Constructing “essential” perinatal care: a qualitative study of obstetric care provider experiences implementing pandemic policies in a tertiary care centre in Newfoundland and Labrador

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Abstract

Background: During the COVID-19 pandemic, healthcare organizations across Canada mandated severe infection control policies surrounding birth and perinatal care, including restricting the presence of birthing support persons. Existing research shows that such policies resulted in birthing people having negative experiences in hospitals, the scaling back of perinatal care and breastfeeding support, and increasing use of medical interventions during birth.

Objectives: This study aims to understand how pandemic policies are interpreted and implemented in perinatal care, specifically in the province of Newfoundland and Labrador, where policies have remained severe despite relatively low COVID-19 caseloads.

Methods: In-depth, semi-structured interviews with eight obstetrics nurses and an obstetrician on their experiences implementing pandemic policies were conducted. Three of the nine respondents held formal policy writing and managerial roles within the healthcare organization. Thematic discourse analysis was used as a theory and method to construct themes from the interview data.

Results: Respondents exercised discretion and followed "unofficial" policy implementation decisions to cope with the stress of rapidly changing pandemic policies. Managers described following the "most conservative" approach, framing all aspects of birth other than medical care as unnecessary and justified trade-offs for COVID-19 safety. Conversely, client-facing staff described a more "patient-centred" approach, including advocating for their clients and emphasizing the wellbeing of birthing people as a priority. Justifying their policy implementation decisions, respondents negotiated between biomedical discourse and alternative, more humanistic discourses, constructing different meanings of "essential" perinatal care.

Discussion: Deficient conceptions of "essential" perinatal care that exclude the psychosocial dimensions of birth and postpartum appear to justify the scaling back of full-spectrum, holistic perinatal care during the pandemic. Such findings emphasize the importance of developing more holistic concepts of "essential" perinatal care and including birthing persons and client-facing

frontline workers in various levels of institutional policy processes. An analysis of such findings alongside seminal theories on obstetric violence is also offered.

Résumé

Contexte : Pendant la pandémie de COVID-19, les organismes de soins de santé de tout le Canada ont imposé des politiques sévères de contrôle des infections entourant la naissance et les soins périnataux, y compris la restriction de la présence de personnes de soutien à l'accouchement. Les recherches existantes montrent que de telles politiques ont entraîné des expériences négatives pour les accoucheurs dans les hôpitaux, la réduction des soins périnatals et du soutien à l'allaitement, ainsi qu'un recours accru aux interventions médicales pendant l'accouchement.

Objectifs : Cette étude vise à comprendre comment les politiques de lutte contre la pandémie sont interprétées et mises en œuvre dans les soins périnataux, en particulier dans la province de Terre-Neuve-et-Labrador, où les politiques sont restées sévères malgré le nombre relativement faible de cas de COVID-19.

Méthodes : Des entretiens approfondis et semi-structurés ont été menés auprès de huit infirmières en obstétrique et d'un obstétricien sur leurs expériences de mise en œuvre des politiques en cas de pandémie. Trois des neuf personnes interrogées occupaient des fonctions officielles de rédaction de politiques et de gestion au sein de l'organisation de soins de santé. L'analyse thématique du discours a été utilisée comme théorie et méthode pour construire des thèmes à partir des données des entretiens.

Résultats : Les répondants ont fait preuve de discrétion et ont suivi des décisions « officieuses » de mise en œuvre des politiques pour faire face au stress lié à l'évolution rapide des politiques en matière de pandémie. Les gestionnaires ont décrit avoir suivi l'approche « la plus conservatrice, » encadrant tous les aspects de l'accouchement autres que les soins médicaux comme des compromis inutiles et justifiés pour la sécurité COVID-19. À l'inverse, le personnel en contact avec les clients a décrit une approche plus « centrée sur le patient, « notamment en défendant les intérêts de leurs clients et en mettant l'accent sur le bien-être des accoucheurs comme une priorité. Pour justifier leurs décisions de mise en œuvre des politiques, les répondants ont

négocié entre le discours biomédical et d'autres discours plus humanistes, construisant ainsi différentes significations des soins périnatals « essentiels. »

Discussion : Les conceptions déficientes des soins périnatals « essentiels, » qui excluent les dimensions psychosociales de la naissance et du post-partum, semblent justifier la réduction des soins périnatals holistiques à spectre complet pendant la pandémie. Ces résultats soulignent l'importance de développer des concepts plus holistiques des soins périnatals « essentiels » et d'inclure les accoucheurs et les travailleurs de première ligne en contact avec les clients à différents niveaux des processus politiques institutionnels. Une analyse de ces résultats par rapport aux théories fondamentales sur la violence obstétricale est également proposée.

Table of Contents

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I would like to say a few personal words in case a person who reads this thesis is in a similar position as me, living through the im/migrant experience somewhere they are made to feel less than, made to feel uncomfortable in academia and other elite spaces, made to feel that they must work extra hard and be twice as good – I dedicate this thesis to you.

I would like to thank my parents, who immigrated to Canada in hopes for me to speak English – even French! – and graduate from a university like McGill. I have a hard time putting into words my gratitude for my family. My mother was born in a small conservative town in Turkey to a father who was a soldier and a mother who never finished elementary school, and she was one of the first in her family to study at a university, obtaining both her B.Sc. and M.Sc. in information science to become a librarian. My aunt is currently a librarian at the Law Society of Canada. My youngest aunt, still living in Turkey, is completing her Ph.D. in health studies and a law degree. They are my inspiration. They lived in a country where, at the time, class mobility was possible, where education was free, and where my grandfather, a staunch feminist and anti-capitalist unbeknownst to him, had a vision for his daughters to be educated and independent. My grandfather always said, translated from Turkish: “Never think about money when it comes to three things: healthy food, education, and community. Those are real investments. The rest is just gambling.” When I told him I am graduating with an M.Sc. soon, he told me that had the sole person who spoke French in his village not left halfway through his elementary education, he would have gone to university to study languages, his passion, and not have to become a soldier. He still remembers, “Je m’appelle Muvvaffak.” On my dad's side of the family, my great-grandmother was among the first generation of women in Turkey to obtain a university degree. She used to tell me, again translated from Turkish: “If you ever have money make sure you buy lots of books. If you don’t, make sure you live close to a library.” I owe everything to my family and their unconditional support and generosity.

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Contribution of Authors

I, Alize Ece Gunay, am the sole writer and contributing author of each chapter of this thesis. Dr. Kathleen Rice and Dr. Zoua Vang provided feedback.

List of Specialized Terms

Before proceeding, it is important to clarify the specialized, medical terms used in this thesis. The definition of other specialized terms pertaining to the methodology and theoretical framework are offered in the body of the thesis and in the footnotes.

Perinatal: The perinatal period is generally defined as the time shortly before and after birth, from the twenty-eighth week of gestation to up to four weeks after birth.

Intrapartum: The intrapartum period is the time period that spans childbirth, from the onset of labour through to the delivery of the placenta.

Postpartum: The postpartum period is the time after childbirth.

Birthing people: In this thesis, I make an effort use gender neutral language to refer to people who birth as "birthing people." This is because not all people who give birth are cis-gendered women and people who are assigned female at birth (e.g., trans-men, non-binary and gender non-conforming people, to name a few) also give birth. Furthermore, the word "mother" is avoided, unless when appropriate, as not all people who give birth are mothers. Some studies that I have cited specifically refer to study participants as "women" – in that case, I use the term "women" and "birthing people" interchangeably. Similarly, in my theoretical framework I also use the term "women" when discussing feminist and intersectional literature, as "women" is frequently the dominant term to describe birthing people in this field. Here, birthing people loosely describe people in the perinatal and intrapartum period, although "pregnant people" or "postpartum people" are also used when specificity is necessary.

Iatrogenesis: Iatrogenesis was first defined by Illich (1976) as the harms "done to patients by ineffective, unsafe, and erroneous treatments" (see Liese et al., 2021). Obstetric iatrogenesis refers to the harms, both physical and psychological, inflicted on pregnant and birthing people through medical interventions or treatments.

CHAPTER ONE: INTRODUCTION

1. Introduction

The COVID-19 pandemic caused by the SARS-CoV-2 coronavirus poses significant challenges for society on all levels. Healthcare systems have exceptionally been pushed to maximum capacity, balancing COVID-19 treatment with routine medical care. Given resource strains and the epidemiological context of the pandemic, many healthcare organizations enforced policies and protocols to limit the transmission of the COVID-19 virus, obstetric units being no exception. This introductory chapter frames Canada's pandemic policy response in the context of perinatal care, summarizing the most publicized policy decisions that have caused harm to birthing people. Policy implementation within obstetric settings is discussed as an area of focus of this study to understand how pandemic policy decisions impact perinatal care. To better understand this area of study, several research objectives are offered.

a. Birthing alone: pandemic policies in perinatal care

Of all the policies implemented in obstetric wards since the beginning of the pandemic in Canada, the most notorious and controversial were perhaps visitor policies that banned the presence of a support person during labour and birth. In April of 2020, the Jewish General Hospital (JGH) in Montreal, Québec announced that labouring and birthing persons were not allowed a single birthing companion with them, prohibiting partners, family members, friends, midwives, and/or doulas from attending the birth. This policy was framed as a necessary measure to ensure pandemic safety, emphasizing the JGH's role as Montréal's designated COVID-19 treatment centre (CBC News, 2020). The decision was reversed after nineteen days in response to massive public backlash and a statement issued by the World Health Organization (2020) emphasizing the right of birthing people to one (asymptomatic) birthing partner, allowing one support person throughout labour and postpartum stay.

While the JGH visitor policy decision was heavily publicized in the media, many healthcare organizations in Canada also took this approach, even in regions with low to non-existent COVID-19 case numbers. The Northwest Territories, for example, allowed only one support person to attend delivery and postpartum stay (Northwest Territories and Social Services Authority, 2020; Pearce, 2020). Hospitals in Atlantic Canada initially banned all support people and visitors from obstetrics wards, even though the region was celebrated for its low number of

COVID-19 cases thanks to the "Atlantic bubble" isolation measures (Gordon, 2020). Notably, policies in the province of Newfoundland and Labrador remained severe for the remainder of 2020, allowing only one support person to attend birth but requiring that they leave immediately after delivery (Bradbury, 2020; Gillis, 2020; Eastern Health, 2020). While "birthing alone" policies have garnered media attention, hospitals across Canada have enforced, and continue to enforce, other restrictive policies in the context of obstetrics that have had a significant impact on birthing people, their families, and care providers. Interrupted perinatal care, limited interpersonal contact with care providers, and severe restrictions on mobility within obstetrics wards are also increasingly part of this conversation in the media (Peesker, 2021; Hwang, 2021; Connors, 2022).

Across the Canadian provinces and territories, there exist several significant inconsistencies in pandemic perinatal care policies. In March of 2020, the governments of Québec and Nova Scotia initially banned midwife-assisted home births as a reaction to the sudden increase in demand for non-hospital births (Maclean, 2020; Sibonney, 2020). This decision was quickly reversed in both provinces. Conversely, the government of Ontario issued guidance emphasizing the birthing person's preferences for birth mode and location, such as midwife-assisted home or community births (Ontario Ministry of Health, 2020). Intra-province discrepancies also exist among individual healthcare organizations. For example, although the British Columbia Center for Disease Control guidelines recommended the presence of only one birthing support person earlier in the pandemic, the BC Women's Hospital in Vancouver allowed birthing people both a doula and an additional support person in the delivery room and postpartum stay, describing doulas as an "essential" part of the pandemic birthing team: "We're very patient and family centred. We support having one support person in the labour room, plus a doula in their care team, because we think that's a hugely important part of the birth process" (BC Women's Hospital, 2020). For this reason, how health authority and individual hospital policy decisions fit into the larger context of provincial policy directives is unclear.

b. Constructing birth in Canada

Such inconsistencies across provinces are reflective of the broader inconsistencies in how pregnancy and birth are conceptualized and managed in the Canadian maternity care system (Rudrum, 2021). In most provinces, pregnant people funded under provincial healthcare insurance can choose a family physician, obstetrician, or midwife as their primary maternity care provider. However, pregnancy and birth are heavily medicalized across all provinces, with 92% of all

pregnancies being followed by a physician and 98% of births occurring in a hospital (PHAC, 2020). All obstetricians and family physicians provide intrapartum care in hospitals, whereas midwife-assisted births also occur in community birthing centres and even home births (Vedam et al., 2014). Midwifery care, since regulated from 1993 onwards, has become available in all provinces and territories, but barriers to access remain in rural and remote areas (Sutherns, 2008; Thiessen, 2020). Midwifery is especially limited in the Eastern provinces, with Newfoundland and Labrador having only six registered midwives (Association of Midwives of Newfoundland and Labrador, 2021), and only 1.1% and 1.4% midwifery-led births and midwifery-involved care, respectively. There is only one midwifery practice in the entire province, making it difficult for a large number of pregnant and birthing people to access midwifery care. Doula practitioners, who offer significant physical and emotional support during birth, and despite their presence during birth being associated with better birth and newborn outcomes (Gruber, et al., 2013; Nommsen-Rivers et al., 2009), still remain an unregulated profession in Canada. As a result, doulas are hired as private professionals, and remain inaccessible for many seeking holistic maternity care.

Physicians and midwives broadly represent two different models of birth in Canada, with the former almost exclusively delivering in hospitals (Shaw, 2013). Physician-assisted births, especially obstetrician-led births, largely subscribe to the biomedical model that views pregnancy and childbirth as a pathological process to be clinically managed versus the "low-tech, skilled touch" (Davis-Floyd, 2021, p. 261) approach of the midwifery model.[1] Within biomedical discourse, maternity care is conceptualized under the "technocratic model of birth" (Davis-Floyd, 2001), where pregnancy and birth are constructed as risky events requiring varying levels of routine, clinical interventions to be managed safely (Benoit et al., 2010; Hausmann, 2005). Under this conceptualization, pregnancy and birth are monitored and treated akin to pathological conditions rather than a "natural" process, often with the use of medical interventions, despite most

[1] To avoid over-simplification, it should be noted that while the physician and midwife model of birth are different, not all hospital births are highly interventive and not all midwife-led births come to term without medical intervention. However, the midwifery model is frequently described in health literature as the alternative to the biomedical model where, unless a high-risk pregnancy, childbirth does not require clinical management and medical intervention. Midwifery also focuses on providing person and family-centred care that prioritizes the empowerment of the birthing person, as well as the birthing person's right to control decisions regarding their body, pregnancy, and childbirth (Shaw, 2013). Indeed, many pregnant people with low-risk pregnancies choose midwifery-integrated care and give birth in community birthing centres to avoid unnecessary medical interventions (Parry, 2008; Rice, forthcoming)

cases not necessitating such levels of medical intervention (Romano et al., 2008).[2] As treating and controlling the transmission of COVID-19 has become the top priority for healthcare systems and organizations, the "tension between the prevailing view of pregnancy and childbirth as pathological, and the challenges of providing comprehensive perinatal care within a healthcare system oriented towards treating and controlling outbreaks of a highly infectious disease" has become even more evident during the pandemic (Rice & Williams, 2021b, p. 2). This tension is exacerbated given the knowledge that pregnant people may face an elevated risk for severe illness from COVID-19. Given the restrictive policies and infection risk that accompanied hospital birth during the pandemic, many birthing people sought community and home births only to be met with a shortage of services (Renfrew et al., 2020; Beaudoin, 2020).

Birthing people and care providers now navigate this complex political and epidemiological context when making perinatal care decisions. The pressure to meet COVID-19-related healthcare needs has resulted in many forms of care to be scaled back, postponed, or virtual. Birth, however, cannot be postponed or virtual – yet, pandemic policies surrounding the context of birth, such as limiting support people, visitors, and interactions with healthcare personnel, entail assumptions of "essential" and "non-essential" perinatal care, based on an assessment of practices, procedures, and their outcomes are considered indispensable to perinatal care. This language of "essential" services is adopted widely in not only healthcare, but all aspects of society, as the pandemic has required prioritization of services and strategic allocation of resources. Beyond normative statements published by individual healthcare organizations and professional associations on the role of support people or doulas, there is very little known about how pandemic policies and guidelines are interpreted and translated in the perinatal context, and how this impacts the provision of perinatal care. What is increasingly more well-known are the impacts of such policies on birthing and postpartum people. Studies from Canada document negative experiences in the hospital, poor postpartum mental health, and breastfeeding challenges because of policies aimed at reducing interpersonal contact in obstetric wards (Rice & Williams, 2021a).

It is well understood by now that continuous perinatal care and continuous social support during labour and birth have positive clinical and emotional outcomes (McCourt, 2017). The presence of a support person during birth is associated with higher rates of vaginal delivery,

[2] A "natural" birth is defined as a birth without the use of the following medical interventions: elective induction, spinal analgesia, general anesthetic, forceps or vacuum delivery, caesarean section, episiotomy, or continuous electronic fetal monitoring (Society of Obstetricians and Gynaecologists of Canada, 2008).

reduced duration of labour, less need for pain relief, and greater overall satisfaction with birth (Hodnett et al., 2013). Given this essential role, the denial of a birthing partner is widely recognized as a human rights violation (Bohren et al., 2015). For those experiencing racism within the healthcare system (e.g., Black, Indigenous, and im/migrant birthing people), the presence of a birthing partner or doula can be a matter of life or death in the face of negligence and biased treatment (Davis, 2019). To ensure the provision of safe, satisfactory, and person-centred obstetric care, such policy decisions ought to be reconsidered through a critical lens.

c. A policy approach to understanding perinatal care provision during the pandemic

As reverberated in the policy literature, the consequences of any policy decision will affect differently positioned people differently, and often, will have greater negative unintended consequences for those who experience multiple forms of oppression (Hankivsky et al., 2014). Pandemic policies can exacerbate existing inequities in access to quality gynecologic and obstetric care for marginalized and underserved populations, increasing the risk for harm in clinical settings (Onwuzurike & Meadows, 2020). A better understanding of the processes in which pandemic policies are translated into the context of obstetrics is thus essential to further analyzing the impacts of such policies on care provision and those receiving it. Qualitative research from previous disease outbreaks, such as the H1N1 pandemic and the Ebola Virus Disease, highlights the importance of qualitative research in understanding how pandemic policy responses work in practice, their adaptation to various policy contexts, such as healthcare, and their unexpected effects and challenges (Flowers et al., 2016; Kodish et al., 2019). Yet, there is limited research on how pandemic policies impact obstetrics care.

2. Study Objectives

To address this gap in research, this study uses qualitative interviews to elicit the experiences and perspectives of care providers, hospital staff, and policymakers interpreting and implementing pandemic policies surrounding obstetrical care. This study builds on a larger, nationwide study, entitled, “Pregnancy and birth during the pandemic: a qualitative study” by Dr. Kathleen Rice. The findings from this study show that people who gave birth in the province of Newfoundland and Labrador during the pandemic have been impacted by pandemic policies to a similar degree compared to those in regions that have had much higher COVID-19 caseloads. Women from NFLD appear to have experienced severely restrictive policies that rendered birth

and the postpartum period incredibly challenging, even when compared to other provinces and territories where exists one tertiary care centre and neonatal intensive care unit for high-risk births. Provincial directives have appeared to be strict, and when interpreted in the context of birth and postpartum, involved restrictions on birthing support people.[3] Interviewing the healthcare providers in charge of translating pandemic policies into the perinatal care context can shed light on these negative experiences and elicit information on the organizational discourses surrounding perinatal care. Findings from this study can then be used in comparison with other areas in Canada experiencing higher COVID-19 cases to ultimately understand the impact of pandemic policies on obstetrical care.

For the reasons outlined above, the specific objectives of this study are to:

1. Describe the organizational policies surrounding perinatal care in the tertiary care centre;
2. Understand how pandemic policies are interpreted within the context of the obstetrics unit and perinatal care;
3. Examine the decision-making processes surrounding policy implementation, and;
4. Understand how this impacts pandemic perinatal care.

a. Justification for this study

This study is important for several reasons. Foremost, it provides an understanding of how actors interpret and implement pandemic policies in practice, including the relevant contextual factors involved in this process. It is increasingly accepted within the field of critical policy studies that policy generation and policy implementation are not two separate, linear steps, but rather mutually constitutive; the social, cultural, and institutional context of implementation transforms and constitutes the policy carried out in practice (Lejano, 2006; Ball, 2015; Carey, 2019). Implementation, then, is not a problem needing solving to ensure the better or more streamlined enactment of a policy in practice, but rather an iterative and ongoing process to be understood (Gill et al., 2017). Within this theoretical paradigm, a policy can be conceptualized as a process that is continually being done to shape care, rather than existing outside of it (Singleton & Mee, 2017). Thus, qualitative methods are particularly responsive to understanding the social, cultural, and

[3] Detailed information on provincial COVID-19 updates and infection control can be found on the Government of Newfoundland and Labrador website. It is important to note that the government has not released an official statement on birthing support people nor explicit directives for labour and delivery to my knowledge. However, global organizational policy changes can be found on the websites of the four different Newfoundland and Labrador health authorities.

material factors involved in interpreting and implementing policy. Such an understanding is important to ensure that policy interpretation and implementation are transparent and participatory processes rather than a "black box" of values and assumptions entrenched in social relations of power. Therefore, these findings can inform multiple levels of pandemic governance to better health system preparedness concerning the COVID-19 pandemic and future disease outbreaks.

This study also contributes to a growing body of knowledge focused on defining, identifying, and measuring obstetrical violence in hospital settings. Obstetrical violence is a term and concept that is useful for critiquing the harmful norms and practices that can accompany routine obstetrical care (Bohren et al., 2016). The pandemic has made explicit how birthing and pregnant people can be harmed through routine, technocratic practices of obstetrical care that are intended to make birth safer (Davis-Floyd et al., 2021). Scholars and activists thus argue for the need for a concept of obstetric violence that is defined not only by overt forms of abusive and/or non-consensual care, but also by the impacts, outcomes, and processes of routine institutional practices (Salter et al., 2021). The pandemic is a time of rapid policy change which has had an immense impact on the physical and mental well-being of pregnant and postpartum people and healthcare providers; studying policy implementation is thus necessary to gather more information on the structural nature of obstetric violence, and how it is perpetuated and sustained through the policy process. This knowledge can aid the creation of better policy processes that prioritize the needs and experiences of people and healthcare providers who must work within constrained occupational contexts under bureaucratic hierarchies.

CHAPTER TWO: LITERATURE REVIEW

1. Introduction

This literature review seeks to map pandemic policy responses in the context of obstetric care. The objectives of this literature review are to summarize major pandemic policy changes in perinatal care; summarize the major changes in perinatal care during the pandemic, including the provision of, access to, and uptake of perinatal care; summarize available research on the impacts of pandemic policy changes on birthing people and healthcare providers, and; summarize the empirical and theoretical literature on obstetrical violence as it pertains to pandemic perinatal care and the experiences of birthing and postpartum people. Finally, four research questions are offered to guide inquiry alongside the study objectives.

