 16, 2021. https://www.cbc.ca/news/health/covid-pregnancy-risk-icu-hospitalization-1.6176742.

Rice, Kathleen F., and Sarah A. Williams. “Making Good Care Essential: The Impact of Increased Obstetric Interventions and Decreased Services during the COVID-19 Pandemic.” *Women and Birth: Journal of the Australian College of Midwives* 35, no. 5 (2022): 484–92. https://doi.org/10.1016/j.wombi.2021.10.008.

Robbins, Joel. "Beyond the Suffering Subject: Toward an Anthropology of the Good." *Journal of the Royal Anthropological Institute* 19, no. 3 (2013): 447–62. https://doi.org/10.1111/1467-9655.12044.

Sargent, Carolyn, and Grace Bascope. "Ways of Knowing About Birth in Three Cultures." Medical Anthropology Quarterly 10, no. 2 (1996): 213–236.

Sharma, Sangita, Fariba Kolahdooz, Katherine Launier, Forouz Nader, Kyoung June Yi, Philip Baker, Tara Leigh McHugh, and Helen Vallianatos. "Canadian Indigenous Womens Perspectives of Maternal Health and Health Care Services: A Systematic Review." *Diversity & Equality in Health and Care* 13, no. 5 (2016). https://doi.org/10.21767/2049-5471.100073.

Smolinski, Amy Barron. "Boobs, Babes, and Boots: Breastfeeding Support, Facebook, and Military Mothers." In *Taking the Village Online: Mothers, Motherhood and Social Media*, 2016.

Taking the Village Online: Mothers, Motherhood, and Social Media. Demeter Press, 2016. https://www.jstor.org/stable/j.ctt1rrd9jq.

"UNSDG | Policy Brief: The Impact of COVID-19 on Women." Accessed September 9, 2022. https://unsdg.un.org/resources/policy-brief-impact-covid-19-women, https://unsdg.un.org/resources/policy-brief-impact-covid-19-women.

Van Hollen, Cecilia. "Perspectives on the Anthropology of Birth." *Culture, Medicine and Psychiatry* 18, no. 4 (December 1994): 501–12. https://doi.org/10.1007/BF01565852.

Veazey, Leah Williams. "Mothering in the Digital Diaspora." In *Taking the Village Online: Mothers, Motherhood and Social Media*, 81–93, 2016.

Vitek, Kali, and L. Monique Ward. "Risky, Dramatic, and Unrealistic: Reality Television Portrayals of Pregnancy and Childbirth and Their Effects on Women's Fear and Self-Efficacy." *Health Communication* 34, no. 11 (September 19, 2019): 1289–95. https://doi.org/10.1080/10410236.2018.1481708.

Wagner, Michael, Veronica Falcone, Sabrina B. Neururer, Hermann Leitner, Irmgard Delmarko, Herbert Kiss, Angelika Berger, and Alex Farr. "Perinatal and Postpartum Care during the COVID-19 Pandemic: A Nationwide Cohort Study." *Birth* 49, no. 2 (2022): 243–52. https://doi.org/10.1111/birt.12594.

Weber, Gerhard W., and Fred L. Bookstein. *Virtual Anthropology: A Guide to a New Interdisciplinary Field*. Softcover reprint of the original 1st ed. 2011 edition. Springer, 2017.

Appendices

Appendix A: Interview Guide

Birth Experiences Under COVID-19 Restrictions in Quebec and Ontario
Interview Guide

The semi-structured interviews will use the framework below to guide the conversation. Based on recipients' responses, follow up questions and prompts may be used. The semi-structured style of interview will allow us to tailor the interview to the participants' unique birth experiences.

Before the Birth
Were you planning on becoming pregnant during the pandemic?
How was your experience of pregnancy?
What, if any changes to your prenatal care occurred?
How did you imagine your experience of birth would be during COVID-19?
What were your fears/hopes?
What was it like preparing for different aspects of your birth considering changing restrictions?
What kind of support were you anticipating would no longer be available to you?
Was this the case?