Given the timely and specific nature of the topic, there is a limited number of studies published on pandemic perinatal care and policy implementation in the Canadian context. To summarize the pandemic perinatal care landscape as comprehensively as possible, this literature review synthesizes findings from both the international and Canadian literature, with a focus on the Canadian context and Atlantic provinces when possible. While healthcare system responses to the COVID-19 pandemic have differed significantly across countries and even regions within Canada, birthing people have been nonetheless affected by similar pandemic policies. Such policies draw on rapidly emerging evidence from different countries and perinatal care guidelines written by physician societies with international influence. It is thus important to locate the Canadian perinatal policy response within this global context of the pandemic.

2. Pandemic-related changes in obstetric care

Healthcare systems around the world have undergone significant changes in adapting to the various phases and challenges of the pandemic. Notably, responses to the pandemic vary significantly by country, region, and even by the individual hospital and/or maternity care site (Schmitt et al., 2021). Despite this heterogeneity, the following themes are observed from the literature: the organizational and spatial re-arrangement of hospital facilities and obstetrics units; staffing changes and redeployment; hospital infection control protocols; protocols to manage birthing people who returned positive screens and/or test results for COVID-19; and visitor policies. These changes are summarized below.

a. Organizational re-structuring and the spatial re-arrangement of obstetrics units

From the onset of the pandemic, many hospitals re-arranged the spatial organization of their units to protect birthing people, newborns, and staff from exposure to the COVID-19 virus. During the first wave, studies were rapidly being published showing that pregnant people were at an increased risk for severe illness from COVID-19 infection, resulting in many maternity wards taking extreme precautionary measures. Waiting areas, delivery rooms, and surgery rooms in maternity wards were re-organized to allow for social distancing between patients and staff (Murtada et al., 2020; Alferi et al., 2020). Hallways and doors were marked with signs, the floor with tape, and the intercom with announcements to manage traffic as care providers and birthing people were moved around the ward (Campbell et al., 2020; Harvey, 2020). A hospital in New York reported re-locating its obstetrics ward to a separate site far from the hospital building as a safety precaution (Bornstein et al., 2020).

At the same time, to manage the concurrent influx of COVID-19 patients within hospitals, the layout of maternity wards, delivery rooms, and emergency rooms was economized to accommodate for shortages in infrastructure treating and isolating COVID-19 positive patients (Schmitt et al., 2021). Single-occupancy rooms were converted into COVID-19 isolation rooms and low-pressure rooms to isolate COVID-19 birthing and postpartum people (Peña et al., 2020; Saiman et al., 2020). In some cases, the capacity of obstetrics wards was directly reduced; for example, in France and Italy, obstetrics and gynecology surgery areas were turned into COVID-19 wards (Alferi et al., 2020). In Canada, many hospitals cancelled elective obstetric and gynecological procedures to increase inpatient capacity and hospital resources for COVID-19 patients; this was reinforced in published guidelines and recommendations (Gold et al., 2022). Conversely, some US hospitals increased the capacity of maternity units and case rooms to ensure that birthing people did not have to go through the emergency room at general hospitals (Davis-Floyd et al., 2020).

b. Scheduling, staffing, and redeployment

To manage the scheduling of care providers, maternity hospitals arranged flexible duty rosters and a formal backup system for staff in the event of a surge in admissions or staffing shortage (Campbell et al., 2020). Healthcare workers in maternity care were redeployed to long-term care facilities, testing centres, and field hospitals to manage COVID-19 outbreaks (Walker et al., 2021; Gold et al., 2022). Redeployment was particularly widespread in Canada as well as the

US, UK, and Ireland (Unruh et al., 2021). Within obstetrics units, maternity staff were assembled into new teams and provided training on adaptability, flexibility, and working collaboratively under pressure and resource strain (Campbell et al., 2020). In Canada, "COVID-19 teams" were designated for COVID-19 suspected or positive birthing and postpartum people (Gold et al., 2022). Cohorts working in delivery rooms were separated from those working in the obstetrics or neonatal wards to limit interpersonal contact between the units (Danvers et al., 2020; Saiman et al., 2020). It was common practice for doctors working in multiple settings to transfer their clients to other care providers in order as a precautionary measure to minimize COVID-19 exposure (Maclean, 2020; Sibonney, 2020).

During the earlier phases of the pandemic, lockdowns, COVID-19 infections, and potential exposures resulted in significant staff shortages in obstetrical wards across the world (Schmitt et al., 2020). Limited access to personal protective equipment (PPE) exacerbated this, as many care providers who had met COVID-19-positive patients without adequate PPE were required to test or isolate them for fourteen days (Rochelson et al., 2020). A global survey found that PPE was prioritized for hospital wards treating COVID-19 patients, but not maternity wards and delivery rooms (Semaan et al., 2020). In Canada, staffing shortages continue to be a major problem as maternity wards shut down completely or reduced capacity due to vacancies resulting from redeployment, burnout, and lack of support to manage pandemic-related changes in occupational conditions, such as paid childcare and overtime pay (Mackenzie & Caruso-Moro, 2021; Raghem, 2022).

c. Infection control protocols

A scoping review of policy responses found that limiting the interpersonal transmission of the virus in obstetrics wards was reported as a top priority for pandemic perinatal care (Schmitt et al., 2021; Gold et al., 2022). As such strict PPE, testing, and risk assessment protocols for both staff and patients were implemented in many obstetrics units in Canada (Gold et al., 2022) and other OECD countries and China (Schmitt et al., 2021). As resources were made more available after the first wave, many hospitals in high-income countries and resource-rich areas administered a rapid test for each person who visited the maternity ward (Alfieri et al., 2020; Campbell et al., 2020; Johnson et al., 2020). Reports from Canada and the US describe the use of mirrors in hallways for convenient PPE fit checks, and the staffing of so-called "dofficers" to monitor and

ensure care providers always adhere to infection control and PPE protocols within obstetrics units (Campbell et al., 2020; Kumaraswami et al., 2020).

d. Caring for COVID-19 positive birthing and postpartum people

Another major change in perinatal care during the pandemic was providing care to symptomatic and/or COVID-19-positive people. Birthing and postpartum people with suspected or positive COVID-19 infection were isolated from the main floor of obstetrics wards and often moved into dedicated COVID-19 units with low-pressure rooms (Saiman et al., 2020; Peña et al., 2020). For some hospitals, this was achieved through the postponement of gynecological clinics and elective gynecological surgery (Sheil, 2021). Canadian case reports and guidelines recommend creating separate clinics and wards designated for providing antenatal care to COVID-19 positive or suspected persons in high prevalence regions (Gold et al., 2022). Contact between hospital staff and COVID-19 positive or suspected persons was reduced to the bare minimum and often over the phone/room speaker, limiting all "non-essential" assessments (Gold et al., 2022; Semaan et al., 2020).

e. Visitor policies and denying birthing support persons

Limiting visitors in the obstetrics ward was a major component of infection control protocols in maternity hospitals. The most notorious and controversial policy decision was to limit the number of, or prohibit altogether, birthing support persons. Hospitals in Canada and many others around the world put in place "birthing alone" policies prohibiting the presence of even one support person in the delivery room and postpartum (Seeman et al., 2020). Partners were also banned from attending appointments and ultrasound scans based on provincial infection control directives to limit the number of people in obstetrics wards (Coxon et al., 2020). Birthing support policies were relaxed after universal public backlash and advocacy by maternity care workers to allow one single accompanying person in the delivery room and postpartum (Danvers & Dolan, 2020; Grant, 2020). Despite this, studies report that 33.5% of people who gave birth in a US hospital from 2020 to 2021 were denied a birthing support person (Liu et al., 2021). The increasing availability of PPE and rapid tests also played an influential role in the easing of such restrictions worldwide; however, if not provided by the hospital, these tests were not widely available to the public and/or expensive to obtain (Wegrzynowska et al., 2020; Peña et al., 2020).

f. Separating newborns from parents or family members

Since the WHO declared the pandemic, breastfeeding, skin-to-skin contact, rooming-in, and maintaining proximity were recommended even for mothers with suspected or confirmed cases of COVID-19 (WHO, 2020). However, recommendations from many professional organizations differed from this; the American Academy of Pediatrics (2020) and national guidelines from China (Wang et al., 2020) and India (Hethyshi, 2020) initially advocated for the separation of COVID-19 positive or suspected mothers from their newborns. In New York, newborns were transferred immediately to the neonatal intensive care unit to be observed for complications if the birthing person was positive for COVID-19 (Peña et al., 2020). Out of 1,344 maternity hospitals in the US, 14% advised against skin-to-skin contact, even among healthy mothers, and 6.5% of hospitals banned it (Perrine et al., 2020). Almost half the respondents from a global, qualitative study reported that even healthy mothers were separated from their newborns at their hospital as a precautionary measure (Asefa et al., 2021). Data on the practice of separating mothers and newborns in Canada is lacking.

g. Inconsistencies in maternity care and response to COVID-19 pandemic

While different healthcare systems are bound to produce different responses to the COVID-19 pandemic, what is notable is the extent to which pandemic policies surrounding perinatal care have varied among different hospitals within the same country or region. In Canada, some hospitals implemented drastically different pandemic policies in the context of obstetrics from others in their region or province. Such inconsistencies are likely reflective of several site-specific considerations, including the number of COVID-19 cases in the hospital or region, the physical infrastructure and capacity of the hospital, resource shortages, and institutional norms surrounding "essential" obstetric care that influence pandemic policy priorities and allocation trade-offs. While it is true that many policy decisions are made based on practical considerations given the complex and strained care environments, the ideological position of institutions on obstetric care mediates how such policy decisions are carried out. For example, despite provincial recommendations, the Women's Hospital in Vancouver, BC, and the Whitehorse General Hospital in Whitehorse, Yukon, were among the first healthcare organizations in Canada to allow birthing people to have two support people during birth and postpartum (Pole, 2020). Conversely, research on obstetric care coming out of Europe shows significant deviance from the recommendations of authoritative bodies such as the WHO, Royal College of Obstetricians and Gynecologists, and American

College of Obstetricians and Gynecologists, with many local and organizational policies going against evidence-based, person-centred maternity care (Lalor et al., 2021).

Push-back against guidelines is not unique to the ongoing COVID-19 pandemic. During the H1N1 pandemic in 2011, many hospitals disputed the specific recommendations made by the CDC for perinatal care given the challenges of implementing them in context (Ruch-Ross et al., 2014). A survey-based study of 2,304 members of the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) reports over 70% of nurses from the US and Canada found that guidelines surrounding visitor policies (at the time, limiting birthing support person and visitors to just one, healthy adult) were the most difficult to implement compared to other infection control directives (Ruch-Ross et al., 2014). The authors presume this is because pandemic policies conflict with patient- and family-centred perinatal care models that are considered, at least in theory, the cornerstone of obstetric practice in North America today (Ruch-Ross et al., 2014). Similarly, other survey-based studies show that while CDC guidelines recommended the immediate separation of healthy newborns from mothers with suspected or confirmed influenza, this was a written policy at only 50.9% of hospitals and implemented only 40.2% of the time (Williams et al., 2013). Infection control policies that went against holistic and family-centred obstetrics care models were inconsistently implemented during the H1N1 pandemic (Williams et al., 2013; Zapata et al., 2013).

The similar response we are now seeing during the COVID-19 pandemic suggests that upstream policy expectations are sometimes not achieved on the frontline and in practice. In the context of obstetrics, this discrepancy is especially profound as infection control policies are often in conflict with patient- and family-centred models of perinatal care. Despite this, how healthcare providers, who act as frontline policy implementors, manage such discrepancies in the ideological basis of policies in perinatal care is unknown. What is well-known is how pandemic policies and healthcare system responses have impacted the provision of obstetrical care and the experiences of birthing and postpartum people. This perspective is crucial to contextualizing the risks and benefits associated with such policies. Further, in more remote regions like Newfoundland and Labrador, the proportionality of the risk of a COVID-19 outbreak is a relevant consideration. A study from the Netherlands found that obstetric care workers from the central part of the country with high COVID-19 caseloads found restrictions to be "tough, but necessary," while workers from the Northern region with lower caseloads perceived the measures to be too strict (Appelman et al., 2022). Another study from Spain found that restrictions surrounding visitors, breastfeeding,

and isolation were much more relaxed in regions with higher caseloads because these hospitals had person- and family-centred maternity care initiatives in place (Muñoz-Amat et al., 2021). Research on this topic coming out of Canada is limited; however, given the severe restrictions in place in Atlantic Canada, it is reasonable to assume that perceptions of COVID-19 risks, infrastructural and resource constraints, and organizational priorities surrounding "essential" obstetric care factor into policy implementation decisions.

3. The impact of the COVID-19 pandemic on obstetric care

Organizational restructuring and policy decisions within hospitals had a significant impact on the provision of, access to, and uptake of perinatal care. This section summarizes these changes in perinatal care, including the access to the uptake of perinatal appointments, telemedicine, medical interventions during birth, breastfeeding support, and postpartum care in hospitals.

a. Global changes to antenatal care and telemedicine

A systematic literature review of the effects of the pandemic on the provision of and access to antenatal care shows that pandemic protocols for birth and postpartum care varied significantly by the healthcare organization and hospital site (Townsend, 2021). Meta-analysis of quantitative studies shows a 38.6% decrease in antenatal care appointments offered during the pandemic (Townsend et al., 2021). In high-income countries, scaling back face-to-face antenatal care was met with an increase in virtual appointments for low to moderate-risk pregnancies, but in low-income countries and rural areas with poor infrastructure, antenatal care suffered greatly (Galle et al., 2021). In one obstetrics service centre in New York, telemedicine was introduced for even high-risk prenatal care as a precautionary measure (Jeganathan et al., 2020). In addition to the overall scaling back of antenatal care, attendance to in-person antenatal appointments also decreased globally due to accessibility issues and fear of contracting COVID-19 at maternity clinics and hospitals (Townsend et al., 2021). In the US and Canada, pregnant people from low-income households, essential workers, and im/migrants were placed particularly at risk, as they are less likely to have access to benefits such as health insurance (in the case of the US). paid sick leave, access to working from home, childcare, and a personal vehicle to travel to and from appointments during the pandemic (Onwuzurike et al., 2020).

b. Increase in the use of medical interventions during birth

Pandemic-related policy changes in healthcare facilities also impacted the birthing process. For COVID-19 positive or suspected people, there was a significant increase in the rates of induced labours and cesarian sections, and an overall shortening of hospital stay (Peña et al., 2020; Semaan et al., 2020; Greene et al., 2020). Studies from the first wave of the pandemic show cesarian section rates of >90% for birthing people infected with coronavirus (Della Gatta et al., 2020; Zaigham & Andersson, 2020; Zhang et al., 2020). The reasoning behind the use of such interventions is rarely justified, with early case reports providing "fetal distress" as a reason for cesarian without other evidence (Zaigham & Andersson, 2020). At the onset of the pandemic, the criteria for caesarean section were lowered in some countries to reduce inpatient stay, ensure the use of PPE, and reduce the risk of infection among staff (Qi H et al., 2020; Asefa et al., 2021). Studies also report birthing people without COVID-19 infection experiencing a change from vaginal birth to an induction or cesarian section birth (Liu et al., 2021; Arab, 2021).

Cesarian births entail a higher risk for ectopic pregnancy, placental problems, uterine rupture, hemorrhage, and stillbirths in future pregnancies (O'Neill et al., 2014; Bodner et al, 2011). This has significant consequences for maternal health and limits future birthing options. A Canadian study of people who gave birth from 1991 to 2005 reported that cesarian section surgeries increased the risk of hemorrhage requiring hysterectomy, infection rates three times of vaginal deliveries, and complications from general anesthesia ranging from cardiac arrest and renal failure (Liu et al., 2007). A link between postpartum depression and cesarian surgery has also been established (Xie et al., 2011). However, the over-medicalization of birth was a problem long before the observed increase during the pandemic (WHO, 2015). In Latin America, 43% of all births are cesarian sections, and in several countries (Brazil, Turkey, Cyprus, Egypt, and the Dominican Republic) cesarian sections are more prevalent than vaginal deliveries (WHO, 2021). The mechanisms behind the increase in medical interventions during the pandemic must therefore be critically examined.

Qualitative research on medical intervention use in Canada explains that both pregnant people and care providers seek medical interventions, such as scheduled inductions and cesarian sections, to mitigate pandemic-related stress and uncertainty (Rice & Williams, 2021b). Pregnant people felt inclined toward scheduling an induction to manage their anxieties surrounding the duration of hospital stay, including ensuring that their partners could be present with them for

delivery and/or postpartum, while time-strained care providers tried to provide their patients with alternatives to such conditions (Rice & Williams, 2021b). A hospital maternity unit in Italy presumes that their higher rate of induction of labour during the pandemic was a consequence of logistical factors, including easier organization of labour and delivery rooms, to ensure a homogenous distribution of work shifts, temporal, and spatial separation of patients, and managing staffing shortages (Cesano et al., 2021). Such an environment of non-decision for birthing people is detrimental to informed consent and a positive birthing experience (Lou et al., 2019). This trend toward medicalization has resulted in a sizable number of birthing people having a more medicalized birth than preferred, associated with a higher risk for iatrogenic harms and lower satisfaction with birth (Preis et al., 2021).

Interestingly, while inductions and cesarian sections are on the rise, several hospitals in the UK have banned all maternal request cesarian sections during the pandemic, ruling it out as "clinically unjustified" and thus non-essential. These include elective or request cesarian section surgeries as a way for birthing people to manage severe birthing anxiety during the pandemic, or requests coming in from people with visible and/or invisible disabilities for whom pandemic policies make the birthing process even more inaccessible and potentially dangerous to psychological and bodily integrity (Romanis & Nelson, 2020). These trends are indicative of the increasingly conservative and technocratic climate of obstetric care, eroding patient autonomy and hard-won birthing rights.

c. Pain management and intrapartum analgesia

Pandemic infection control threatens other aspects of patient choice in perinatal care, namely access to preferred pain medications. Alongside increases in inductions and cesarian sections, a meta-analysis of studies reporting on analgesic use show an overall decrease in access to preferred medications before and after delivery, such as nitrous oxide, and a decrease in general anesthesia use for emergency cesarian sections (Liu et al., 2021; Bhatia et al., 2021). This is likely due to several organizations advocating for suspending nitrous oxide and general anesthesia use because of the possibility of aerosolization and COVID-19 transmission (Boelig et al., 2020; Donders et al., 2020; Ashokka et al., 2020). However, some organizations argue the use of nitrous oxide is safe and essential to perinatal care, given that single-use microbial filters are in place and the staff wears PPE (Bauer et al., 2021). In the province of Prince Edward Island in Eastern

Canada, the policy decision to ban the use of nitrous oxide during birth was not communicated during consultations with physicians (Davis, 2020).

The discrepancy in opinions surrounding nitrous oxide use during the pandemic speaks to the tensions between person-centred perinatal care and pandemic infection control. These trends are significant given inadequate pain management is associated with an increase in risk for clinical depression and PTSD symptoms postpartum (Creedy et al., 2000; Soet et al., 2003; Kountanis et al., 2022). Access to pain relief during the pandemic is especially crucial, as studies document birthing people's perception of pain during delivery to be significantly heightened during the pandemic (Ostacoli et al., 2020). The decisions to decrease access to preferred pain medications must be assessed alongside bans on birthing support persons, considering documented evidence exists on the effects of a birthing companion on birthing people's perception of pain during vaginal delivery (Lopez-Sola et al., 2019) and during and after elective caesarian surgery (Keogh et al., 2006). There appears to be no research on whether adequate pain relief is considered within pandemic resource allocation decisions.

d. Breastfeeding support and postpartum care

The breastfeeding support available to pregnant and postpartum people has also decreased during the pandemic. A study of 1,344 maternity hospitals in the US reports that only 17.9% provided breastfeeding support for postpartum people (Perrine et al., 2020). Some hospitals in Europe initially advised not to breastfeed (Coxon et al., 2020; Pietrasanta et al., 2020). Postpartum people in Canada were also left with inadequate breastfeeding support in hospitals (Rice & Williams, 2021a). While Canada's guidelines for breastfeeding and skin-to-skin contact have followed WHO guidance, the organizational response has mainly prioritized a hospital-centric approach and decreased breastfeeding services (Haiek, 2021). On the other hand, hospitals in Spain with Baby-Friendly Initiatives (BFI) were committed to providing postpartum care and breastfeeding support during the pandemic (Muñoz-Amat et al., 2021). The consequences of this are reflected in postpartum people opting out of breastfeeding plans for formula during the pandemic (Burgess et al., 2021).

The pandemic has exposed the pervasive assumption underlying technocratic models of birth that breastfeeding can be disregarded in the broader context of "essential" perinatal care. Other aspects of postpartum also suffered during the pandemic, with an overall decrease in postpartum stay in hospitals, postpartum depression screening, contraceptive consultations, and

mental health support (Sakowicz et al., 2021; Townsend et al., 2021; Greene et al., 2020). Despite the paucity of research on the postpartum period during the pandemic, qualitative research on the experiences of postpartum women in Canada and Finland shows that this was particularly a stressful time in the hospital with limited access to healthcare personnel (Rice & Williams, 2021a; Kuurne & Leppo, 2022). These findings suggest that pandemic policy decisions greatly impact the provision of full-spectrum perinatal care as individual hospitals or care providers are left to determine the urgency and necessity of a broad range of services (Onwuzurike et al., 2020). These decisions have a significant impact on birthing and postpartum people's health and experiences in the healthcare system.

4. The impact of pandemic policies on pregnant and birthing people

These documented changes in perinatal care worldwide and in Canada show an overall decrease in access to and quality of care available to pregnant, birthing, and postpartum people. The effects of organizational restructuring, pandemic policies, and changes to perinatal care have significantly impacted birthing people and their well-being. This section documents these impacts, describing prenatal and postpartum mental health, changes to birth plans, and satisfaction with birth and postpartum care during the pandemic.

a. Changes to pregnant people's birth plan

Single and multi-site studies from the US report that nearly half of people who gave birth during the pandemic experienced an unanticipated change to their birth plan (Gildner et al., 2021; Liu et al., 2021). The most common changes include modifications to an existing hospital birth plan, such as shortening postpartum stay, increase in labour inductions, lack of choice surrounding pain management and intrapartum analgesia; changing birth locations or providers, including the unavailability of preferred care provider during birth; and, pandemic-related changes to childbirth, including having fewer support people at birth and postpartum; and, disrupted prenatal and postpartum care (Gildner et al., 2021; Liu et al., 2021). On top of an overall observed decrease in satisfaction with birth, those who had to birth alone had significantly lower levels of birth satisfaction than those allowed one support person (Preis et al., 2021). Black and Latina women in New York reported lower birth satisfaction and higher postpartum anxiety, stress, and depressive symptoms compared to White birthing people that were associated with one or more incidents of health care discrimination (Janevic et al., 2021). In comparison to people who gave birth at a

hospital, those attended to by midwives in community birthing centres experienced fewer disruptions to perinatal care and reported being generally satisfied with their birth experiences (Rudrum, 2021).

b. Experiences of birth

Overall, hospital infection control measures and restrictions on the presence of support people during birth and postpartum were reported to be major sources of concern for pregnant people in the prenatal period (Gildner & Thayer, 2020; Ahlers-Schmidt et al., 2020). Qualitative research on the experiences of birth shows that many women experienced feelings of significant fear, stress, and anxiety during labour and birth as a result of pandemic policies restricting the presence of support persons during delivery (Boukoura, 2021; Mollard & Wittmaack, 2021; Kuurne & Leppo, 2022). Birthing people who had to undergo an emergency cesarian section were often denied their support person; these individuals had exceptionally negative birth experiences compared to those who underwent a planned cesarian section (Liu et al., 2021). In the absence of support persons and limited medical staff, the stress became debilitating for many, with narratives of birthing people often documenting states of intense fear, crying, and isolation (Kuurne & Leppo, 2022). Furthermore, visitor policies disproportionately impacted racialized birthing people, as many relied on an extended support network to protect themselves against the racist and discriminatory treatment by healthcare professionals (Altman, 2021a). Studies also report that White birthing people demanded exemptions or accommodations from policies more than racialized birthing people, and care providers frequently bent the rules for White patients (Altman, 2021a; 2021b).

c. Experiences postpartum

From the research available on the experiences of birthing people postpartum, some of the most difficult experiences notably took place in the days following delivery. Many postpartum women felt overwhelmed having to care for their newborns alone right after delivery without support from their partners or hospital staff (Rice & Williams, 2021a; Wilson et al., 2021; Silverio et al., 2021). Research documenting such postpartum experiences shows that women were frequently left alone in a room after delivery and cesarian section surgery without adequate support for tasks such as getting up from bed, moving around the room, and going to the bathroom (Kuurne & Leppo, 2022; Rice & Williams, 2021a; Wilson et al., 2021). These situations inevitably placed postpartum people in demeaning and humiliating situations, such as being unable to fetch water

and sitting in urine (Rice & Williams, 2021a; Kuurne & Leppo, 2022). In some cases, neglect was almost life-threatening (Rice & Williams, 2021a).

These experiences were amplified amidst quick and dramatic hospital policy changes that, for some, were instantiated in the middle of their stay. This resulted in some postpartum women being reprimanded and verbally abused by nursing staff for asking for help when policies had changed effectively overnight (Rice & Williams, 2021a). Many did not feel comfortable asking for help because of this hostile environment and the pandemic restrictions in place (Kuurne & Leppo, 2022). As reported in studies published in the US, Canada, UK, and Finland, respectively, many described their intrapartum and postpartum experiences as akin to being in prison (Breman et al., 2021, p. 531; Rice & Williams, 2021a, E559; Silverio et al., 2021, p. 6; Kuurne & Leppo, 2022, p. 94). Interrupted breastfeeding support also contributed to the negative experiences of many first-time mothers postpartum. Research shows that those who experienced breastfeeding difficulties were more at risk for depression at two months post-partum (Watkins, 2011). Having to breastfeed without adequate guidance amidst physical pain and no support person left many postpartum women feeling overwhelmed, hopeless, and exhausted (Rice & Williams, 2021a; Kuurne & Leppo, 2022).

However, not all postpartum experiences were negative. Policies limiting the number of visitors on the ward were preferable to some postpartum people, as such conditions allowed for rest and uninterrupted bonding time with their newborns (Ostacoli et al., 2020; Grumi et al., 2020; Rice & Williams, 2021a; Kuurne & Leppo, 2022). This was even observed as a protective factor for postpartum mental health (Ostacoli et al., 2020; Grumi et al., 2020). It is important to note that those who had positive birth and postpartum experiences were individuals who gave birth without complications and medical interventions, who required less postpartum support, and who were mostly second or third-time mothers (Rice & Williams, 2021a).

d. Trends in maternal mental health

Of all studies available on pregnancy and birth during the COVID-19 pandemic, there is relatively the most known about the effects of the pandemic on maternal mental health. Research on earlier pandemics and environmental disasters shows that pregnant and postpartum people experience a higher incidence of mental disorders than the general population (Vesga-López et al., 2008; Harville et al., 2010). This trend is again observed during the ongoing COVID-19 pandemic. In Canada, there is a reported increase in symptoms of depression and anxiety among pregnant

and postpartum people (Davenport et al., 2020). Studies from China (Wu et al., 2020; Dong et al., 2021), Italy (Zanardo et al., 2020; Ostacoli et al., 2020), Spain (Mariño-Narvaez et al., 2020), Turkey (Güvenç et al., 2021), the UK (Riley et al., 2021), India (Jungari, 2020), Australia (Frankham et al., 2021), and Brazil (Galletta et al., 2022), including several systematic reviews on maternal health during the pandemic (Yan et al., 2020; Kotlar et al., 2021), corroborate these findings.

The role of COVID-19-based fear is an essential factor in maternal mental health. For example, a study from Canada shows that COVID-19-based fear, defined as the participant's perception of threat from the virus to themselves and their unborn baby, was associated with increased odds of clinical depression and anxiety postpartum and a significant reduction in neonatal birth weight and gestational age at birth (Giesbrecht et al., 2021). Interestingly, this study also found that COVID-19-based fear was the highest among im/migrants, those self-identifying as a "person of colour" or racialized, and those residing in specific geographic locations; Newfoundland and Labrador, followed by Saskatchewan and Manitoba, report the highest levels of COVID-19 based fear, while Northwest Territories and Québec report the lowest, suggesting no correlation between regional per-capita deaths or caseloads within the region (Giesbrecht et al., 2021). However, such trends did correlate with information-seeking behaviour from news and media (Basu et al., 2021).

e. The impact of hospital policies on maternal mental health

Hospital pandemic policies appear to play a role in driving this observed increase in mental disorders among postpartum people. It is generally understood that changes to birth plans, unexpected situations, and restrictive policies, such as the denial of a birthing companion, harm the mental health and well-being of pregnant and postpartum people. Studies report that changes or interruptions to prenatal care and birth plans, including changes to the presence of birthing support persons and personnel during labour, delivery, and postpartum, are associated with an increase in the prevalence of mental disorders, notably PTSD symptoms, among pregnant and postpartum women (Pries et al., 2020; Gildner et al., 2020; Beeson et al., 2021; Liu et al., 2021). Two other studies report that giving birth alone was associated with an increase in anxiety and PTSD symptoms (Puertas-Gonzales et al., 2021; Yakupova et al., 2021a; 2021b). However, a study from Italy reports that while perceived support provided by healthcare staff during birth was a protective factor against postpartum depression, no significant associations were observed

between depressive symptoms and not having a birthing partner (Ostacoli et al., 2020). Given interruptions to prenatal care and the high incidence of postpartum depression before the pandemic, depression symptoms might be difficult to detect (Puertas-Gonzales et al., 2021). Prior studies have established that specific negative experiences of birth recalled by women, including birthing alone, may have an enduring and complex effect on maternal mental health months postpartum (Bohren, 2017).

5. The impact of pandemic policies on obstetric care providers and hospital staff

The pandemic has also had a significant impact on the well-being and practice of obstetric care providers. Notably, care providers are placed in difficult positions having to navigate pandemic policy orders while balancing the provision of patient-centred maternity care. How this impacts care providers and decision-making processes is largely unknown. This section presents the available research on the mental health of maternity care providers, including issues of burnout, moral injury, and the impact of pandemic policies on mental health and practice.

a. Care provider mental health

Care provider health also suffered during the pandemic as a result of having to manage staffing shortages, limited PPE, increased workloads, and increased emotional and physical burdens (Bailey & Nightingale, 2020). Studies show anxiety and depression to be higher among obstetric staff than the rates of the general population in the UK (Shah et al., 2020). Of all allied health professions, several studies report midwives to have higher rates of mental disorders and chronic stress compared to physicians and nurses (Yörük & Güler, 2020; Holton et al., 2020). Occupational exposure to the virus and the risk of transmission to mothers and newborns was a prevailing concern among hospital-based obstetric care workers (Bradfield et al., 2021; Riggan et al., 2021). Physician burnout was also a problem in maternity care staff, especially among neonatal health workers who were worried about spreading the COVID-19 virus to newborns in the neonatal ICU (Haidari et al., 2021). Care provers also report experiencing stress from having to implement severe pandemic policies, namely denying support persons during birth and separating newborns from mothers (Riggan et al., 2021; Hantoushzadeh et al., 2021).

b. Moral injury

Moral injury, the psychological stress stemming from making decisions that one believes to be morally or ethically wrong or inappropriate (Griffin et al., 2019), is an increasingly

documented phenomenon among healthcare workers during the COVID-19 pandemic (Čartolovni et al., 2021; Raiff et al., 2022). Maternity care workers were expected to implement policies that caused suffering, such as prohibiting birthing support persons, separating mothers from newborns, and limiting contact with postpartum people (Dethier & Abernathy, 2020). In a global survey of maternal health professionals, one female gynecologist shared her outrage at the association's recommendation to ban birthing support persons and doulas partners during birth (Seeman et al., 2020). These experiences of maternity care providers are significant and can result in occupational moral injury, influencing decision-making (Litz et al., 2009).

The pandemic presents a unique context wherein healthcare providers must negotiate between protecting themselves and their families from exposure to COVID-19, protecting birthing people and newborns, and providing personalized, patient-centred care to birthing and postpartum people (Horsch et al., 2020; Danvers & Dolan, 2020). In the absence of occupational support, toxic workplace cultures that normalize burnout, and organizational hierarchies, moral injury puts care providers at significantly higher risk for mental disorders such as PTSD and depression (Williamson et al., 2018). Research on how care providers navigate such ethical tensions is crucial to understanding decision-making processes during a time where person-centred care is overshadowed by policies prioritizing infection control.

c. The impact of rapid hospital policy changes on care provider well-being

Adapting to the rapid and inconsistent policy changes during the pandemic was a significant source of stress for obstetricians, nurses, and midwives (Riggan et al., 2021; Gonzáles-Timoneda et al., 2021; Schmitt et al., 2021; Bradfield et al., 2021). A global survey found that the most significant factor in work-related changes to mental health status among obstetricians was keeping up to date with policies and guidelines related to COVID-19 (Shah et al., 2020). Staff also reported anxiety surrounding not being able to react quickly enough in emergencies because of first having to get dressed in full PPE (Semaan et al., 2020). Around the world, maternity care providers ubiquitously report feeling overwhelmed and burnt out from having to adapt to rapidly changing infection control policies (Asefa et al., 2021). Obstetric care providers also report dissatisfaction with the (lack of) support offered by their employers amidst their occupational conditions during the pandemic (Haidari et al., 2021).

d. Implementing pandemic policies and healthcare provider decision-making

How care providers respond to such stress and implement policies in practice is largely unknown. Considering the rise in medical intervention use during birth as a pandemic stress-mitigation strategy (Rice & Williams, 2021b), exploring the relationship between rapid policy change and policy implementation from the perspective of care providers is imperative to understanding how the pandemic impacts the provision of obstetrical care. Qualitative research on the experiences of midwives suggests that amidst the scaling back of perinatal care and pandemic-related restrictions, midwives struggled with creating a safe and respectful environment for people giving birth while trying to adhere to COVID-19 guidelines (Schmitt et al., 2020; Bailey & Nightingale, 2020; Gonzáles-Timoneda et al., 2021). Interestingly, many described having to re-position their role as a midwife, adjusting to providing less emotional support and instead prioritizing COVID-19-related care and precaution (Gonzáles-Timoneda et al., 2021). Similarly, obstetrics nurses and obstetricians also found it difficult to provide comfort to patients, such as through a smile or touch, which was an aspect of care that many felt was a cornerstone of their practice (Yates et al., 2020).

Given rapidly changing policies surrounding infection control, many healthcare providers reported confusion over how to implement COVID-19 policies (Asefa et al., 2021). Within the context of emergency obstetric care in Uganda, a qualitative study found that healthcare providers coped with unclear policy expectations, inadequate workforce and skills, resource strain, and emotional stress by "improvising" the implementation of policies (Mukuru et al., 2021). This involved providing services based on resource availability rather than the needs of pregnant people, modifying policies to meet contextual needs, and referring mothers to different healthcare facilities. Policy implementation decisions were made via "word of mouth" – namely, the word of the attending staff (Mukuru et al., 2021, p. 265).

Institutional hierarchies and the interpretive processes of obstetric care workers as frontline policy implementers may play a significant role in how pandemic policies get carried out in practice. These interpretive repertoires include norms, values, and assumptions that surround obstetric care and biomedicine, shaping views on what constitutes "essential" obstetric care among care providers. Research from previous pandemics and other disasters shows that obstetricians in such emergency contexts tend to entrench their beliefs more deeply in technocratic and highly medicalized models of birth (Davis-Flyod, 2001; 2021). The observed increase in medical

intervention uses and other pandemic policy implementation decisions can be attributed to this "reflex reaction" of obstetric care providers reverting to deeply held beliefs surrounding birth and risk (Davis-Floyd et al., 2020). Given this increase in the prevalence of the technocratic model of birth, uncovering discourses underpinning the decision-making processes of obstetric care providers during the pandemic is a crucial component of understanding how policy implementation impacts obstetric care.

6. Obstetric Violence

Findings from this literature review suggest that birthing people experienced unnecessary harms during childbirth and postpartum because of pandemic policies in hospitals. Evidence also suggests a significant increase in the prevalence of mental disorders and moral injury among obstetric care providers who are often required to implement such policies in practice. Disruptions to respectful, person-centred perinatal care are symptomatic of how maternity care is organized in Canada and around the world, and the power imbalances between patients, care providers, and biomedical institutions. The pandemic has exposed harmful norms and practices in biomedicine that are now felt, seen, and experienced widely, even by healthcare providers occupying relative positions of power. In response to this, many scholars and activists are demanding attention to how the COVID-19 pandemic has increased the prevalence of *obstetric violence* worldwide (Sadler, 2020; Salter, 2021).

a. Historical review of obstetric violence

Obstetric violence is a form of gender-based violence encompassing mistreatment, disrespect, and abuse in obstetric settings. Historians of medicine have traced the roots of obstetric violence to colonialism and the violent appropriation of Indigenous and Black women's bodies and reproductive labour as a means for economic profit and colonial expansion (O'Brien, 2022). Antebellum-era physician James Marion Sims, heralded as the "Father of modern gynecology," violently and unethically experimented on the bodies of seven enslaved women suffering from vesicovaginal fistulas[4,5] (Ojanuga, 1993). He performed surgeries on these women dozens of times

[4] Vesicovaginal fistulas are tears in the vaginal wall connecting to the bladder from a difficult childbirth (prolonged or obstructed labour) and may lead to urinary incontinence (Safe Mother, 1999).

[5] Only three out of the seven women are known through historical records. Their names were Betsey, Anarcha, and Lucy. They lived in Alabama (Owens, 2017).

without anesthesia based on the racist assumption that Black women could not feel pain as much as White, upper-class women (Owens, 2019). Using silverware to hold open the vagina for stitching, Sims founded the speculum, still used today to examine the vagina and the cervix (Kaupp-Roberts, 2020). He later performed experimental gynecological surgeries on working-class Irish immigrant women at a teaching hospital in New York, where the medical notes of the observing physicians themselves document abuse (Dexter, 1845; Elliot, 1856; Emmet, 1893). Through the 19th and 20th centuries as birth became increasingly medicalized, birth attendants and midwives, who were traditionally women, were systematically replaced with male obstetricians (O'Brien, 2022). Unnecessarily aggressive medical interventions, the technocratic management of risk, and the subordinate position of the birthing person as the "patient" eventually normalized the routine denial of patient autonomy for many procedures (O'Brien, 2022).

The term "obstetric violence" was first introduced in Latin America in the 1990s to call attention to the human rights violations subjected to women and girls during childbirth. This literature documented and focused on extreme forms of mistreatment in maternity care settings, such as instances of physical, sexual, and verbal abuse, coercion, non-consensual treatment, and deprivation and neglect violating the autonomy and dignity of birthing people (Castro 2019; Castro & Savage, 2019; Sadler et al., 2016; Williams 2018). Activism against obstetric violence in Latin America resulted in the passing of legislation in Venezuela (2007), Argentina (2009), Chile (2015), Colombia (2017), Ecuador (2018) and Uruguay (2018) that recognizes obstetric violence as a form of gender-based violence, punishable by law. In South Africa, where obstetric violence is a significant issue, discussions to take legal action against obstetric violence are also becoming more prevalent (Chadwick, 2016).

The term "obstetric violence" has since evolved to include routine practices that cause harm to birthing and postpartum people, including the non-evidence-based use of medical interventions, routine episiotomies, routine inductions, unnecessary caesarean sections, and the prohibition of labour companions (Chadwick, 2016; Sadler, 2016). Indeed, contemporary debates on obstetric violence draw attention to how a wide range of routine practices in obstetric care intended to make birth safer lack evidence-based and increase the risk for iatrogenic harm (Cheyney & Davis-Floyd 2019, Davis-Floyd et al., 2021). Scholars also draw attention to the various coercive methods utilized in hospitals, such as threats directed at birthing people to call child services and litigation against refusing medical interventions (Diaz-Tello, 2015). These forms of covert violence have

been described as expressions of a kind of "structural" violence that is rooted in the colonial, heteropatriarchal, and cis-normative institution of Western biomedicine. This discourse recognizes the violence of degrading attitudes and behaviours towards birthing women and people, the authoritative power of biomedical knowledge over the embodied knowledge of the birthing person, and the fragmented, hierarchical organization of healthcare systems that result in disproportionate levels of harm to socially marginalized birthing people (Davis, 2019; Chadwick, 2021b).

As a form of intersectional gender-based violence, obstetric violence is produced and sustained through biomedical structures, norms, and healthcare practices (Sadler, 2016; 2021). In patriarchal societies where women, trans, and non-binary people experience gender-based violence and face state-sanctioned control of their reproductive capabilities, obstetric violence is not an isolated case of medical malpractice but structural and systemic. In Canada, Indigenous women and two-spirit people historically have, and continue to, disproportionately experience coercion into abortion (Kirkup, 2018) and sterilization (Action Canada for Sexual Health & Rights, 2019). Forced birth travel and evacuation policies for birthing Indigenous women and two-spirit people residing in remote reserves were put in place by the 1970s as a coercive and assimilationist measure to marginalize Indigenous traditional birthing practices and midwifery (Cidro, 2020). Obstetric violence is thus inextricable from state-sanctioned violence against Indigenous Peoples, specifically, women, two-spirit peoples, trans, and non-binary birthing people. To reflect the intersectional nature of obstetric violence across the full spectrum of reproductive care and not just birth, scholars are increasingly theorizing obstetric violence as a kind of violence against "reproductive subjects" (Chadwick, 2021a, p. 111).

Conceptualizing obstetric violence as a form of structural violence against reproductive subjects requires the structural conditions and processes that result in harm in obstetric settings to be examined (Sadler, 2020). This includes how healthcare systems function and operate, especially during intense resource constraints and pandemic-related pressures. Research from low and middle-income countries documents the challenges of providing holistic, person-centred maternity care when healthcare systems are strained to maximum capacity and met with severe resource constraints (e.g., Castro & Savage, 2019; Chadwick, 2017; Smith-Oka, 2013). The pandemic has intensified this reality even in high-income countries like Canada and the USA, where stark disparities in access to care and health status exist. As discussed in the literature review above, care providers working under such occupational conditions frequently experience burnout, mental

health disorders, chronic stress, toxic workplace culture, and moral injury. Many healthcare providers working within bureaucratic, hierarchical institutions are required by their job to implement severe policy directives that erodes patient-centred and evidence-based obstetric care. During the pandemic, the individual-level concerns of healthcare workers (e.g., COVID-19 infection and burnout) intersected with institutional-level concerns, such as feeling unvalued by healthcare organizations and concerns over lack of transparency of institutional leadership (Berkhout et al., 2021). Recognizing that healthcare providers are also survivors of structural violence is a necessary conceptual point to identify and intervene in norms and practices within medical institutions that perpetuate harm.

b. Research on obstetric violence during the pandemic

Despite theoretical advances, there is still limited research on obstetric violence coming out of the pandemic. However, scholars are increasingly naming experiences of harm as a result of pandemic policy decisions as obstetric violence (Rice & Williams, 2021a; 2021b; Sadler, 2020; Salter et al., 2021; Lévesque & Ferron-Parayre, 2021; Kuurne & Leppo, 2022; Davis-Floyd et al., 2021; Friesen, 2021; Smith-Oka et al., 2021; Yakupova et al., 2021; Mayra et al., 2022; Khalil et al., 2022; Rice, forthcoming). These studies document the experiences of birthing and postpartum people that entail indirect forms of harm, such as inductions of labour for logistical purposes, the negligence of women in the postpartum period, inadequate pain relief. However, they also document more severe forms of harm, including the denial of a birthing partner and accounts of bullying and verbal abuse. The increase in the prevalence of indirect harms resonate with current discussions on obstetric violence that go beyond the focus on intention and overt physical violence, but rather, institutionalized attitudes, beliefs, and practices that result in harm (Rice & Williams, 2021a; 2021b). That harm to birthing and postpartum has intensified during the COVID-19 pandemic is also corroborated by findings from studies documenting negative experiences of birth and postpartum in Canada (Rudrum, 2021; Rice & Williams, 2021a;2021b), US (Mollard et al., 2021; DeYoung & Mangum, 2021), UK (Silverio et al., 2021), Brazil (Paes et al., 2021), Australia (Wilson et al., 2021; Frankham et al., 2021; Bradfield et al., 2021), and Finland, (Kuurne & Leppo, 2022). With the rise in social and health inequities, and the implementation of non-evidence based, severe infection control policies, the COVID-19 pandemic has been declared a "risk factor for obstetric violence" (Sadler et al., 2020).

c. Obstetric violence and the policy process

Studying pandemic policies and policy implementation processes is an urgent matter, as such policies both create the conditions for obstetric violence and justify the denial of forms of care that birthing and postpartum people require. This literature review shows that pandemic policy responses have failed to account for the needs of birthing people and even care providers. As a precautionary measure against COVID-19 infection, many healthcare organizations have ignored best practice guidelines in perinatal care and enacted severely restrictive infection control policies despite the lack of conclusive evidence on their effectiveness. Furthermore, the harms of these policies have been significantly minimized and even publicly justified by healthcare organizations as necessary trade-offs for infection control. Thus, the process by which pandemic policies get interpreted and implemented in obstetrics practice presents a unique opportunity to identify assumptions surrounding "essential" perinatal care that result in subpar care and sustain conditions for obstetric violence. Research into the policy implementation process is a necessary step in characterizing how obstetric violence is (re)produced and sustained within the biomedical system.