The Birth
Can you share with me your birth story? What happened?
What were some of the challenges you faced during your labour?
What kinds of supports did you have available to you despite restrictions?
Who attended your birth with you?
Are there any supports you wish were available to you during your birth?
What were the restrictions like in the city/province you gave birth in at the time of the event?
What kind of information and where were you getting it from about pregnancy/birth during this unique time?
What, if any changes did you have to make/consider to your birth plan (or what you imagined your birth experience to be)?

After the Birth
How was it different than you anticipated?
If you have had birth experiences before COVID-19, how did your experience during the pandemic compare?
What was one thing you wish you could have had that you had in your previous birth?
Did you feel you were prepared for this birth?
How did your experience of birth impact or change your entrance to parenthood?
Was there anything positive about your birth experience during COVID-19 pandemic that surprised you?

Was there anything negative about your birth experience during COVID-19 pandemic that surprised you?
What was your post-partum experience like?

Is there anything unique to your situation that you would like to share?
Is there anything else about your experience of birth during COVID-19 pandemic that you would like to share?
If there is one (or more) things/ pieces of advice you would give to someone who will give birth soon (or to your past self) what would it be?

Birth setting specific questions:
How did you feel about birthing in a hospital considering the added risk of contracting the virus?
Did the COVID-19 pandemic restrictions make you reconsider your place of birth?

Appendix B: REB Approval Letter

Date: 18 May 2021

To: Dr Lindsay Bell

Project ID: 118345

Study Title: Birth Experiences Under COVID-19 Restrictions in Quebec and Ontario

Short Title: COVID-19 Birth Experiences

Application Type: NMREB Initial Application

Review Type: Delegated/Full Board

Meeting Date / Full Board Reporting Date:

Date Approval Issued: 18/May/2021 15:05

REB Approval Expiry Date: 18/May/2022

Dear Dr Lindsay Bell

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above-mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Interview Guide, 23 Feb 2021	Interview Guide	23/Feb/2021	
Instagram recruitment poster, 23 Feb 2021	Recruitment Materials	23/Feb/2021	
Letter of Information and Consent- Interview Participants, March 1 2021	Written Consent/Assent	01/Mar/2021	
Focus Group Guide, 3 May 2021	Focus Group(s) Guide	03/Mar/2021	**2**
Facebook recruitment poster, 3 May 2021	Recruitment Materials	03/Mar/2021	**2**
Letter of Information and Consent- Focus Group Participants, May 5 2021	Written Consent/Assent	05/May/2021	**2**

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Asynchronous Focus Group Recruitment Questionnaire, 23 Feb 2021	Screening Form/Questionnaire	23/Feb/2021	
Interview Recruitment Questionnaire, 23 Feb 2021	Screening Form/Questionnaire	23/Feb/2021	

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations

of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Ms Kelly Patterson , Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Ms Kelly Patterson, Research Ethics Officer on behalf of Dr. Riley Hinson, NMREB Vice-Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Curriculum Vitae

Name:	Fattimah Hamam
Post-secondary Education and degrees:	Master of Arts in Socio-cultural Anthropology Supervisor: Dr. Lindsay Bell Western University 2020-2022 Bachelor of Arts Honors Anthropology Western University 2014-2018
Honours and awards:	Social Science and Humanities Research Council (SSHRC) Canada Graduate Scholarship-Masters 2021-2022 Faculty Association Scholarship Western University 2017 Four-year Continuing Admission Scholarships Western University 2014-2017 Dean's Honor List Western University 2014-2018
Related Work Experience:	**Graduate Teaching Assistant at Western University**: Endangered Languages and Language Revitalization Dr. Tania Granadillo Sept. 2020 – Dec. 2020 Introduction to Sociocultural and Linguistic Anthropology Dr. Tania Granadillo & Dr. Pamela Block Jan. 2021 – April 2021
Academic Conferences	A Malagasy Ramadhan: Reflections on an Anthropological Fieldwork Experience in Northern Madagascar. 6th Annual Western Anthropology Graduate Student Conference, London, Canada 2018