7. Conclusion

This literature review summarizes the healthcare system and policy responses to the COVID-19 pandemic within the obstetrics context. While inconsistencies and variances exist among the federal, regional, and organizational levels, universally, across all obstetric contexts, infection control policies were introduced to control the transmission of the COVID-19 virus. However, some organizations adopted exceptionally severe infection control policies that have caused harm to birthing people despite a lack of evidence for efficacy. Similarly, some organizations have implemented more person- and family-centric pandemic policies that better align with current evidence-based standards for respectful perinatal care. Emerging research shows that care providers make policy implementation decisions under rapid policy change, resource strain, and stress, potentially explaining why hospital-centric and technocratic beliefs surrounding "essential" perinatal care prevail over considerations of person-centred care. Such interpretive processes in policy implementation thus warrant further investigation to understand how policy implementation processes impact the provision of perinatal care during the pandemic.

8. Research Questions

Given the findings presented in the literature review and the study objectives, the following research questions are proposed to guide inquiry:

1. How do care providers interpret pandemic policies in the context of perinatal care?
2. How are pandemic policies implemented in practice?
    a. What are the informal decision-making processes surrounding policy implementation?
    b. How does this impact the provision of perinatal care?
3. How do care providers justify policy implementation decisions?

The following chapter will describe the methodology used to answer these research questions.

CHAPTER THREE: METHODOLOGY

1. Introduction

In this chapter, I will describe the methodological approaches of this study. I will clarify my epistemological position, positionality, and how these theoretical and philosophical orientations shape the design of this study. I will also offer a summary of the literature that makes up this study's theoretical framework, namely, the prominent frameworks in critical policy studies, street-level bureaucracy and organizational theory, and feminist studies as it relates to the concept of obstetric violence, and how these theories shape the assumptions underpinning the study's research questions and analytical approach. Finally, I will describe the methods of study recruitment, data collection, and data analysis, specifically the thematic discourse analysis framework.

2. Epistemological Perspectives

a. Social Constructionism

This study is grounded in a social constructionist epistemological paradigm that views knowledge as a social construction, that is a product of culturally situated social processes (Grasswick, 2006). Although social constructionist epistemology has diverse applications and nuances in different fields of study, its core tenant is centred on the belief that knowledge is subjective and produced through relational interactions among people. Within this belief, researchers establish not the objective truth on a matter, but construct "truths" based on the traditions of their given epistemic community through consensus-oriented processes (Given, 2008). Science and the scientific method are still considered human constructions. As summarized by renowned feminist philosopher of science, Donna Haraway (1988), uncritical conceptions of objectivity assume a "view from above, from nowhere," and "God's eye view," but as she emphasizes, "vision is always a question of the power to see – and perhaps, of the violence implicit in our visualizing practices. With whose blood were my eyes crafted?" (p. 585). Social constructionism destabilizes claims to objectivity and instead questioning – consistent with Haraway's metaphor of vision – how we learn to see, through our social, cultural, and political conditioning. Assuming that knowledge is socially constructed brings into question how power relations are at play in the processes of knowledge production and the production of truths (Haraway, 1988; Harding, 1995). Without delving into the ontological debate of realism vs.

relativism, social constructionism questions how our methods of knowing can capture a given reality, or Reality, and what social factors mediate this.

b. A turn to discourse

Social constructionist theories and research methods increasingly rely on describing knowledge as "discourse." Discourse theory and its methods of analysis are rooted in the academic disciplines of linguistics and the social sciences, specifically in the study of sociolinguistics and pragmatics (Yazdannik et al., 2017). These fields of study are primarily concerned with language-in-action, namely the text and its micro-linguistic elements of grammar, syntax, and structure (Nevin, 2002). Developments by social science theorists grounded within a social constructionist paradigm asserted that language does not transmit or describe knowledge but plays a role in *constituting* it. Discourse is therefore a social practice, a system of meaning-making shaping how we understand the world (Fairclough, 1998; 2001; 2010). Through the influence of philosophy coming out of the Frankfurt School of Critical Theory, and in the latter half of the twentieth century, the works of Michael Foucault and Jacques Derrida, "discourse" no longer referred to formal linguistics but more broadly, knowledge and power. The word 'discourse' is used in many ways in everyday lexicon and academic disciplines, but for Foucault, it referred to the "ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them" (Weedon, 1987, p. 108). In other words, power relations are (re)produced through discourse; dominant discourses acquire the status of truth.

Discourse analysis and its various theories and methods are increasingly used in nursing and public health research to understand how medicine is constructed as a social practice (Lupton et al., 1992; Yazdannik et al., 2017). More critical forms of discourse analysis have also been used to critique the ideologies operating in clinical settings (Weeks, 2004), healthcare systems (Smith, 2007), and health policy (Evans-Agnew et al, 2016). Within the context of pregnancy and birth, discourse analysis and its various iterations have been used to understand how pregnancy is discursively constructed through magazines (Shannon, 2006), pregnancy advice literature (Rodgers, 2015), pregnancy apps (Thomas & Lupton, 2015; 2016), social media (Tiidenberg & Baym, 2017), and how discourse plays a role in determining individual experiences and understandings of pregnancy (Darroch & Giles, 2016), the organization of maternity care services (McIntyre et al., 2012), and constructions of "normal" birth (Clews,

2013). At the level of health policy, discourse analysis has been used alongside policy analysis approaches to understand how obstetric policies are created in the international (Carant, 2017) and Canadian contexts (Hankivsky et al., 2014; Rudrum, 2012), and healthcare policy implementation (Ciccia & Lombardo, 2019).

c. Qualitative study design

This study is informed by social constructionist epistemology and the Foucauldian definition of "discourse" as it relates to both the research process and analytic framework. Social constructionist epistemological frameworks are increasingly applied in qualitative health research. Even interview-based, empirical qualitative research has increasingly developed social constructionist, reflexive practices, seeing the interview "data" not as factual accounts but as situated constructions of knowledge (see section d. below). However, within the health research field, positivistic and post-positivistic approaches still predominate, and qualitative research in the field has increasingly had to adapt a language of objectivity that conflicts with its epistemological claims (Varpio, 2019). For this reason, I intend to clearly describe the epistemological and theoretical framework of this study, and why this approach is appropriate both in terms of the study design and methodological rigour.

Firstly, this study intends to understand how healthcare providers implement pandemic policies in the context of perinatal care and its implications for obstetric care. Policy implementation is a social process that cannot be understood using biomedical frameworks, and which cannot be fully captured through quantitative methods alone. Secondly, eliciting healthcare provider narratives allows us to understand not only what such experiences entailed, but also *how* such experiences are described in the context of the interview. Focusing on *how* participants speak about policy implementation is a useful method to understand how societal discourses are reiterated, resisted, and negotiated in everyday narratives (Souto-Manning, 2014). Decision-making processes surrounding appropriate policy implementation in the perinatal care context are inextricable from the broader discourses of biomedicine and even the COVID-19 pandemic. Thus, a discourse-analytic approach provides a deeper insight into the contextual factors and decision-making processes surrounding policy implementation beyond a literal account of what is said by the interview respondent. The methods for this study and their justifications are further summarized in the methods section of this chapter.

d. Qualitative research as a social construction

The social constructionist epistemological position conflicts with the idea that an interview is the capture of objective information residing in an individual's mind. Rather, this position argues that the interview process is an interactive process of meaning-making between the researcher and the participant, where accounts of lived experiences and perspectives elicited, the 'data,' are too constructed through dialogue (Koro-Ljungberg, 2008). The knowledge produced in the interview encounter is dependent on the interaction of historical, cultural, social, and linguistic factors of both participants (Cisneros-Puebla, 2007). Interview narratives elicited in this process are thus situated, constructed accounts, rather than fixed factual experiences. A significant epistemological implication of this is that the research process is itself a social construction to be scrutinized (Charmaz, 2006). Data analysis is then tasked with both an interpretation of the *content* of the data and *how* it was produced (Braun & Clarke, 2019).

e. Positionality statement

For the reasons outlined above, it is relevant that I explicate my positionality. My experiences being socialized as a cis-gendered woman in the Middle East, and now in Canada, have greatly shaped my research interests and theoretical perspectives on women's health and maternity care. Living as a settler-immigrant who is part of a Muslim family, we experience colonial violence in the form of islamophobia through the expression of our ethnic identity in Canada. These experiences provide me with the standpoint to recognize and critically engage with the concept of obstetric violence, recognizing it as a form of gender-based, colonial violence. At the same time, as a settler on unceded Indigenous territories, I continually think through my positionality and my complicity in settler colonialism to ensure that I am not reproducing its harmful power dynamics through my academic work. Given my political commitments, I gravitate towards qualitative, social constructionist, and post-structuralist theoretical and methodological approaches that grant me a degree of interpretive freedom to deconstruct dominant discourses and ideologies of power. While this study is not explicitly on the topic of colonialism and racism in healthcare, I am aware of the oppressive history of the biomedical institution in Canada, especially in the field of obstetrics and gynecology. I acknowledge that the field in Western medicine is rooted in colonial violence, specifically in the form of medical experimentation on slave women's bodies (Amster, 2022). In Canada, birth evacuation policies forcibly remove Indigenous birthing people from their communities,

functioning as an "invisible assimilationist policy" towards structural de-investment from community-based midwifery and traditional birth work (Kaufert & O'Neil, 1990; Cidro, 2020). However, despite such structural barriers, much radical work is also taking place towards expanding midwifery care, community-based birthing centres, and healthcare education and cultural safety training (Cidro, 2020). The work of my supervisor, my thesis committee members, and communities of practice committed to the provision of person-centred, respectful maternity care continually inspires me. It is in this political context that I situate my research and my motivations to ultimately work towards making the medical institution safer for all birthing people, and ultimately eradicating obstetric violence and gendered-based violence writ large.

My interests in maternity care also directly stem from my experiences working with im/migrant women and birthing people at a community health centre in Toronto and my more recent volunteer work at Maison Bleue in Montréal. At these centres, many clients do not have permanent Canadian residency, provincial healthcare, or knowledge of English or French. Although I have never given birth, I firmly believe that all pregnant and birthing people have a right to accessible, free, and respectful maternity care that centers on their wellbeing and that is inclusive of their relational networks of family, friends, and belief systems. While I am aware that institutional research is not historically the most effective way to change politics, my perceived neutrality has afforded me the ability to access university-level education and a degree of epistemic authority in producing authoritative "knowledge." It is with this privilege and motivation that I write this thesis, advocating for the protection of birthing rights and better maternity care, positioning my work alongside those who are also committed to strengthening healthcare systems against obstetric violence. However, it is also because of the blind spots of this privilege that I continually re-assess my positionality in the broader context of this work, namely, what it means to be an institutional "knowledge producer" and how this shapes the ways in which I represent history, people, and communities in my research.

Beyond my motivations for this study, my positionality is also inextricable from the construction of my interview data. My departmental affiliations with Family Medicine and the Biomedical Ethics at the University of McGill unit play a role in balancing the power dynamics at play during the research interview process with healthcare providers. Being part of the Faculty of Medicine also affords me funding from bodies like the Canadian Institutes for Health Research and fosters a sense of inter-professional familiarity and comfort for interview

participants. I predict that this has allowed my interviews to unfold more naturally and candidly than if I were a researcher outside of the medical community. Further, given all of the nurses that I interviewed were women, I suspect that our common gender identity also helped facilitate how they shared their stories with me, including their own experiences with birth and maternity care. This is best summarized by the quote from my interviews: "I know these are not policy stuff but I'm bringing it all up, girl!" Equally, it could be that respondents mediated their answers given my role as a graduate student and early-career researcher. This professional discrepancy is especially relevant now, as care providers shared with me incredibly stressful experiences working at the frontlines of the COVID-19 pandemic that I, nor anybody else who was not a frontline worker, cannot fully understand or relate to. In this sense, taking a discourse-analytic approach is especially useful, given how participants describe their experiences provides insight into how they make meaning of their situations and how they position themselves, their occupational roles, and their stories within the broader context of the interview process.

Another point to consider is that I have never visited the province of Newfoundland and Labrador. My interest in this project follows from my supervisor, who is originally from the city of St. John's, and her work on obstetric care during the pandemic that shows birthing and postpartum people experienced particularly severe policies in the region. My motivations also stem from my interest in health equity and access to high-quality, respectful maternity care in remote and rural regions of Canada. Despite having extensively researched its history and healthcare system, my thesis committee member, Richard Budgell, who is an ex-resident of the province, said to me during a meeting: "You need to get to know the smell of the place." I do not know the smell of Newfoundland and Labrador. And I can tell respondents knew this too, as one told me at the end of our interview: "Good luck transcribing with all the Newfie accents!" For this reason, I have entrusted Richard, and my supervisor, Dr. Kathleen Rice, to let me know when I confuse the smell of the place with that of another from my memories.

f. Reflexivity and rigour in qualitative research

Overall, stating my positionality and continuously interrogating it allows me to take up a reflexive practice attuned to how my subjectivities are, to an extent, inextricable from how I interpret my data. As a graduate student trained in qualitative methods, I also have the methodological and theoretical tools to make conscious analytic decisions. Practicing reflexivity not only allows me to question my assumptions but also to engage with my data thoughtfully and

creatively, problematizing the normalized discourses within the dataset. Given this, reflexivity enhances analytic rigour (Rettke et al., 2018). A theoretical framework, as described below, is necessary for directing this reflexive engagement with, and interpretation of, study data.

3. Theoretical Framework

The role of theory is often understated in qualitative health research despite its influence on study design (Moira, 2010). In this section, I will summarize the literature making up the theoretical framework of this study and emphasize its methodological implications. The first section describes the critical policy analysis literature, wherein the stage of "policy implementation" is not a logistical problem to be fixed to streamline the implementation of a policy, but an ongoing social process to be understood (Gill et al., 2017). Theories in critical policy studies problematize the natural distinction between policy and implementation, theorizing that implementation transforms the policy that is carried out in practice (Lejano, 2006; Ball, 2015; Carey, 2019). Seminal theories within the domain of policy implementation view healthcare providers as "street-level bureaucrats," implementing (and transforming) policies in their front-line practice within bureaucratic organizations (Lipsky, 1980). Drawing on these theories, this study positions policy as a discourse that is negotiated, contested and transformed in practice (Bacchi & Goodwin, 2016). The policy-as-discourse approach can be a useful tool to understand how power operates in biomedicine and healthcare (Shaw, 2010). Finally, a summary of how this theoretical literature translates to feminist theories of obstetric violence is also offered.

a. A critical approach to policy analysis and implementation

Within the field of policy studies, the "policy cycle" typically plays out linearly, from agenda-setting, policy formulation, policy implementation, and evaluation. This template of the policy cycle was developed by Lasswell (1956) and has since garnered a large amount of theoretical and methodological criticism (see Jann & Wegrich, 2007), but has nonetheless remained cornerstone to the field. Given this conceptualization of the policy cycle, the social context is commonly viewed as a barrier to the perfect implementation of a given policy. Further, dominant policy analysis approaches reside mostly within the positivist or post-positivist frames of implementation science, striving to discover and intervene in these barriers to implementation. The evidence-based policy movement frames policies as addressing problems that exist

independent of the policy, and the "evidence" founding this problem is dominated by quantitative, experimental, and trial-based data and cost-effectiveness analysis (Shaw, 2010). Within this rationalistic approach, natural science and quantitative methods are often employed, and the features of social life that are more difficult to understand such methods are side-stepped in policy analysis. Overall, the field has, for a large part of history, ignored how the policy cycle is an assemblage of social actors, social roles mediated through power dynamics (e.g., man/woman, doctor/patient), cultural norms, material realities, and technologies that constitute the very processes of knowledge production and policymaking (Gill et al., 2017).

Throughout the latter half of the twentieth century, sociologists, anthropologists, and historians of policy, particularly in the fields of health and education, have claimed policy as a type of discourse (Goodwin, 2011). It is in this movement that "critical policy analysis" as a field came into existence. Drawing on Foucault's theories of discourse, policies were increasingly recognized as a set of discourses that present a particular reality of the world, and that constitute and govern subject positions (e.g., citizen, doctor, nurse, patient) (Fairclough, 2003; Doherty, 2007). This critical position challenges the common conceptualization of a policy as responding to a problem that exists independently in reality; from the post-structural view, policy is a process of recognizing and constructing a problem (Bacchi & Goodwin, 2016). This theoretical literature also points to the agency and "creative social activity" of people to negotiate, resist, and transform a given policy while enacting it in context (Ball, 2015). The most prominent theories on this matter are summarized in the section below.

b. Street-level bureaucracy theory

Bureaucracy, as defined by Weber, is "a hierarchical organizational structure designed rationally to co-ordinate the work of many individuals in the pursuit of large-scale administrative tasks and goals" (1949, cited in Slattery, 2003, p. 28). Political scientist Michael Lipsky later applied this definition to theorize street-level bureaucracy, being public service organizations that work with the public, face-to-face, and "street-level bureaucrats" as frontline workers, such as doctors, nurses, and social workers, "who interact with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" (Lipsky, 1980, p. 3). Street-level bureaucrats implement institutional policies in their practice and have the power to do so with discretion. Lipsky's theory also posits that public frontline workers operate within bureaucracies that make it difficult to meet the needs of individual clients due to institution-related factors,

such as workloads, tight schedules, and bureaucracy. This results in what he calls the 'the fundamental service dilemma of street-level bureaucracies,' where frontline workers are required to manage the demands of bureaucracy, as well as the demand for individualized and attentive service (1980, p. 44).

Research in various fields, including healthcare, has shown that frontline workers manage this dilemma by engaging in unofficial routines and coping strategies in the enactment of a given institutional policy or protocol (Meyers & Vorsanger, 2007; Tummers & Bekkers, 2013). For example, research in the context of obstetrics from the UK shows that midwives struggled to provide patient-centred maternity care under the bureaucratic pressures of the National Health System. Midwives working in the "standard" model of care within the hospital system, this dilemma is more intense than midwives working in the "caseload" model of clinics providing consistent care to a roster of longer-term clients (Finlay & Sandall, 2009). The "caseload" model allowed midwives to be better advocates for clients, often advocating against the grain of institutional and medical guidelines for the birthing person's right to choose care (for example, birthing place or mode), even when such advocacy work is not recognized or compensated for by the hiring institution (Finlay & Sandall, 2009, p. 1233). Because social structures need to be enacted to exist, this study concludes that midwives as street-level bureaucrats both reinforce and resist bureaucratic pressures in their practice at the level of the clinical encounter (Finlay & Sandall, 2009).

More recent iterations have focused on how discourses shape the street-level bureaucrats' perceptions of their occupational role and the "client," and how this impacts the implementation of policies (Walker & Gilson, 2003). Theoretical work also highlights the role of social networks and "discursive styles" in policy implementation, namely the interactive (conversational) processes by which street-level bureaucrats transform technical information into more accessible resources for themselves and their clients (Lotta & Marques, 2019). Power and hierarchies within institutions are also recognized as strategies of legitimation for the use of discretion by street-level bureaucrats (Lotta & Marques, 2019; Tummers & Bekkers, 2013). Research at the intersections of critical policy studies and health studies has also shown the role of discourses in naturalizing dominant ideologies and societal power relations at the level of street-level bureaucracy (Evans, 2016; Nunes & Lotta, 2019). Specifically, these studies show that care providers utilize discursive strategies that define available subject positions for clients, ultimately

implementing a given policy "appropriately" in different contexts (Nunes & Lotta, 2019). Given these theoretical advancements, this study is underpinned by the assumption that obstetric care providers operate as street-level bureaucrats, transforming policies within the context of their practice and the provision of perinatal care.

c. Care, policy, and feminist science and technology studies

Literature from the field of sociology and feminist science and technology studies (STS) offers significant theoretical contributions to critical policy studies, namely in its nuanced ways of problematizing the distinctions between policy and its implementation. Within this field, "policy" is conceptualized as a distributed practice that consists of diverse actors, social relations, physical spaces, and material realities that are continually being enacted in practice (Gill et al., 2017). In feminist STS, care is theorized as a "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol et al., 2015, p.14). In simpler words, care is bottom-up, experimental work that is responsive and relational, opposite to how we conceptualize policy as top-down and technocratic (Mol et al., 2015; Pols, 2006). However, care is not always a given good; how "good" or nurturing care comes to be defined is dependent on a given community of its practice, and how a given community of practice or scientific community defines "good" care is dependent on discourses of care (Daykin & Clarke, 2000).

Speaking on other disaster situations, Gill et al. (2017) describe care as "at times becoming distorted, almost unrecognizable as care" (p. 10). It is in this theoretical context that I position theories of obstetric violence. The COVID-19 pandemic has made this tense and complex relationship between policy and care even more evident, as policies enacted to care for care providers and birthing people have caused explicit harm (Rice & Williams, 2021a;2021b; Friesen et al., 2021; Rice, forthcoming). Indeed, problematizing care and re-considering taken-for-granted assumptions is necessary. Given the theoretical perspectives summarized above, I hypothesize that the dominant discourses of perinatal care will play a significant role in influencing how pandemic policies get carried out in practice.

4. Study Design and Methods

To answer my research questions, I conducted semi-structured, in-depth interviews with perinatal care providers working at a tertiary care centre in Newfoundland and Labrador to

understand how they implement pandemic policies into practice. A summary of the study design and its methods are provided below.

a. Sampling Method

Purposive sampling was used for this study. To answer the study research questions, healthcare providers and department managers were recruited through a mix of critical case and snowball sampling. Critical case sampling was used to include participants who could provide critical information on policy implementation at the obstetrics ward, such as department heads, nurse managers, and charge nurses. Nurses without a management role were also recruited to generate insight into how power operates within the obstetrics ward and its impact on policy implementation. Given the busy schedules of care providers, snowball sampling was used to gain access to more respondents. This sampling method was also used to ensure that healthcare providers in a variety of professional roles (e.g., nurse managers, labour and delivery nurses) were interviewed for the study.

b. Sampling Site

The sampling site for the study was a major tertiary care hospital in the province of Newfoundland and Labrador. This site was selected based on the objectives of this study, which was to understand how pandemic policies surrounding obstetric care are formed and/or implemented in the province. Thus, the findings from this study apply to how pandemic policies are implemented in obstetrics wards in the province writ large (see Chapter 6 for a detailed discussion on the wider applicability of the study and its findings).

c. Participant Inclusion and Exclusion Criteria

Participants were included in the study if: they worked on creating and/or implementing pandemic policies surrounding perinatal care during the COVID-19 pandemic; were full-time or part-time employees of the hospital; and were obstetric care providers (e.g., nurses, physicians, nurse-midwives). Regarding the first criterion, care providers in charge of implementing policies in their everyday practice without a formal policy role were also included. The reasoning behind this was that even care providers who did not have formal policy roles acted as "street-level bureaucrats" implementing and transforming a given top-down policy in practice. The participant's eligibility for the study was clarified through e-mail communication asking about their role in the hospital. Participants were excluded from the study if: they were not involved in

forming and/or implementing pandemic policies surrounding perinatal care; were not full-time or part-time employees of the hospital; and were not care providers. Selecting full or part-time employees for the study was important, as this elicited insight into the institutional hierarchies and stresses surrounding policy implementation that may not be experienced as directly by freelance employees who spend time considerably less in the hospital (e.g., doulas).

d. Sample Size

A total of nine respondents were interviewed for this study. Of these respondents, eight were nurse practitioners or nurse managers with a policy role, and one was a family physician with an obstetrics practice. Given the specific sampling site, inclusion/exclusion criteria for the study, and the busy schedules of healthcare providers during the ongoing COVID-19 pandemic, the number of recruited respondents was always expected to be modest. Further limitations to the number of people interviewed include the time and resource constraints of a graduate thesis. This thesis took place during the COVID-19 pandemic, specifically the surge of the Omicron variant, where heavy restrictions were in place for travel to the Atlantic provinces. Entering the transitional phase where restrictions were being lifted in the province and in Canada, the recruitment of participants was limited given the busy pandemic workload of care healthcare providers. Care providers interested in this study were often struggling to find time to schedule a thirty-minute interview, some even needing to leave during the interview to assist in delivery. Furthermore, heavy restrictions were still in place throughout the obstetrics ward, barring entry for all visitors who are not visitors to birthing people. To ensure rigour, critical case sampling was used to recruit participants who would produce the most critical insights regarding how policies are implemented within the obstetrics ward. It is also important to note that within the specific scope and conceptual framework of the study, the small number of interviews allowed for the in-depth discourse analysis of policy implementation narratives.

e. Recruitment Process

Administrative staff working at the obstetrics department of the Health Sciences Centre were contacted via an introductory email to the project. A nurse manager agreed to be the contact person for the study. She advertised the study and consent forms through email, departmental listserv, and physical copies on a bulletin board in the staff breakroom. The recruitment email for the study was also sent to the Memorial University Department of Obstetrics and Gynecology, the Association of Midwives in Newfoundland and Labrador, and the Newfoundland and

Labrador Medical Association were also contacted via email. Once these avenues were not fruitful, personal recruitment emails were sent to Dr. Kathleen Rice's contacts in Newfoundland and Labrador. Thesis committee member and obstetrician Dr. Hannah Shenker also reached out to her contacts in the province to recruit family physicians specializing in obstetrics for the study.

5. Data Collection

a. Ethics and informed consent

A study amendment to Dr. Kathleen Rice's larger research project was submitted to the McGill Medicine REB in September 2021 and approved within two weeks. A full application was made to the Memorial University Health Research Ethics Board in October 2021 and approved in November 2021. Following approval from the MUN HREB, an application was submitted to the institutional research protocol approval committee in November 2021 (see supplemental files). The study was granted organizational approval in January 2022 and data collection commenced immediately until May 2022.

b. The data collection process

This project is a qualitative interview study, following a semi-structured interview guide (Bernard, 2017). This interview guide was a written list of clear questions and instructions for eliciting responses on topics covered in a particular order. This semi-structured interview guide was written to answer the research questions and achieve the study objectives (see Appendix II). A semi-structured interview guide affords flexibility for the interview questions to be adapted to the specific expertise, experiences, and concerns of the individual interviewees, and captures the variability in perspectives among stakeholders. Flexibility also facilitates the richness of the data, allowing participants to give detailed, nuanced, and personalized accounts of their experiences (Bernard, 2017). Compared to a completely unstructured approach, the semi-structured interview guide offers the benefit of understanding a specific phenomenon – the implementation of pandemic policies surrounding prenatal and postpartum care – in detail. Further, this method is most effective for interviews with professionals who are accustomed to the efficient use of their time for the reasons outlined above (Bernard, 2017).

All interviews for this study took place remotely, at any time that was convenient for the participant, either via telephone or via Zoom. These interviews were mostly conducted during lunch breaks or on days when participants had time off from work. Interviews lasted between

thirty (30) to sixty (60) minutes. Due to COVID-19-related reasons, interviews were conducted virtually, rather than in-person. The absence of physical and visual interaction between the interviewer and interviewee has several important methodological and analytical implications. The absence of one's body language in an interview forgoes insights that contextualize interview data. To account for this, non-verbal utterances (e.g., laughing, sighing, and muttering) were marked in the transcripts. This allowed the verbal accounts of participants to be better contextualized within the non-verbal data (Braun & Clarke, 2006; Howlett, 2021). Information regarding the hospital setting and contextual cues are missing from the transcripts. Thus, the analysis presented in this thesis does not account for such cues, but rather, the verbal and (audible/visible) non-verbal accounts given by the participants.

c. The shifting landscape of the pandemic

It is important to note that this study captures a particular point in time during the pandemic, namely the tail-end of the Omicron wave, from January to March 2022. Following the interview guide, I asked respondents to reflect back over the past two years of the pandemic, summarizing the policy changes; therefore, the interview data analyzed provides the account of a time during the pandemic where Omicron restrictions were gradually being lifted in the province and in the healthcare organization. Policies have since shifted over that time. For this reason, it is beyond the scope of this thesis to document the step-by-step changes in policy in the province and healthcare organization. However, the broader applicability of this study to the pandemic is possible, as narrative accounts of severely restrictive policies earlier in the pandemic can be evaluated alongside the newfound "post-pandemic" reality and government measures.

6. Data Analysis

a. Transcription

All interviews were digitally recorded, either through the Zoom audio function or on the PI's laptop using QuickTime Player. Interviews were transcribed verbatim using Otter.ai software in two steps. All identifying information from the interview recordings was removed at the time of uploading onto the Otter.ai software. The first step involved listening to the audio recording and reading over the auto-generated transcript to ensure that the transcript was accurate and included all verbal and non-verbal utterances (e.g., laughs, sighs, etc.). Short notes with initial reflections gleaned from the data were written down on the transcripts. The

transcripts were then downloaded and entered into NVivo software (QSR International, 2022) for data management and analysis.

b. Data Analysis Framework

The thematic discourse analysis framework followed Braun and Clarke's (2006) six-step approach. This framework is an ideal method for research question and data set as it is exploratory and structures the data set. It is also not based on a specific epistemological or theoretical position; thus, it is applicable across a range of approaches, and specifically, social constructionist discourse analysis (Braun & Clarke, 2006; 2019). Given the comprehensive theoretical framework informing the design of this study, the flexibility of this framework is ideal for a reflexive coding process that is less constrained by the strict epistemological and theoretical parameters of other analytic frameworks (Braun & Clarke, 2019).

Following this framework, data analysis commenced at the stage of transcription, where initial ideas about the data were formed. Once the transcripts were uploaded into NVivo, the transcripts were read multiple times to form a list of analytic memos, capturing initial ideas about what the data means. The formal process of coding took place over two iterations. The first phase followed a descriptive/semantic approach (see Jenkinson et al., 2016; Braun & Clarke, 2019), focusing on participants' experiences implementing pandemic policies in perinatal care. This step entailed a largely "bottom-up" or inductive process, constructing themes from the data using the open coding approach. These initial codes were semantic, sorting the descriptions of events, experiences, and perspectives in the data. In the second phase, "latent" codes were created, coding around the higher-level discourses underlying such descriptions (Braun & Clarke, 2006). These latter codes were formed to identify features of the dataset. This step took a more "top-down" or deductive approach, as coding was driven by the research questions and theoretical framework of the study. This more flexible approach was essential to achieve both an exploratory and a theory-rich analysis of the data, where semantic codes often informed latent codes and subsequent themes. In a more recent paper, the founders of the thematic analysis method speak on the utility of this flexibility, and how "mixed" semantic/latent coding can be utilized towards the end of answering a specific research question or theoretical framework (Braun & Clarke, 2019; 2021).

The next step for analysis was searching for broader themes among the codes. The concept map function on NVivo 12 was utilized to create visual representations of the

semantic/latent codes and how they relate to one another (see Appendix I). For this phase, Parker's (1992; 2002; adapted from Shaw and Greenhalgh, 2008) framework was drawn upon to distinguish discourses in the interview text. This framework has been similarly applied to primary healthcare research on health policy (Shaw, 2010). Taking a predominantly poststructuralist approach, the framework first contextualizing discourses in their immediate and social milieu. Then, coded extracts were interrogated for how respondents use language to present the reality of their world, their roles, subject positions (e.g., "patients"), and other discourses. These coded extracts were grouped into candidate themes. Data extracts coded "miscellaneous" were assessed for how they fit or did not fit into existing themes. These themes were then considered alongside the entire data set. At this step, Parker's framework was again used to interrogate how identified themes or "discourses" reflect institutional and societal power relations and ideological contestations. This data analysis approach draws on the Foucauldian discourse analysis tradition that analyzes how institutional practices and social reality are constructed in text and talk (Talja, 1999; Yazdannik et al., 2017). By studying the ways in which participants construct versions of their actions and medical practice within the historical moment of the interview, Foucauldian discourse analysis is useful for uncovering assumptions productive of authoritative knowledges (truths) and social reality (Talja, 1999). In making such discourses and their resulting outcomes in medical practice visible, it becomes possible to then critique, evaluate, and transform their consequences.

c. Assessing for rigour

After the descriptive coding phase, for the rest of the data analysis process, interview data was interrogated with theories from the literature that aided in the explanatory power of policy implementation decision-making (Spiggle, 1994). This approach was useful for assessing the theoretical sufficiency of the data to answer the research questions. Given this, the study has sufficient explanatory power with nine participants (Guest et al., 2006; see Chapter 6 for a comprehensive discussion on the limitations of this study). Here, an effort is made to avoid terms such as "theoretical saturation" and "emergence" and instead use language consistent with the constructionist epistemological orientation of the study, such as "theoretical sufficiency" or "explanatory power" (Varpio et al., 2017). This is because themes do not emerge but are rather interpreted and constructed by me, and data is interpreted not in the correct way, but rather, in line with the study objectives and theoretical framework.

Member-checking was taken up in informal ways throughout the process of the interviews, by verbally summarizing to the participants what they had just said. This allowed participants to either approve, correct or add to the summarized account as necessary, ensuring that the co-constructed interview dialogue was representative of their experiences. Although offered, I did not send transcripts or data analysis to participants for member checking. With the busy workload of clinicians and difficulties following up via email, formal member-checking exercises were not feasible for this study. As the study is social constructionist in its approach, study data and its themes are actively interpreted by the researcher; therefore, it is both possible and compatible for the researcher and study participants to have differing interpretations of the data. However, the themes were co-analyzed with Dr. Kathleen Rice, an expert in qualitative research and social constructionist methods, to ensure that the analysis was consistent with the study's theoretical and methodological framework. Following an iterative process of reviewing and refining, themes and their coded extracts were collaboratively evaluated for internal coherence and external heterogeneity among other themes (Braun & Clarke, 2006).

CHAPTER FOUR: RESULTS

1. Introduction

This chapter summarizes the findings from interview data with obstetric care providers using thematic discourse analysis. The first section provides a summary of organizational policy processes and significant pandemic policy changes. The second section describes the occupational conditions of perinatal care providers and pandemic policy changes within the unit. The third section presents care provider narratives surrounding "unofficial" and informal policy implementation processes that take place within the unit. Such strategies are described to be coping mechanisms for managing an overwhelming amount of rapid policy change, uncertainty surrounding policy implementation, and importantly, the discordance between a written policy and the contextual realities of its implementation. Finally, the fourth section provides an analysis of how respondents, negotiating between discourses of biomedicine and person-centred care, construct meanings of "essential" perinatal care to justify their "unofficial" policy implementation decisions. These findings show that patient-centred perinatal care exists through informal mechanisms during the pandemic; individual care providers, advocating on behalf of their client's wellbeing, omit the enforcement of certain COVID-19 policies, request exemptions, and in their narratives of policy implementation, discursively resist conceptions of "essential" perinatal care that exclude the perspective and needs of the birthing person.

2. Policy changes

a. Levels of organizational policy

Within the healthcare organization, four levels of policy were identified. The first level are global policies that apply to all departments and employees of the organization. The second level of policy is specific to the broader department, the third to the program, and the fourth to the specific unit. Within this hierarchy, pandemic policies were global policies applied at all levels, interpreted specifically to meet the needs of the department, program, and unit by managers at each respective level. For example, visitor policies were interpreted into the context of the obstetrics unit level by divisional managers and high-level unit managers. A rotating cast of charge nurses provided leadership for the implementation of such policies into practice by frontline staff. Non-pandemic policies, such as policies directly relating to medical practice (e.g., infant hypoglycemia, induction of labour), were researched and written by program educators.

At each level of policy, staff receive an email updating them on relevant policy changes, with a two-week period to provide feedback. Level one policies regarding infection control require providing feedback to the organization through regularly held Zoom meetings during the pandemic. Feedback at the program or unit level is offered through primarily informal means, either directly to the policy author via email, team huddles, and stakeholder meetings. There exists no formal mechanism for client involvement in the policy making and feedback process for neither COVID-19 policies or other obstetric policies. Such informal policy implementation processes are described in further detail in the section below on this chapter.

b. Pandemic policy changes

The most prominent policy change for obstetric staff during the pandemic were the visitor policies. Visitor policies in March 2020 allowed the birthing person one asymptomatic support person, who was allowed to stay in the obstetrics unit for twenty-four hours. Visitors were limited to two visitors at the bedside during specific visiting hours. By May 2020, restrictions tightened, and birthing people were allowed one asymptomatic support person during active labour and then only four hours postpartum. All visitors, including support people, were prohibited from entering the obstetrics unit. Along with Newfoundland's small peaks and valleys of COVID-19 case numbers, visitor restrictions went back and forth between these two policies until right prior to February of 2021, where one asymptomatic support person was allowed to stay in the obstetrics unit postpartum until time of discharge provided that they remain within the facility. Eventually, doulas were allowed in the delivery room alongside one additional support person, as of June 2021. However, with the omicron surge from December 2021 up until March 2022, the one support person rule was re-adopted, excluding doulas. Documenting the incremental changes to all pandemic policies (e.g., PPE guidelines, testing protocols, virtual care, self-assessment, etc.), is beyond the scope of this study. The section below describes how such pandemic policies were met with occupational restructuring and the experiences of obstetrics staff.

3. Occupational changes

The occupational conditions and professional roles of care providers were significantly transformed during the pandemic. Respondents described redeployment, working overtime, caring for COVID-19 positive patients, and managing the implementation of rapid pandemic-

related policy change as significant sources of stress at work. The findings from this study corroborate existing knowledge that the pandemic has been mentally, physically, and emotionally taxing on perinatal care providers, with rapidly changing pandemic policies as a significant source of occupational stress.

a. The impact of public health redeployment on perinatal care staff

In Canada, care providers, particularly nurses, were redeployed by the regional public health department to retirement homes, COVID-19 testing centres, and vaccination clinics. Despite regional numbers of COVID-19 cases remaining low in the province of Newfoundland and Labrador, respondents described redeployment as a significant factor that resulted in an increase in workload and occupational stress:

> *"And just the redeployment of our staff here, like it's caused our nurses their caseload to be much higher. I know my caseload or who I see has been doubled or tripled since COVID. It's same with the nurses. So instead of having four for moms and babies to care for now, they might have five or six"* (Interview 4; nurse manager).

> *"At the beginning [of the pandemic] swabbing was really intense. Here a lot of people were pulled to do that. There was a lot of overtime offered if you wanted to do it, so the redeployment in public health was the biggest impact and our nurses -- we're kind of on a skeleton crew, you know . . . . It's been very stressful for the people that had to be redeployed. We were told early on that if the numbers got low enough, we may have to go . . . . The first day out of graduate school was the day I had actual hands-on clinical nursing because for the rest I was in public health, which is different from hospital nursing. So that was really scary, because I thought, my gosh, I can't just become a nurse, I'd have to be completely retrained! And it's been 10 or 12 years since I even did anything like that! I gotta say, everyone was kind of worried about where they were going to be put if they had to be put somewhere"* (Interview 2; obstetric nurse).

b. Working an "extra" job

In addition to being short-staffed, nurses were frequently required to work overtime to implement new pandemic-related policies, uphold strict sanitation and infection control requirements, and provide care for COVID-19 positive patients. These changes resulted in a lot of nurses feeling overworked:

> *"I've been fit testing [PPE] now for about 15 years . . . Since the pandemic, I'm constantly refitting people, because they run out of masks. So fit testing has been a big part of my job now . . . . I've been very, very busy with the pandemic, it can be quite exhausting, actually"* (Interview 4; nurse manager).

> *"We were punching a lot more hours [during the pandemic]. I mean, it wouldn't be unusual to punch in 60 hours a week"* (Interview 1; nurse manager).

> *"If they [the birthing person] screen positive, then they have to go into a private room. And at that point, you have to don [wear] all your PPE if they're positive, right. So like N-95s, gown masks, visor, all those. And then usually, there'll be just a nurse assigned that patient and that's it. But then [for the COVID-19 positive patient] there would need to be another nurse who is running. So, then you have your extra people that have to be with somebody who normally would have just had one. And then once the once the baby is delivered, there's different things that you have to do for baby. So, there's a lot more care to prepare a mom for delivery"* (Interview 6; obstetrics nurse).

Following hospital guidelines surrounding infection control and PPE was framed as another source of exhaustion for care providers. Implementing pandemic policies was frequently described as an extra job on top the respondent's regular duties:

> *"Yeah, so I find that is the hardest part in the last couple months is the face shield and taking the time to make sure you change your mask between symptomatic patients and change your gown your gloves, you know, it definitely does add time on to your day" (*Interview 3; obstetrics nurse*).*

> *"I think we're just all tired. Like we're tired of this extra layer of mess that is added to anyway, busy workload, right. So like we're already stretched thin with the things that we're asked to do anyways, and then you also tell me 'Okay, well I need to force masks on I need to do it with a gown, visor, and an N-95, I need to make a woman push with a mask on, I need to check and monitor symptoms for COVID, I need to watch the women and the baby when they come out if they're positive they now need to be in a negative pressure room'. You know, there's a lot of extra"* (Interview 6; obstetrics nurse).

Nurses in policy-writing positions also framed their policy role as an "extra" to their regular job:

> *"If you had one person that was responsible for all the policy writing... It's just I can't do a justice to my job I feel like. I have lots of guidelines, you know, that need to be converted into policies that are region wide. I think having a person that could really*

delve in and really keep on top of the policy writing would be crucial. I just can't keep on top of it" (Interview 8; nurse manager).

Forced to work overtime under stressful conditions, many nurses quit their jobs:

"I think like if you look at just the general burnout, stress, and added weight on an already overloaded, tired nursing staff... There is a huge turnover for the first time in years in the unit, like before you couldn't get a job within a case room because people stayed here for years and years and years. And our turnover in the last few years has been insane. So that's 100% COVID" (Interview 6; obstetrics nurse).

c. Pandemic policy change

In addition to managing a demanding workload and the general stress of the pandemic, perinatal care staff were also required to stay on top of implementing institutional policy changes surrounding infection control. Respondents described having an initial lag period of a couple of weeks at the beginning of the pandemic where no infection control policies were put in place at the hospital. During this period, respondents remarked on the lack of responsiveness of the institution and described feeling unsafe at work:

"Originally when things started to shut down, it was not responsive at all and the nurses were extremely worried. We were not wearing masks. We were not wearing face shields. And the visiting did not stop. So that happened for probably a week or two, when the management was going up and down the hall and saying 'No, no, we're not going to change yet. No, we're not changing yet. Yeah, we know we're watching, we're watching and waiting to see'. And then all of a sudden, 'You need to wear a mask'. And the visitors had stopped" (Interview 1; nurse manager).

"*Like at the beginning, I remember coming to my manager and saying 'Like, we are really close to people when we're helping them breastfeed, we're really within a few inches of their face. We really feel like we should be wearing masks.' We were told 'No,' which I understand, because if we were, then everybody would be looking for masks that we just didn't have at the time. But then two days later, everybody had to wear a mask all the time, and then, of course, the visors came and the worrying about what clothing to wear... It's all coming back to me...all the traumatic parts... [laughs]*" (Interview 2; obstetrics nurse).

The uncertainty of the pandemic was traumatic for many respondents as there was very little information on the nature of the virus, fatality rates, and how long the pandemic would last. This

was exacerbated by the stress of having to protect their families from exposure while at the same time fulfilling their professional duties. Many had to make personal sacrifices:

> *"We had nurses that left their families, brought their children to their grandparents, isolated in hotels, so that they would not be around their families for the first month of COVID in March of 2020. As we became more comfortable with it, and as we became realizing that this will be longer term, then we had to start balancing benefits and whatnot. A lot of my nurses are a bit older, a lot of them didn't see their grandchildren. A lot of them cried, because they weren't able to see their grandchildren and they chose work over their family, it was really hard"* (Interview 1; nurse manager).

d. Responsiveness to policy change

Once infection control policies were in effect, respondents described how policies changed rapidly, sometimes by the hour:

> *"Honestly, every week there will be a new policy. Like the policy changes are constant. And they just kind of like brought down onto us half the time they don't make sense to anybody here in the unit. It is usually in relation to like visitors, the type of PPE we have to put on, COVID testing, who do we need to test, and how? And like, all these things about the actual delivery and postpartum care have changed like, every week"* (Interview 6; obstetrics nurse).

> *"They were sending email every time a policy change, there was an email coming through our workplace email, or the beginning of the pandemic, I felt every hour phone was dinging something was changed"* (Interview 3; obstetrics nurse).

Staff were required to be extremely responsive to policy change:

> "*For a long time, what we actually did was we watched the Facebook Live, of what the government was putting out in our pandemic, media availability that day. And we would watch that, to see what we had to do in our job, maybe within the hour. So, we were required to be extremely responsive. I would argue that sometimes the responsiveness was not required, it created undue stress in the system, that probably didn't have to happen. . . . . I remember, I left here one night on Friday night at 8:30pm. And I got a call from my staff member at 11pm on Friday night. They were so upset, saying 'Oh they're trying to put the St. Pierre[6] person here on the unit, but the St. Pierre person has*

[6] St. Pierre and Miquelon are small islands by Newfoundland and Labrador that are part of France. People are frequently transferred to St. John's to access healthcare services (Walsh, 2015). During the COVID-19 pandemic, people from St. Pierre and Miquelon were considered international travellers and therefore required to quarantine for two weeks upon entry to Canada. As explained by a nurse manager, all patients from St. Pierre and Miquelon were

> *to go in the COVID unit! What are they doing? Why is this happening?' I was like – guys, I just left at 8:30pm, I thought we were all straightened away. An email had come out at 10pm that changed the process. And it was effective immediately. Had it been that it would come out and then the next day we would implement it"* (Interview 1; nurse manager).

Keeping track of and implementing policies that change every hour caused extreme strain on care providers. Managers were tasked with quickly interpreting and translating a given policy into the obstetrics context and then providing guidance for the frontline staff. In the quotation above, a manager describes watching the news at work in order to anticipate rapidly changing policy directives. The expectation to change practice so quickly, while in the middle of providing care to birthing people, resulted in staff to feel overwhelmed:

> *"After a while you get six emails a day [of policy changes], you're not going to read every single one, it gets to the point where it was just an overwhelming amount of information. And that's what it was like, especially at the beginning [of the pandemic]"* (Interview 3; obstetrics nurse).

> *"That has been the hardest thing [keeping up with policy changes]. I feel I almost don't know what the word is like to describe that experience . . . . Everyday there were new emails coming through, it was so overwhelming. You're getting emails from all over from different units that didn't really apply to you but then you also had to be kind of in the know"* (Interview 2; obstetrics nurse).

> *"Where we would have had, you know, 12 or 13 managers [in the daytime], in the nighttime we had only two, so those managers I'm sure had a whole lot of stress in trying to move through and change mandates in the middle of a night shift in the middle of care currently being provided"* (Interview 1; nurse manager).

Prior to the pandemic, staff described policy changes surrounding best practices to occur much less frequently, with sufficient education provided by the clinical educators. During the pandemic, the expectation was to track organizational emails and to implement the new infection control policy into all aspects of perinatal care, immediately. Staff, including those in managerial

taken to the Patients Under Investigation Unit (alongside other people with suspected/non-conclusive COVID-19 status), which was later transformed into a general COVID-19 ward.

and education roles, were not provided with adequate support from the institution to facilitate such policy change. A manager describes having to "best just go along" and accept the situation:

> *"[Staff] They were being asked to do so much different, and so much more. And then they're being asked to do it immediately. Which really, it was undue stress, it didn't need to be immediately. Over time, the staff kind of got used to it – 'this is what this is what's gonna happen. This is the way they're going to talk to us. And this is the way we're going to find out. I guess we had best just go along'"* (Interview 1; nurse manager).

This environment of policy change was not only stressful but also demoralizing. Enjoyable aspects of work (e.g., friendly interactions among staff) was also taken away:

> *"From my perspective it is exhausting [laughs] right? You come in one day and you got to sign papers that you got a mask, and if you change masks you gotta sign the paper. And another says 'No, you don't need to do that, we're just going to assume that you took that responsibility yourself.' Oh [laughs and then sighs exasperatedly]! Then there's another thing about how many visitors are allowed and how many people is allowed in each room. And then there was confusion about the staff as to how many people -- you are not allowed to eat together now. So, we weren't allowed to have lunch with each other. So, whatever we learned in kindergarten about being nice to people and being friends with people all went out the window [laughs]!"* (Interview 4; nurse manager).

4. "Unofficial" strategies of policy implementation

Given the circumstances described above, care providers experienced significant amounts of stress and uncertainty when implementing pandemic policies in the context of perinatal care. Respondents described policies changing rapidly, inconsistently, and without clear directions for implementation within the obstetrics unit. To cope with these uncertainties, respondents describe utilizing "unofficial" strategies for staying on top of new policies and implementing them in practice. Care provider narratives of such strategies are summarized below.

a. Manager discretion and policy implementation

While staff received institutional infection control policy updates through email, how such policies were to be implemented specifically within the obstetrics unit largely depended on the discretion of unit managers. To ensure that staff were up to date with pandemic policy

changes, managers created a shared policy binder with pandemic policies relevant to the obstetrics unit, printed off from email and organized by date:

> *"I know it sounds silly, but we have a COVID-19 binder. Every policy or change and practice that happened would be printed off and placed into that binder"* (Interview 3; obstetrics nurse).

> "*We would do it and we will send it to the charge nurse. And they will put it into charge nurse binder which is their communication binder. So that if you haven't been in charge, you'd read all the way back down until you got to the ones that you would read previously, so that you're up to date on what's coming forward*" (Interview 1; nurse manager).

While respondents stated that every new policy was printed and placed into this binder, how exactly managers exercised discretion over this process (e.g., which policies were omitted from the binder, whether policy implementation directions were included) in context is unclear. Interestingly, some staff (in this case, a more senior nurse with a managerial role) kept a personal email folder with bookmarked policies:

> "*Email is overwhelming . . . . It's been a lot to read so I actually got my own little COVID binder folder in my email where keep track of it all so that I can reference back to it . . . . Eastern health wide policy the specifics might not really be suitable for your work area. Then you got to change it for every work area. It's a constant changing process with policies and procedures with regards to COVID, right? . . . . You know, and I got to the point of having to stick with my main stuff, and I just put it all into folder and I said, 'If I gotta do something different, someone let me know'"* (Interview 4; nurse manager).

Managerial staff also held regular "huddles" throughout the day to update frontline staff on new policy changes and how to implement them into practice:

> *"So, we go up and down the hall -- it could be the charge nurse, it could be a champion frontline worker, it could be the educators, it could be with the doctor. And we're walking down the hallways and doin' huddles . . . . you remind them that it's in their email, you let them know that it's printed in the break room, and you give them the gist of what it is and that now it's a change of practice that is an expectation"* (Interview 1; nurse manager).

Care providers without managerial roles sought guidance on policy implementation through personal communications with other staff, via word of mouth, text, or email:

> *"Often what would happen is we would just go to the unit and say, 'Okay, whoever is in charge – what's changed today? What do I need to know today?' So that was definitely pretty exhausting to try and keep up on it"* (Interview 2; obstetrics nurse).

> *"Often times it is not the usual channel [to learn about policy changes]. I'm teaching a class, and someone says, 'Oh no we are allowed two people [visitors]!' I said 'Oh, I better call up and check.' And so, I go up, because I like I said, I worked in the case room for many years. I'll pop up to the unit and just have a visit and just ask 'Oh so has anything changed?' And a lot of the staff are like 'Oh, no, no, nothing changed nothing changed.' And then I go, and I find out there's been three or four changes, and no one told me about this"* (Interview 5; obstetrics nurse).

> *"I have an email connection with my group . . . . Because things do kind of get missed and I'll hear about it through one of our colleagues who might've been on call and in the case room. I would then send the text or an email to the group and say, 'Hey, did you know about this?'"* (Interview 9; family physician obstetrician).

Notably, these communication channels depend on interpersonal relationships ("*I've worked in the case room for many years*" and "*I'll hear about it through one of our colleagues"*) and manager guidance ("*whoever is in charge"*). In fact, in the absence of a formal system, manager discretion functioned as the "unofficial" authority over policy implementation:

> *"I don't think there is anything formal in place. Our managers are on site, they're in the unit. So you know, it was easy to reach about and talk to them about stuff"* (Interview 2; obstetrics nurse).

> *"For the most part I go to the manager to get the gist on what's goin' on. And sometimes I find out a bit late. So usually I'll just pop up to the unit and ask in person or like call up"* (Interview 5; obstetrics nurse).

> *"They [obstetric staff] will just send me an email, I am always available by email, or they will go to the charge nurse or the manager. Those are three people they go to for direction on policies"* (Interview 8; nurse manager).

The obstetric unit has several managers with varying levels of power, as described above. Charge nurses and care facilitators are managers that rotate on a daily basis, overseeing the frontline staff who work with patients. Clinical and patient educators are also staff with managerial roles and policy-writing roles specific to the program or unit. Then there are managers who oversee the entire unit, and finally, a regional manager who oversees the broader program. This explains the finding that while pandemic policies for the unit were interpreted by high-level managers, there existed more heterogeneity at the frontlines of implementation. The section below summarizes the role of manager discretion, specifically in contexts where policy directives are inapplicable in the context of their implementation.

b. Discordance between policy and realities on-the-ground

In addition to difficulties staying on top of policy changes, staff were also required to execute policies that were often not applicable in practice given contextual constraints. For example, many policies did not account for regional, organizational, and unit-specific resources shortages. Such policies had to be interpreted, without any formal direction and very quickly, to account for such limitations. This is especially relevant for PPE and COVID-19 testing policies:

> "*But remember, there is only so much supply - wear it when you need it, but don't wear it when you don't need it, we can't burn through PPE that we can't replace. It's been a really big part of things here, especially being in Newfoundland. And everyone has been very, I'll say, fiscally and supply responsible in that way. You know that it if the ferry is off for three days your PPE supply is going to change because you didn't get your boxes in"* (Interview 1; nurse manager).

> *"If you're telling us that we have to say now swab every single patient, but we don't have a machine or a way to swab them, then guess what? They don't get to be swabbed. Usually what will happen is policy will come down, like, 'Oh, you want us to do this now? Okay, well, then you need to provide us with the means to do it'"* (Interview 6; obstetrics nurse).

Effectively, directions from managers such as "wear it when you need it, but don't wear it when you don't need it" function as informal policies in situations where the written policy is

inapplicable in context. Speaking on the experience of writing policies for rural sites[7], a manager describes the difficulty they experience accounting for resource shortages while writing best practice policies:

> *"The way they're [rural sites] staffed is different. You really have to think about policy writing and not setting the rural sites up for failure, they don't have all the resources at their fingertips. And the way you write it and the way you word it, is different. But then you still have the standard of care that they also need to abide by . . . . I think the value [for wording policies differently] is that people aren't misinterpreting policies, that policies are applicable to the rural sites, and the rural sites feel heard -- like I'm not setting them up for failure. I'm not setting them up with a policy that a) they can't interpret or b) they can't follow. But I think it's just making sure that obstetric obstetrical care is, I guess, streamlined throughout the four facilities and the staff has the ability to perform the policy with the resources that they have"* (Interview 8; nurse manager)

In this statement, the respondent narrates how they write policies for rural sites to be interpreted and implemented a certain way. For example, writing a policy deliberately vague but still specific enough to the rural site ensures that it can follow the necessary guidelines for obstetric care and be implemented into practice. In other words, managers were strategic in their interpretation so as to allow for greater flexibility of policy implementation:

> *"But maybe in the rural sites, they don't present labor and delivery [due to a lack of capacity], they present to the emergency department. So maybe I have to reword it like - if in rural site, present to emergency, then they would [get taken] to labor and delivery"* (Interview 8; nurse manager).

These findings suggest that manager discretion surrounding implementation is accounted for in the policy writing process given such limitations. In the context of the urban obstetrics ward, other infrastructural constraints, such as the size of the unit, the number of beds, and its layout were also factors affecting how the formal policy was transformed in practice:

> *"The infection control guidelines... they sort of outline of what we need to be doing with regards to the pandemic. Each unit and each area will do something a little bit different,*

[7] The health authority in Newfoundland and Labrador has several sites across the province, in both urban and rural sites.

depending on the layout and capacity of the facility, the services they provide" (Interview 4; nurse manager).

"I mean if you think about any policy, it's a guideline they've come up with. Sometimes policies have been changed because of some incident that occurred. So, you know, policies always have limitations" (Interview 5; obstetrics nurse).

Care providers describe policies as "sort of [an] outline of what we need to be doing" that depend on the contextual factors that influence their implementation. This conceptualization of policy contrasts with formal definitions of policy, where contextual factors are seen as a challenge to implementation. Ultimately, such findings show that the "unofficial" strategies of policy implementation and manager discretion appear to be significant mechanisms through which a policy gets transformed in practice. The following section describes how care providers operationalize such discretion.

c. Pandemic policy implementation as "following the science"

Exercising discretion over policy implementation is ultimately an exercise of agency and power (Nunes & Lotta, 2019). This section focuses on such processes of discretion, explaining how managers translate general policies into the perinatal care context and enforce its implementation. For example, managers and senior-level staff were required to interpret and translate pandemic policies into unit- specific policies surrounding perinatal care. Care providers describe this process:

"From our family medicine point of view, caring for our patients prenatally, we really just kind of, when we were primarily doing virtual care there, we were left to our own devices to say, 'Okay, well, who we needed to see and who we didn't need to see.' We kind of used the WHO document that guides the ideal frequency of seeing a woman in person for an in-person assessment, for example" (Interview 9; family physician obstetrician).

"Well, some things happened in our unit. We had doulas coming in with patients as support persons. So, what is the role of the doula [to write into policy]? Because, like, they don't do any medical stuff. They're just really more of the emotional and physical support to make sure you are comfortable when you move through the labor stuff. Another example is a birthing ball. Okay so what to do with a birthing ball? How is

> *supposed to be used when a patient brings in the birthing ball? . . . . We had to look at other facilities, what are they doing, right? And that's what I usually do when I'm asked to work on anything like that. I go in and I search the Internet and other health facilities about what they did for this particular thing. And then I don't try to reinvent the wheel, just try to adjust it so that it applies to what we do here at this hospital itself"* (Interview 4; nurse manager).

> *"Our visiting hours had changed based on the pandemic and based on the pandemic numbers and based on -- the science, essentially"* (Interview 8; nurse manager).

In such narratives of policy writing, care providers describe being allowed a significant level of discretion ("*we were left to our own devices*") over pandemic-related policy decisions. They describe writing unit-level policies surrounding visitors, doulas, and the use of birthing balls "based on the science," adapting the recommendations outlined in documents published by reputable scientific bodies like the World Health Organization and other healthcare facilities to the unit. Dominant discourses of "following the science" (thus, evidence or truth) of the pandemic era assert themselves in the narratives of respondents, effectively working to rationalize such policy decisions. Policy decisions are further rationalized through discursive strategies that characterize them as typical ("*I don't try to reinvent the wheel*") and common-sense ("*we had to look at other facilities, what they are doing, right?*"). As noted by one manager:

> *"So you'd be walking up the hall town and one day saying they [frontline staff] didn't need it [PPE] and the next day tell them it's mandated and required. So that the same thing happened when we had face shields because they [frontline staff] were asking – 'Do we need face shields? We see on TV people got it on. Is it airborne? Is doing even an N95 or is a surgical mask enough? We don't know! We don't feel safe! It's changing too much! We don't feel safe. Yesterday you told me I was okay - am I not? Because yesterday, I didn't do that.' Yesterday, what I told you is true. Now it's changed. And today what I'm telling you is true . . . . the staff eventually did get used to changing information that evolved with evidence versus 'You kind of lied to us yesterday.' Yesterday, that was the truth, now the evidence has changed, and today we have a new truth. And that was really hard. And one of the reasons that the staff will call me at home is that if a manager told them something that they didn't trust, they weren't sure that they were getting the right information because they didn't have all the evidence in front of them"* (Interview 1; nurse manager).

In this case, the discourse of "following the science" was a coping strategy for managers to justify and enforce the implementation of rapidly changing and inconsistent pandemic policies. Ultimately, framing policies as science ("*what I told you is true*") procures trust in leadership ("*versus you kind of lied to us yesterday*") and rationalizes the implementation of severe policies in a context with resource constraints and elevated levels of occupational stress. These discursive strategies allowed managers to better ensure the receptiveness and responsiveness of frontline staff to implementing pandemic policies into practice. Further, given the rapidly changing pandemic landscape, framing policies as the "truth" legitimates their implementation where there exists no conclusive evidence to support such decisions.

5. Constructing "essential" perinatal care

In their narratives of policy implementation, care providers describe aspects of care they deem indispensable to, or the ultimate goal of, obstetrics care. They use terms such as "medically necessary" or "the hallmark of obstetrical care and labour delivery nursing," constructing a discourse of "essential" pandemic perinatal care to justify their policy implementation decisions. These interpretative processes are most apparent in care provider narratives describing unanticipated situations where implementing an existing policy or informal guideline was unclear or difficult in practice and required a rapid evaluation of risks and benefits by the medical professional. Respondents stated that they encountered such situations frequently:

> *"Constantly [decisions are made on the go]. Because you never know what's gonna come through the door"* (Interview 6; obstetrics nurse).

> *"There's always gray areas where exemptions need to be made . . . . There are many scenarios where we have had to make exemptions on the go. There's been situations where we've had patients that were delayed [had a cognitive and/or physical disability] and needed an extra support person for communication purposes. We've had situations where we've had partners who work out of province and do rotational work. I'm trying to think of other scenarios but there have been many, many more"* (Interview 7; obstetrics nurse).

When asked to describe such unanticipated situations and the policy decisions that ensued, two main discourses were identified: the "most conservative" on the one hand and the "patient-centred" approach on the other. The language used by participants to describe their decisions and "essential" perinatal care align with these two approaches.

a. Minimizing COVID-19 risk by taking the "most conservative" approach

The "most conservative" approach involves taking the most severe policy implementation decision, such as denying a birthing person their support person who may be at a higher risk for COVID-19 infection. The following quote by a manager summarizes the "most conservative" approach:

> *"Okay, so let's say somebody shows up in the case from for labor and delivery and has a sniffle. Or their partner is a rotational worker [travels outside of Newfoundland and Labrador for work on a set schedule], or they're from St. Pierre and Miquelon [classified as an international traveller]. And in that moment, when things are changing, so greatly, a decision has to be made but you don't have time to go look it up. Right? So, you need to say what you are going to do and implement right this second. The nurses would make a decision that would be usually most conservative. 'Okay, you - I don't know if you're allowed to be here as a support person, you go back to the car, give me your phone number, and I'll call you.' 'You, I don't know if I am supposed to put you in isolation, and in the negative pressure, but I'm going to do it, I'm gonna put you in isolation room with negative pressure' . . . . There's no reason to believe she [birthing woman] isn't positive, we weren't swabbing. We're just going on a risk assessment through the tools. The questionnaire tool changed every week. So, they would always do it more conservative, then that puts everyone around them in this globe of protection, right?"* (Interview 1; nurse manager).

The "unanticipated" scenarios described here, such as someone having a "sniffle," a partner being a rotational worker that travels outside of the province, or a patient incoming from St. Pierre and Miquelon, an island that regularly relies on healthcare services in Newfoundland and Labrador (Walsh, 2015), are arguably regular occurrences within the obstetrics unit, highlighting the discordance between pandemic policies and the realities on the ground. Thus, "unanticipated" scenarios appear to be situations not explicitly written into a given policy. In such scenarios, the "most conservative" approach involves taking the most severe policy implementation decision in practice. In this discourse, a severe policy decision is constructed as the common-sense response, justified by the imperative to protect staff and patients from COVID-19 ("*there's no reason to believe she isn't positive*" and "*that puts everyone around them in this globe of protection, right?*"). In doing so, the "most conservative" approach only allows for "essential" perinatal care to take place, eliminating services considered "non-essential" as a justified trade-off for COVID-

19 safety ("*I don't know if you're allowed to be here as a support person, you go back to the car*").

In their narratives of taking the "most conservative" approach, respondents also draw on biomedical discourses of birth, constructing meanings of "essential" perinatal care:

> *"I will say that, as a manager, I was granting exemptions as required for visitors. If someone was in palliative care on my unit or if there was a bereavement on pregnancy loss, I was granting exemptions for this. But the number of exemptions that I was asked for because the female patient who was the mom was anxious...I don't know if I was surprised by it, but it was more than I anticipated . . . . I spent a lot of time with the nurses and the patients and the public letting them know that this is what we do. This is our job. And we're really good at it. So rather than being so anxious before you even arrive and assume that we can't do our job, why don't you assume that we're really good at our job, we got you, we will support you. Our goal is to have a healthy mother and a healthy baby leave this unit . . . . But definitely those policy changes, it didn't change what we do: babies still come out babies still breastfeed babies still go home. But it did change a little bit of the layers that interfere with how we were able to do that easily"* (Interview 1; nurse manager).

> *"There are situations where they were concerned that they might have to see someone that could possibly have COVID. Like if their point was medically necessary, like say they had cervical cancer or something like that, well those patients gotta be seen" (Interview 4; nurse manager).*

> *"At the height of the pandemic, we still fought to make sure that the fetal health surveillance education went ahead. Because we felt that it was important for quality obstetrical care, and we made sure that I went ahead [in person]. We just got a big enough firm that everybody social distance everybody masked . . . . Because it's the hallmark of obstetrical care and labor delivery nursing. A lot of medical legal cases come out of fetal surveillance"* (Interview 8; nurse manager).

In these texts, the goal of perinatal care is positioned as ensuring that the delivery of the baby is without medical complications ("*our goal is to have a healthy mother and healthy baby leave this unit*"). Given this, pandemic policies did not change the provision of "essential" perinatal care ("*those policy changes, it didn't change what we do: babies still come out babies still breastfeed babies still go home*"). However, within this construction, "healthy mother" does not necessarily include the birthing person's psychosocial needs and feelings of safety ("*so rather*

than being so anxious before you even arrive and assume that we can't do our job"). This is reverberated in how another manager describe doulas, that "they don't do any medical stuff they're just really more of the emotional and physical support to make sure you are comfortable when you move through the labour*"* (Interview 4; nurse manager). Here, respondents draw on biomedical discourses to construct meanings of labour in their narratives; labour is a biophysiological process to be managed by medical professionals, and its success is defined and measured by a specific set of clinical interventions and outcomes that overlook the various psychosocial dimensions of pregnancy and birth. This construction of "essential" perinatal care is used to justify policies exclude doulas from the birthing team and rationalize severe policy implementation decisions that cause harm to birthing people and their families. Granting exemptions as required means that certain reasons were considered "medically necessary," the "hallmark of obstetric care" or categorically different (e.g., fetal health monitoring, palliative care, bereavement on pregnancy loss, cervical cancer), while others were not (e.g., anxiety about birthing alone).

b. Minimizing risk to the patient by taking the "patient-centred" approach

Respondents in client-facing roles (e.g., labour and delivery nurse, lactation consultant, prenatal educator), contested the "most conservative" approach and the strictly biomedical discourses of birth in their narratives of policy implementation. This "patient-centred" approach or discourse is most evident in care provider narratives of disagreements and experiences not enforcing policies. For example, a physician counters the discourse of the "most conservative" approach to instead reframe risks from a more patient-centred perspective:

> *"We didn't know a whole lot at that time. But what we did know was that the prevalence was pretty low. So, from a medical point of view, one can recognize that the risk pretty low to the staff. And so, for what benefit it was it to potentially turn them [support person] away at the door and damage the therapeutic relationship? The risks outweighed the benefits of turning them [support people] away in that situation"* (Interview 9; family physician obstetrician).

Respondents with client-facing roles all resisted the discourse of "following the science" by describing pandemic policies as "making no sense." Notably, they pointed out that infection control policies were particularly severe with respect to protecting staff from birthing people and their support network:

> *"If you're on the floor, and you're looking after patients, clients, you're supposed to wear a face shield, and something covering your eyes, or the mask with the eye shield on it. So, like, you know, what's the difference if they are a patient or co-worker any of them could have COVID, that don't make sense to me, right?"* (Interview 4; nurse manager).

Respondents also felt that the policy requiring the support person to leave four hours after birth was unnecessarily severe and not scientifically sound in terms of protecting staff of birthing people from COVID-19 risk. One family physician obstetrician explains having to enforce the policy to clients despite it not making any logical sense:

> *"The father basically wasn't allowed to stay at all for the postpartum inpatient part of the birth and I think that I found that a hard pill to swallow myself as a practitioner, because it just logically didn't make sense . . . . And that wasn't really something that you could have a conversation with your patients about to, to logically explain. I was just saying, 'Well, this is the rule, and the rules are the rules, and we're kind of stuck between a rock and hard place with following the rules'"* (Interview 9; family physician obstetrician).

In their narratives of public backlash against birthing support person bans, respondents also used language that actively resisted such policies from an ethical perspective by describing them as an "injustice" or expressing that they "disagreed" with visitor policies:

> *"When the initial wave passed and they [healthcare institution] started getting the feedback, incredible feedback publicly, that this is not satisfactory, that, you know, you're doing these families an injustice. Then things started to soften a little bit and partners were allowed to stay"* (Interview 9; family physician obstetrician).

> *"I'm so thankful that the support person and the fathers eventually were allowed to stay the full admission and eventually changed it so they could come and go as many times as they wanted. Because I think what's most important is the family unit. I really disagreed with the policy at first, and I'm glad it changed. Even though the policy at first was put in place for my safety I disagree with it completely"* (Interview 3; obstetrics nurse).

In framing policies as scientifically unfounded and illogical ("*it just logically didn't make sense*") care providers appropriate biomedical discourse to express disagreement with policies they find deeply unethical or unjust. They do so by providing firsthand accounts of choosing not to implement a given policy in practice, going against the "most conservative" approach:

> *"I was in helping the mom with breastfeeding and she did cough like a good wet cough kind of really close to my face. She didn't have a mask on. Women had to wear the masks at the beginning, and technically, I'm not even sure right now if they have to or not, but support people also have to wear masks when they're in the room. But it's really tricky with breastfeeding when you have a mask, and you're just trying to learn how to breastfeed because you're trying to look down at your baby. It is tricky. And this woman had taken hers off"* (Interview 2; obstetrics nurse).

While this is clearly a stressful situation for the respondent, they nonetheless defend the woman's decision to take off her mask while breastfeeding by emphasizing the difficulty of learning how to breastfeed with a face mask ("*it's really tricky with breastfeeding when you have a mask*"). Referring to the mask policy in place at the time ("*women had to wear the masks at the beginning*"), the respondent centers the needs of the breastfeeding woman to justify her not wearing a mask. Similar strategies were also used to describe instances of not enforcing the mask policy during birth:

> *"Personally, I totally get it. Like, I think that it's, it's crazy to ask somebody in labor to wear a mask and pushing it, you know, I feel bad for them. And to be honest, I guess I'm guilty. Like, I'm not one of those nurses that would force you. If you're there, you're in pain, you're frustrated, you're pushing like, you know, emotions are high, whatever"* (Interview 6; obstetrics nurse).

In this excerpt, the respondent justifies not enforcing the mask policy by describing it as illogical in the intrapartum context ("*it's crazy to ask somebody in labour to wear a mask*"). Here, the respondent explicitly acknowledges how this decision goes against the rules ("*I guess I'm guilty*") and perhaps the norm ("*I'm not one of those nurses that would like force you*"). In doing so, they center the birthing person's experience and empathy to justify their decision ("*personally, I totally get it"* and "*you're in pain, you're frustrated*"). Indeed, respondents frequently drew on firsthand, personal experiences when explaining how a given policy is challenging or inapplicable in practice:

> *"So, in terms of infection control, it didn't make any sense to take away the support person from the woman in this so vulnerable time -- like I myself have two children, I don't know how I would done it without my husband. And like, you know, you're telling me that I can't -- you're telling them you can't have a support person, then that we limited it. But then there is no correlation between the actual infection control and what you're*

> *doing. So yeah, like this is a good example of, like, somebody who made the policy has no idea what's going on in real life, and they've probably never stepped foot [in a labour and delivery room] and never seen how it actually works"* (Interview 6; obstetrics nurse).
>
> *"I wish my daughter was out here [to tell you about it] . . . . They [pregnant clients] had a lot of anxiety about not being able to have their partner present or, or not being able to have their mom come the next day"* (Interview 5; obstetrics nurse).

By framing the impact of pandemic policies through the perspectives of birthing people, respondents emphasize the emotional and deeply personal experience of birth. Respondents utilize this patient-centred frame again when justifying exemptions for their clients:

> *"I just had another situation where my client, it was her second baby. Her husband got like white coat syndrome. She said 'Well, what am I going to do if he flakes out and faints and I got nobody, right?' That caused more anxiety for her so I said let me just speak to the manager and see what they think and what can be done here. So, she wrote a letter up and told us about her situation with her husband and her anxiety. I submitted it and communicated with the case room manager and the obstetrical manager, and we allowed her to have that second support person here because we didn't know if her husband was going to be reliable. We got to look at the patient's perspective too – she don't have anybody with her. You know, her coping mechanisms probably won't be as good. So, we did it for certain situations like that, we did allow it, right. But not at the obstetrical unit, we didn't do that. A little bit different on obstetrics than being in the case room having the baby, but she could have two support people up there, which at the time we were only allowing one, but they had to visit at different times. So, they limited that way. So, we've had to adjust things depending on the patient's situation, too. And there's probably a lot of people out there that have the same situation, they were probably just afraid to ask'* (Interview 4; nurse manager).

Here, the respondent advocates for the patient, emphasizing the importance of considering their perspective ("*we got to look at the patient's perspective too*"). Similarly, a physician describes how they allowed clients to come to appointments with a partner, despite it being against the official rules of the clinic:

> *"For the most part it wasn't an issue. They did come and they were already there, so you know, we would just kind of take their information for contact tracing and allow them, to come in as long as they were asymptomatic . . . . I think that if they're bringing them to the appointment, then obviously they were doing it with some inner motivation. I mean, people don't do things to be rebels or to go against the grain, you know. Obviously, it*

> *would've held some personal importance to them for some reason or another. And we would just be able to fulfill that for them"* (Interview 9; family physician obstetrician).

This focus on the client or patient works against the top-down policy imperative to take the "most conservative" approach, emphasizing risks to the birthing person ("*her coping mechanisms probably won't be as good*" and "*obviously it would've held some personal importance to them for some reason or another*"). Several other respondents emphasized physical, psychological, and interpersonal risks of such severe pandemic policies to the birthing person and the newborn:

> *"I think excluding the fathers was very risky. And you know, that part of the child's development, even if you want to say its only 24 hours or so, that is still precious bonding time for that family unit. And yeah, so I definitely didn't agree with that"* (Interview 3; obstetrics nurse).

> *"When women delivered, you gave them four hours. And unless those four hours were out, we're basically telling a woman, even if she had a c-section, she can't move. 'Sorry, your husband has to go. Until you're discharged you can't see him.' And baby daddy can't be with the baby. Isn't that heartbreaking? Not mentioning like, you know, this huge bonding time. Say you got a woman who had depression before and has this high risk for postpartum and you send her up to a floor. There its very busy. Here in the case room we have one to one nursing but up on the floor, its one to four. She can't even move half the time yet. By the time we send her up there, especially if she had a section, she can't go and pick up a baby. But there is nobody there to help her. Does that sound right to you?"* (Interview 6; obstetrics nurse).

In centering the potential risks of severe pandemic policies to birthing people, respondents resist biomedical discourses that exclude psychosocial factors from conceptualizations of "essential" perinatal care. In the absence of protections from such risks, care providers express empathy for their clients ("*I feel bad for them*," "*she don't have anybody with her*," "*people don't do things to be rebels*," and "*does that sound right to you?*"), while some respondents even describe going out of their way to provide them with necessary support:

> *"I've had personal calls from people, their daughters have babies, and I've had to actually go to their home as a friend. And talk to 'em. Again, and I'm thinking, you know, that's what I'll do. If that's what will get them through this, that's what I'll do"* (Interview 4; nurse manager).

> *"To prepare them [for birth], I tell them [about policies] when I teach a class because most people are finishing their labour and birth class four weeks before they deliver. So I say this is how it is now, this is how I can help"* (Interview 5; obstetrics nurse).

Such narratives show that in the absence of person-centred policies, humanistic perinatal care operates through exemptions and care provider advocacy. Patient-centred perinatal care thus functions as an informal policy:

> *"You have to apply for an exemption from a manager or the director on call if you get the exemption - and they're pretty much offering exemptions to everybody now, there's really no one that wouldn't be granted an exemption to come in and be a visitor"* (Interview 8; nurse manager).

A discussion of these findings is offered in the next chapter.

CHAPTER FIVE: DISCUSSION

1. Introduction

In this study, I find that perinatal care providers exercise a significant level of discretion over the implementation of pandemic policies in practice. Encountering uncertainty, resource shortages, demands to overwork, and misalignment between written policies and the context of implementation, care providers must adjust policies to the on-the-ground realities of the job. They do so by operationalizing "unofficial" or informal policy implementation strategies that depend on informal communication networks, manager discretion, and client advocacy. Two courses of "unofficial" or informal policy implementation strategies were identified: the "most conservative," or on the other hand, the "patient-centred" approach. Respondents justify their policy implementation decisions by negotiating between biomedical discourse and alternative, more humanistic discourses of obstetrics care, constructing different meanings of "essential" perinatal care in the process. This chapter will discuss such findings in more detail alongside the relevant literature. As the findings are extensive, this discussion will focus on four key points related to the study's research questions and conceptual framework: discretion, the construction of "essential" perinatal care, and how the findings of this study contribute to the existing literature and theory on obstetric violence.

2. Discretion

Discretion is defined by theorist Michael Lipsky (1980) as having the power to make decisions in circumstances where "complex tasks for which elaboration of rules, guidelines, or instructions cannot circumscribe the alternative" (p. 15). For Lipsky, discretion is intrinsic to welfare bureaucracies and public service. In line with its theoretical underpinnings, this study corroborates that care providers regularly exercise discretion, making on-the-job decisions and utilizing "unofficial" strategies to implement pandemic policies in practice. Indeed, research on policy implementation in nursing before the pandemic shows that nurses regularly exercised discretion when interpreting and implementing policies into practice and, notably, felt overwhelmed by organizational policies that changed rapidly and lacked nuance for the context of nursing practice (Hoyle, 2013). With the pandemic, bureaucratic demands for client processing and resource rationing have also intensified (Meza et al., 2020; Gofen et al., 2021); the increasing complexity of tasks, alongside rapid policy changes, resource shortages, and the

conflict between infection control and person-centred care have significantly expanded healthcare provider discretion (Davidovitz et al., 2020).

At the time of the interviews, care providers described the formal infection control policies as "sort of an outline of what we need to be doing," with discretion as a necessary component to tailor formal policies to the everyday realities of practice. Studies on street-level bureaucracy in health policy (Erasmus, 2014) public health, (Harrits & Møller, 2014; Tummers & Bekkers, 2014; Lotta & Marques, 2020), general practice (Sirovich et al., 2008; Cooper et al., 2015), maternity care (Finlay & Sandall, 2009; Feltham-King & Macleod, 2020), and nursing (Hoyle, 2013) corroborates these findings. Research on discretion in the context of primary care and nursing shows that care providers, managing both the bureaucratic pressures of the healthcare organization and the provision of personalized, comprehensive care to clients, regularly make "micro choices" that eventually function as *de facto* policies within the occupational context (Hoyle, 2013; Cooper et al., 2015). Likewise, my results showed that "unofficial" strategies of policy implementation effectively functioned as informal policies ("*wear it when you need it [PPE] but don't wear it when you don't need it*") and even evolved into formal exemption procedures *("you have to apply for an exemption from a manager or the director on call -- they're pretty much offering exemptions to everybody now*").

Interpreting the findings of this study alongside policy literature, care provider discretion appears to be a significant resource for managing the misalignment between organizational priorities and the on-the-ground realities of perinatal care during the pandemic (Finlay & Sandall, 2009; Thomann, 2018; Tummers & Bekkers, 2014). As is theorized in the policy literature, *de facto* or informal policies were even at times incompatible with organizational infection control priorities and goals (Cooper et al., 2015; Evans, 2015). While this misalignment between formal policy and its context of implementation is a significant determinant for the use of discretion, the question remains as to why variation in discretionary practices exist, namely the "most conservative" and "patient-centred" approaches. As Lipsky (2010) has noted, excessive or severe bureaucratic regulations could conflict with professional norms; indeed, research has shown that nurses and physicians tend to prioritize patient-centred goals over organizational goals (Newman & Clarke, 1998; Hoyle, 2013).

My analysis of interview data shows that discretion was operationalized differently by managers and client-facing care providers to achieve, ultimately, different outcomes. This is

consistent with the limited existing research on policy implementation in nursing and healthcare practice (Hoyle, 2013; Tønnessen et al., 2017). Managerial staff operationalized discretion to meet infection control guidelines and organizational priorities, while client-facing staff operationalized discretion to meet client needs and cope with the difficulties of implementing pandemic policies on the frontlines of perinatal care. While both managers and client-facing care providers were required to make such choices in complex circumstances where there existed no formal guidance, it appears that managers follow the "most conservative" approach and client-facing care providers the "patient-centred" approach due to professional roles and an increased sense of responsibility to the organization or client, respectively. For example, while overwork, resource shortages, rapid organizational policy change, and the risk of COVID-19 infection were significant sources of stress for all respondents in this study, those in managerial roles described overseeing infection control policies in the obstetrics unit and being responsible for their impact on staff. The responsibility to manage COVID-19 transmission according to organizational standards was a significant priority that uniquely shaped manager discretion and policy implementation decisions. On the other hand, more client-facing staff with direct responsibility to their clients or birthing people prioritized their needs ("*I've had to actually go to their home as a friend. And talk to 'em")* and the therapeutic relationship ("*for what benefit is it potentially turn them [support person] away at the door and damage the therapeutic relationship")* over organizational infection control goals.

To my knowledge, research on the discretionary practice of healthcare providers within bureaucratic tertiary care centres is scarce. Policy scholars have pointed out that discretion, especially in healthcare, remains significantly undertheorized (Akosa et al., 2017). Here, I argue – alongside scholars of street-level policy implementation – that the divide in policy implementation approaches between local managers and client-facing staff suggests that professional roles play a role in shaping the discretionary practices of street-level bureaucrats (Lipsky, 2010; Evans, 2010; 2015). Managers, by way of professional role, prioritized meeting regional and organizational infection control guidelines, and given the circumstances of the pandemic, intensified allegiance towards the organization conflicted with their professional role and values of nursing practice (Finlay & Sandall, 2009; Hoyle, 2013; Tønnessen et al., 2017). Unlike managers, client-facing staff without managerial roles prioritized the values of patient-centred perinatal care. Respondents justified not enforcing policies or requesting exemptions

from policies on grounds that they were too unreasonable to implement in practice ("*somebody who made this policy has no idea what's going on in real life, they've probably never stepped foot [in a labour and delivery room"]*). Taking the "patient-centred" approach was frequently described as the logical thing to do given the circumstances ("*it's crazy to ask someone in labour to wear a mask and push it*") and evidence-based practice ("*The risks outweighed the benefits of turning them [support people] away*"). This position was even justified by moral discourse and the ethical permissibility of such policy decisions ("*you're doing these families an injustice*"). Closely witnessing the impact of severe pandemic policies on birthing people and being responsible to clients through an established relationship, they positioned themselves on the "side" of their client versus organizational imperatives ("*I was just [telling patients] . . . . 'we are stuck between a rock and a hard place with following the rules*' and *'I feel bad for them").* Having no way around accommodating clients with extra needs, some client-facing care providers even went beyond their professional roles to support clients as friends ("*I've had to actually go to their home as a friend. And talk to 'em. Again, and I'm thinking, you know, that's what I'll do. If that's what will get them through this, that's what I'll do"*).

Lipsky (1980) defined 'advocacy' as street-level bureaucrats "[using] their knowledge, skill, and position to secure for clients the best treatment or position consistent with the constraints of the service" (p. 72). Care providers utilizing discretion to meet the personalized perinatal care needs of clients is considered a form of advocacy (Finlay & Sandall, 2009). While research on how the managerial or client-facing roles of care providers impact client advocacy within bureaucratic tertiary care centres is limited, a small body of existing literature suggests that nurse managers will focus on achieving organizational goals, targets, and budgets, while frontline nurses are concerned with everyday working conditions and client service (Hoyle, 2013); Bogaert, 2015). My analysis also corroborates these studies, showing that a client-facing role was a significant determinant of whether care providers utilized their discretion to advocate for birthing people. However, this does not necessarily suggest that they were not committed to organizational goals altogether. Rather, respondents negotiated between top-down, organizational pressures and bottom-up, client pressures, positioning themselves, to varying degrees, as both bureaucratic employees and client advocates. The tension between top-down and bottom-up pressures is best demonstrated in the narrative of a respondent who occupies both a managerial and client-facing role. Speaking from her managerial role, the respondent justifies

the "most conservative" approach to limiting the presence of the doula on the obstetrics ward ("*they [doulas] don't do any medical stuff*") and forms of perinatal care ("*if it [appointment] was medically necessary, like cervical cancer or something like that*"); however, speaking from her client-facing role, she describes requesting an exemption from the visitor policy from her manager for an anxious client, advocating for her needs ("*we got to look at the patient's perspective too. She don't have anybody with her*").

The question remains as to how client-facing care providers interpret what is 'best treatment' and even "constraints of the service" (Lipsky, 1980). The findings of this study show that manager discretion plays a role in both. Indeed, theoretical perspectives in policy studies define managerialism as a form of organizational governance that orients street-level practices (Evans, 2011). Managers are afforded greater discretionary power within the organization than frontline workers and therefore have the power to decide what counts as the best way to implement policy (Brodkin, 2011). Ethnographic research with community health workers in public health organizations also shows that high-level manager priorities and framings of a policy issue played a significant role in orienting the discretionary practices of street-level bureaucrats at the front lines, influencing how clients accessed public healthcare (Perna, 2021). Findings from this study show that client-facing care providers regularly sought direction from their managers when implementing policies. Managers held team meetings and "huddles," organized a unit-specific policy binder, and interpreted pandemic policies into the obstetrics context, for example, the doula or birthing ball policy, to provide this guidance to staff on how to interpret and implement policies in practice. In line with the theoretical perspectives summarized above, the findings from this study can be interpreted as evidence that managerialism might play a role in orienting policy implementation at the frontlines. Although many resisted the "most conservative" policy implementation approach in their narratives, client-facing care providers also positioned themselves as the recipients of severe pandemic policies ("*Even though the policy at first was put in place for my safety I disagree with it completely")* and as rule-breakers for exercising advocacy ("*To be honest, I guess I am guilty. I'm not one of those nurses that would force you [to put on a mask]*").

Managers also sought to establish power over the discretionary practice of client-facing care providers. For example, managers evoked discourses of "following the science" or "policy as truth" when describing how they managed resistance from staff towards implementing

pandemic policies (*"Yesterday, what I told you is true. Now it's changed. And today what I am telling you is true").* Framing policies as the 'truth,' especially in a time when scientific evidence is limited and confounding, is an effort to rationalize their implementation through claims of objectivism. Interestingly, studies on policy implementation have found that managers tend to justify organizational policy decisions based on a discourse of conviction, rather than evidence-based practice (Jarvis, 2014). The findings of this study are suggestive of a similar phenomenon, as managers utilize discourses of evidence or "truth" to rationalize policies that are not necessarily based on available evidence in both obstetrics and the pandemic, but on the priorities of the healthcare organizations. As shown by research from the H1N1 pandemic, policies going against the values of respectful, patient-centred maternity care were the policies that were most inconsistently implemented in practice, often outright disregarded (Williams et al., 2013). This discourse of "policy as truth" frames resistance as unfounded, and ultimately facilitates better cooperation with organizational imperatives. Theoretical perspectives in critical policy studies draw heavily on the works of Foucault (1977) to explain that knowledge linked to power within organizations is often naturalized, and even internalized, as the "truth"; eventually, frontline staff accept, or even self-discipline according to what is "true," without manager intervention (Doherty, 2007; Nudzor, 2009; Ritchie, 2021).

The section below discusses the findings of this study alongside such theoretical perspectives in more detail, focusing on how power and discourse, at both the organizational and institutional levels, influence care provider interpretation of pandemic policies and their implementation in the context of perinatal care. Policy literature on street-level bureaucracy interacts limitedly with theories of discourse and power; ultimately, alongside the feminist (Lejano, 2006; Ball, 2015; Carey, 2019) and post-structural turn in policy analysis (Bacchi & Goodwin, 2016; Hankivsky et al., 2014), I examine how biomedical discourses influence policy implementation and thus, the provision of pandemic perinatal care.

3. Constructing "essential" perinatal care

My analysis of care provider narratives of policy implementation shows that discretion depends on a given assumption of "essential" perinatal care. For example, manager decisions to implement the "most conservative," severe policy decision as precautionary measures depended not only on the organizational imperative for infection control but a conceptualization of

"essential" perinatal care that justifies the exclusion of psychosocial and emotional support as a necessary trade-off for COVID-19 safety. Within critical policy literature, discretion is theorized as both a localized and structural phenomenon, the strategic interpretation of a given policy depending on occupational constraints and personal beliefs of street-level bureaucrats situated within an organizational and institutional context (Jewell & Glaser 2006). Indeed, research on policy implementation shows that organizational, institutional, and broader societal discourses play a significant role in shaping discretionary practices, especially for staff in managerial positions (Evans-Agnew, 2016; Johnson, 2013, Zarychta et al., 2021). Specifically, in health studies, scholars have shown how biomedical discourses on health and illness have shaped policy processes and workplace relationships (Lupton, 1995; Armstrong, 1995).

My analysis of respondent narratives shows that managers construct meanings of "essential" perinatal care through the recycling of powerful biomedical discourses that conceptualize birth as a biophysiological process to be managed by medical professionals in clinical settings. Given this governing rationality, essential perinatal care is synonymous with medical care, which is ensuring that the birthing person and the newborn have no physical, life-threatening complications ("*Our goal is to have a healthy mother and a healthy baby leave this unit*"). Indeed, managers argue that the pandemic did not affect the provision of "essential" perinatal care (*"But definitely those policy changes, it didn't change what we do -- babies still come out, babies still breastfeed, babies still go home"*). In medical discourse, childbirth is viewed as the main "medical" event where a woman "delivers" her baby, with its success defined by a specific set of clinical procedures and outcomes (Davis-Floyd, 2001; Hunter, 2006; Chadwick, 2014). This deficient conceptualization of childbirth justifies taking away a birthing person's social support network and scaling back postpartum care as "non-essential" and nonetheless necessary trade-offs for COVID-19 safety. Growing evidence of the increasing use of medical interventions during birth to mitigate pandemic pressures and birthing people experiencing neglect in the postpartum period aligns with this interpretation (Rice & Williams, 2021a; Kuurne & Leppo, 2022; Sakowicz et al., 2021; Townsend et al., 2021).

Furthermore, managers justified policies that restricted the presence of doulas during birth and postpartum by describing doulas as not having a "medical," and thereby, "essential" role in perinatal care ("*They don't do any medical stuff. They're just really more of the emotional and physical support to make sure you are comfortable").* However, that birthing people be

allowed to have their partners in the delivery room, that they have access to a doula if they so wish, and that their experiences, beyond the "medical," are recognized and respected by healthcare professionals are hard-won birthing rights to make childbirth not just more "comfortable," but lead to better outcomes (Davis-Flyod, 2001). As scholars have shown, a "medical" birth does not always equate to an evidence-based birth (Kaufert & O'Neil, 1990; Davis-Flyod, 2001; Chadwick, 2018; van der Waal et al., 2021). Doula support is widely seen by healthcare professionals as not an "essential" part of perinatal care, despite research suggesting that birthing people matched with doulas have better health outcomes, including four times less likely to have a baby with low birth weight, two times less likely to experience birth complications, and significantly higher breastfeeding prevalence at six weeks (Gruber, et al., 2013; Nommsen-Rivers et al., 2009)[8]. Especially for Indigenous women, a doula is essential to successful outcomes in childbirth, as they integrate trauma-informed care, harm-reduction, and cultural practices and teachings into perinatal care to help alleviate the effects of medical racism in the hospital (Cidro et al., 2021). Yet, biomedical discourses of health and illness are founded on assumptions of the separation of the body and mind, of the birthing subject as a distinct individual rather than relational, and the epistemic privilege of medical knowledge over embodied knowledge (Davis-Floyd, 2001; Chadwick, 2018; 2021a). By way of this authoritative knowledge, conceptions of "healthy mother and healthy baby" exclude the aspects of perinatal care beyond treatment of serious medical complications and is blind to the significant disparities in birth experiences and outcomes between differently positioned people, such as between white women and racialized women[9].

Biomedical discourses of birth and their cultural and social derivations have been extensively studied and characterized by medical sociologists and anthropologists. In her writings on biomedicine and birth, Davis-Floyd (2021a) theorizes that the "technocratic model of

[8] It is important to note that more affluent and educated birthing people are more likely to have access to doulas in the first place, which may be a factor influencing better outcomes (Wint et al., 2019). Research coming out of the pandemic further corroborates this disparity, as those who chose to give birth in a birthing centre with midwives to avoid a technocratic and medicalized birth were more affluent, white women with high levels of formal education (Rice, forthcoming).

[9] As my study does not explicitly engage with issues of race, the data does not allow me to comment on how race impacts perinatal care in Newfoundland and Labrador or Canada more generally. However, I added this point to emphasize how such constructions of "essential" perinatal care overlook considerations for race (and other systems of power).

birth" underpins Western obstetric practice, conceptualizing the birthing body as "mechanical and dysfunctional," and thus "constantly in need of technological surveillance and intervention" to manage risk (p. 418). Decolonial and afro-feminist theorists argue that discourses of birth as a chaotic, unpredictable, and dangerous biological process are intertwined in colonial narratives of conquering, civilizing, and race, and have resulted in an ongoing history of the violent appropriation of birthing bodies and traditional midwifery practices (Rucell, 2017). The Western imperative to control nature, what Davis-Floyd (2001) calls the 'technological imperative,' motivates biomedicine's vested interest to intervene in birth to ultimately make it more predictable, controllable, and consequently, safer (Davis-Floyd, 2001). Paradoxically, medical interventions do not always lead to better outcomes than low-tech births. Evidence shows that most pregnancies finish term without the anticipated complications that call for medical intervention, and unnecessary medical interventions significantly increase risks for iatrogenic harm (Romano et al., 2008).

Scholars speculate, based on research from previous natural disasters and pandemics, that the pandemic has resulted in obstetric care providers reverting to deeply held beliefs surrounding technocratic, "essential" perinatal care that they have been socialized into (Davis-Floyd, 2020). This "reflex reaction" (Davis-Floyd, 2020, p. 419), particularly during a time of uncertainty, resource constraints, and risk trade-offs, is underpinned by the institutional imperative for the discipline and control of birthing bodies under the technocratic model of birth (Davis-Floyd, 2020; Sadler, 2016). While the pandemic has further exposed its conceptual deficiencies, nowhere is the authority of the technocratic model of birth more apparent than in pandemic perinatal care "trade-offs" and the "most conservative" policy implementation discourse. Studying policy implementation during the pandemic has made evident how institutional priorities and person-centred care comes into conflict in the context of everyday practice, especially within the perinatal care context.

Nevertheless, alternative discourses of "essential" care therefore exist and are operationalized in institutional obstetrics practice. During the pandemic, while many healthcare organizations enacted policies going against evidence-based guidelines and recommendations by authoritative bodies such as the World Health Organization, other hospitals with commitments to person-centred maternity care (e.g., Baby Friendly Initiatives), prioritized support for people, postpartum care, and breastfeeding, even in regions with high COVID-19 caseloads (Muñoz-

Amat et al., 2021). Indeed, such constructions of "essential" care presented in this study directly contrast with the BC Women's Hospital and its decision to have a doula present as part of the "essential" care team. Many client-facing care providers also resisted narrow conceptualizations of "essential" care, advocating for more client-centred policies. Thus, individual care provider constructions of "essential" perinatal care can be interpreted as not just personal beliefs with localized effects, but as a reflection of organizational priorities operating within the broader healthcare system and biomedical institution. The section below discusses the implications of such conceptualizations of "essential" perinatal care through the concept of *obstetric violence.*

4. Obstetric violence

My motivations for this study were borne as a response to the widespread and avoidable harm caused by pandemic policies to birthing and postpartum people in Canada (Rice & Williams, 2021a; 2021b). In this section, I will take up a discussion of care provider discretion in policy implementation as it relates to the concept of obstetric violence. Obstetric violence has been developed as a tool for naming and critiquing how healthcare systems and even routine obstetric practice can cause harm to pregnant and birthing people. While a contested term (see Lappeman & Swartz, 2021; Chadwick, 2021b; Lévesque & Ferron-Parayre, 2021; Burnett, 2021), in this study I use it to recognize, and draw attention to, the structural underpinnings of the harm caused to birthing and postpartum people during the pandemic (Sadler, 2016; 2020). In response to the groundswell of evidence, many scholars are voicing their concerns that COVID-19 is eroding hard-won birthing rights, and in doing so, explicitly name obstetric violence as a call to action (Rice & Williams, 2021a; Sadler, 2020; Salter et al., 2021; Lévesque & Ferron-Parayre, 2021; Kuurne & Leppo, 2022; Davis-Floyd et al., 2021; Friesen, 2021; Mayra et al., 2022; Khalil et al., 2022; Rice, forthcoming).

While I acknowledge that some forms of obstetric violence are undeniably violence in its most explicit, overt, and dangerous sense (e.g., hitting), other forms are unintentional, indirect, and even routine. Indeed, this is what scholars naming obstetric violence during the pandemic claim; that is, harm caused by neglect, an environment of non-consent, and the systematic use of severe pandemic restrictions without evidence base. Echoing feminist scholars, I recognize that a part of the resistance towards naming indirect harms as *obstetric violence* come from the strict opposition of care and violence in their common conceptions. However, I argue that resisting

naming obstetric violence for such a reason oversimplifies boundaries between care and violence, obfuscates the complex, political nature of care work, and thus stifles inquiry into how healthcare systems and medical practice can be strengthened against obstetric violence (Chadwick, 2021b; Mulla, 2014). Further, I also do not regard individual care providers as sources of or perpetrators of obstetric violence (although, in certain cases, they are), but rather, the practices, discourses, and institutional organization of biomedicine that structure the conditions of its manifestation and use the term to critique such. With this, I position the findings of this study alongside the works of these scholars, discussing my findings from two theoretical angles: one being an extension of the concept presented in Chapter 2 of this thesis, that is, the "structural" nature of obstetric violence, and a deeper point of analysis, that is the epistemic injustice of obstetric violence (Fricker, 2007; Cohen-Shabot, 2021; Chadwick, 2021b).

a. Theorizing the "most conservative" approach

The organizational adoption of the "most conservative" approach to policy can be attributed to an interplay of political, social, and epidemiological factors. For one, as evident from the interviews in this study, it can be attributed to a lack of scientific knowledge on the SARS-CoV-2 infection and its epidemiology. However, as shown in this study, the lack of correspondence between such an approach and COVID-19 case numbers suggests other factors at play. One is, undoubtedly, political. Focus on the management rather than prevention of infection spread is on the Canadian and provincial governments' failure to provide citizens with social safety in the form of paid sick leave, childcare, and elderly care assistance, compensation for informal care work, affordable housing, among many others. Researchers have long argued that policy directives following social justice principles, that is, distributive justice and the prioritization of the most vulnerable of society, is essential to successful pandemic preparedness and response (Kayman et al., 2006; DeBruin et al., 2012). As a result of the failure to control community transmission, the healthcare system has been strained to maximum capacity, managing the consequences of weak pandemic preparedness.

This tendency to individualize responsibility in the face of community transmission is, perhaps, reflective of the widespread belief within the healthcare system that each patient, and in the perinatal context, each birthing person and their social networks, are individual disease vectors to be isolated as measures for protection. The findings of this study, along with others (Richmond et al., 2021), show that organizations were largely unprepared for a pandemic of this

scale, resulting in severe policy measures to be adopted as precautionary measures without evidence base. Research with frontline healthcare providers during the severe acute respiratory syndrome (SARS) shows that perceptions of personal preparedness were related to perceived institutional preparedness, influencing decisions regarding policy implementation (O'Sullivan et al., 2017). From the perspective of managers required to manage infection control within their wards, each birthing person and their support network were treated as a potential source of infection. This may have been exacerbated in the case of remote provinces such as Newfoundland and Labrador, given resource constraints.[10] Feminist scholars have theorized that the perinatal healthcare system's failure to consider the health and wellbeing of birthing people as interdependent on family and social networks has justified policy decisions that have resulted in obstetric violence (Rice, forthcoming). Furthermore, rarely do these individualistic calculations of COVID-19 risk consider infection risk from staff to birthing people, nor the risk of severely restrictive policies on the wellbeing of birthing people and newborns (Davis-Floyd et al., 2020; Rice & Williams, 2021a; Rice, forthcoming). Considering that for many, especially the most vulnerable in society, birthing in the hospital is the only option, the "most conservative" approach to policy implementation is concerning.

As Sadler and colleagues point out, "we carry a history of decades – even centuries – of harmful biomedical childbirth practices that are not evidence-based and have proved difficult to change in practice. The COVID-19 scenario reminds us of the fragility of the advances in the rights of these groups" (p. 47). Underlying the "most conservative" approach is, as Davis-Floyd (2020) has called out, an epistemic "reflex reaction" towards deeply entrenched beliefs surrounding childbirth and perinatal care (p. 419). As one respondent noted:

> *"Moms were without that that partnership in in taking care of their baby throughout their stay. They didn't have that support, which really, the way it should be [having birthing support person], and the way it is these days. I mean, it's not like we should have done what we did fifty years ago, when women were dropped off at the door and picked up [laughing]"* (Interview 5, obstetrics nurse).

Studies show that the forms of obstetric violence experiences by birthing people stemmed directly from severe policies aimed at reducing interpersonal contact and infection control. The quick reversal of many hard-won birthing rights is indeed motivated by the epidemiological and

[10] The lack of midwifery-integrated care in Newfoundland and Labrador is also a significant structural barrier to accessible, person-centred and holistic maternity care in the province.

sociopolitical landscape of the pandemic, but its ideological foundations and such normalized forms harmful of perinatal care cannot be ignored. Ultimately, as shown by this study, the "most conservative" logic is justified through a conceptualization of indispensable aspects of good perinatal care determined by the biomedical model and its authoritative knowledge. How such knowledge legitimizes such policy decisions, and ultimately, indirect forms of obstetric violence, is discussed further below.

b. The authoritative knowledge of biomedicine and obstetric violence

As discussed in the section above, technocratic models of birth are underpinned by institutionalized biomedical knowledge that constructs a particular reality of birth (Foucault, 1978). The biomedical model plays a significant role in determining what is considered "essential" medical care, what does not, and as a result, how birthing people's bodies are to be disciplined and managed during a pandemic. Indeed, scholars have argued that the systematic mistreatment of birthing people is rooted the technocratic model of birth (Liese et al., 2021). My analysis, consistent with the theoretical literature on obstetric violence, shows that biomedical discourses, functioning as authoritative knowledge of "essential" perinatal care deny experiences of, and even normalize, obstetric violence stemming from the implementation of severe pandemic policies (Chadwick, 2021a; Liese et al., 2021).

Scholars have pointed out that to intervene in accepted practices of obstetric violence, the unexamined ways of thinking underpinning such practices need to be reconsidered (Chadwick, 2021a). In this section, I would like to take up a discussion of the epistemological implications of my findings as it relates to the concept of obstetric violence. Evident in the controversy surrounding the use of the term "obstetric violence" rather than softer words like "mistreatment," "disrespect," or even "abuse" is a critical reframing of how we think about birth and obstetrics care. In describing the potential of the term to destabilize common sense assumptions of the world and specifically, discourses of biomedicine, Chadwick (2021a) describes the concept of obstetric violence as an "epistemic intervention that demands the recognition of unjust and violent practices in reproductive healthcare contexts" (p. 109). More specifically, Chadwick (2021a) theorizes obstetric violence as beyond just violence against women, but a "specific form of violation against reproductive subjects" (p. 111). This concept emphasizes the intersectional nature of obstetric violence, showcasing how Western biomedicine, as a colonial, cis-normative, heteropatriarchal knowledge system, does not recognize gestating and birthing persons as

"embodied subjects" with "mind-body integrity, embodied capacities, epistemic agency, intentionality, and the rights to situated modes of freedom" (p. 120). Scholars have even argued that the birthing subject is especially subjected to such violence precisely because they are in labour, and the dominant interpretative concepts of biomedicine conceptualize labour as a state wherein a woman is intrinsically irrational and uncontrollable (Cohen-Shabot, 2021). These institutionalized stereotypes of women in labour are significant because they directly underpin practice and shape decision-making and increase the risk for obstetric violence (Villarmea & Kelly, 2020).

Looking at the authoritative knowledges that constitute obstetric practice, it is evident how biomedical discourse positions care providers in powerful positions over the birthing person by way of epistemic agency; a person in labour is ascribed "patient," a subject whose body is to be examined and practiced upon by medical professionals (Chadwick, 2018). It proposes that only the medical professional, through institutionalized medical knowledge and the use of technological interventions, knows the objective truth about a birthing body (Cohen-Shabot, 2021). Constructing birth as a biophysiological event requiring clinical intervention necessarily devalues the embodied experiences and knowledge of the birthing subject. As shown in this study, managers, in recycling biomedical discourses in their narratives, position the birthing subject as subordinate to the medical professional by way of medical expertise. Anxiety surrounding giving birth without a partner, doula, or support person was devalued and denied as a legitimate reason to allow support people during birth and postpartum. Managers even described the anxiety of birthing people as stemming from the assumption that obstetrics staff could not do their job properly ("*So rather than being so anxious before you even arrive and assume that we can't do our job, why don't you assume that we're really good at our job*"). The perspectives of, even consideration for, birthing people are missing in such narratives.

Client-facing care providers, on the other hand, frequently negotiated with, and even resisted, biomedical discourses of birth. Notably, many reframed risks away from bureaucratic goals of infection control towards risks to the birthing person ("*I think excluding fathers was very risky*" and "*for what benefit was it to potentially turn them [partners] away at the door and damage the therapeutic relationship?*"). Some also emphasized the birthing person's experience ("*you're frustrated, you're pushing, like, you know, emotions are high*"), often using first-person narratives ("*I don't know how I could have done it without my husband*") and stories of personal

experiences ("*I wish my daughter was out here [to tell you about birthing without her husband"*). Respondents also acknowledged the relational personhood of their clients when requesting exemptions from policies, emphasizing the important role of the birthing support person ("*We got to look at the patient's perspective too – she don't have anybody with her. You know, her coping mechanisms won't be as good*"), while others spoke to the epistemic agency of the pregnant subject ("*obviously, it would've held some personal importance to them [to bring partners against policy] for some reason or another*"). These narratives intervene on the common sense assumptions surrounding "essential" perinatal care by positioning an "alternative epistemology" of birthing that is grounded not within biomedical objectivity but embodied subjectivity, considering the birthing body as a knowing subject (Chadwick, 2021a). Crucially, this epistemological practice underlies respectful, person-centred care as it recognizes the birthing person's capacity as a knower; a birthing person, by way of experiencing birth, has an embodied, relational, and subjective knowledge of their body.

Claims of objectivity underlie the technocratic model of birth. Quantifiable, "objective" knowledge produced by technological instruments, mediated by patriarchal arrangements of power endowed to the physician, nurse, or technologist, is considered more accurate and reliable than the embodied knowledge of the birthing subject (Freeman, 2015). The epistemic authority of technocratic knowledge renders itself impartial and therefore, ethically neutral (Solli & Barbosa da Silva, 2018). For this reason, obstetric violence and its epistemic roots are too often minimized, and even rationalized, as biomedical practice is considered impartial and independent of culture or value (Chadwick, 2021b). Exposing the partiality of biomedical knowledge and constructions of "essential" perinatal care is particularly an important endeavour for the work against obstetric violence. While some client-facing care providers described severe pandemic policies as an "injustice," nobody utilized the term "obstetric violence" nor softer terms such as "disrespect" or "mistreatment." However, obstetric violence closely escapes being named:

> *"When women delivered, you gave them four hours. And unless those four hours were out, we're basically telling a woman, even if she had a c-section, she can't move. 'Sorry, your husband has to go. Until you're discharged you can't see him.' And baby daddy can't be with the baby. Isn't that heartbreaking? Not mentioning like, you know, this huge bonding time. Say you got a woman who had depression before and has this high risk for postpartum and you send her up to a floor. There it is very busy. Here in the case room, we have one-to-one nursing but up on the floor, it is one to four. She can't even move half*

> *the time yet. By the time we send her up there, especially if she had a section, she can't go and pick up a baby. But there is nobody there to help her. Does that sound right to you?"* (Interview 6; obstetrics nurse).

This narrative is exemplary of why the term obstetric violence is a productive epistemic intervention. Firstly, the respondent emphasizes the importance of postpartum care and mental health support, intervening in the authoritative conceptions of "essential" perinatal care that center on the "delivery" of the baby as the job of the medical professional. Here, they emphasize the dangers of isolating a postpartum person in the hospital ("*She can't go pick up a baby. But there is nobody there to help her*"). Secondly, in calling out normalized practices of disrespect towards birthing people during the pandemic, the biomedical epistemological frame denying the birthing person's embodied subjectivity and experiences of childbirth is destabilized. This directly challenges manager constructions of "essential" perinatal care that overlook the emotional, physical, and social needs of postpartum people. Thus, discretion in policy implementation has the potential to advocate for clients not only practically, but also as an epistemic intervention in and of itself, as care providers justify their decisions to advocate for clients utilizing frames of embodied subjectivity that biomedical discourse does not have the language nor the concepts to articulate.

An interesting concept that can facilitate the acceptance of the term obstetric violence as an epistemic intervention is *epistemic injustice*. Miranda Fricker (2009) theorizes epistemic injustice as "the wrong done to someone specifically in their capacity as a knower" (p. 1). Fricker postulates that there are two kinds of epistemic injustice: one is *testimonial injustice,* where there exists a credibility deficit of the speaker by way of social identity prejudice, and the other is *hermeneutical injustice*, where there exists a gap in our collective interpretive repertoires necessary for someone experiencing identity prejudice to make sense of their social experiences. Scholars of obstetric violence have pointed out the occurrences of testimonial injustice where labouring people are not believed when they say they are in labour or experiencing pain (Cohen-Shabot, 2019, 2021; Chadwick, 2019; Gabriel & Santos, 2020) and hermeneutical injustice where people who have experienced obstetric violence do not have the term or concept of "obstetric violence" available to them to understand their experiences, or they live in a society where experiences of obstetric violence are systematically unacknowledged or silenced

(Chadwick, 2019; Lévesque & Ferron-Parayre, 2021). Obstetric violence thus cannot exist without epistemic injustice to reproductive subjects.

Naming obstetric violence can be an epistemic intervention to broaden our collective resources for recognizing, articulating, and addressing experiences of obstetric violence toward strengthening healthcare systems against it. Care providers are an essential part of the work towards eliminating obstetric violence; nuanced concepts and language for obstetric violence can provide both birthing people and care providers with the ability to interpret and explain the unexplainable ("*Does that sound right to you?"*"). Equipping care providers with such concepts can empower advocacy, as shown in this study. Recognizing obstetric violence as structural violence can also allow care providers to see themselves as part of the solution towards eradicating obstetric violence and protecting the workforce against its damaging effects of moral injury and burnout. Such concepts are also immensely important for people who have experienced obstetric violence to cultivate critical consciousness, to recognize and process their own experiences, and for such experiences to be recognized as a reflection of not just individual behaviour, but inequalities inextricable from medical institutions and social systems of power.

CHAPTER 6: CONCLUSION

1. Introduction

This chapter presents the conclusion of this study. Firstly, I will also provide a discussion of how the results of this study can inform policy and organizational policy processes. Here, I will present my arguments for why policy processes ought to be more participatory, with the inclusion of client-facing, frontline care providers and birthing people in all stages. Finally, alongside scholars like Chadwick (2021a), I will discuss why the concept of obstetric violence is a useful tool or "epistemic intervention" for policymakers and care providers towards strengthening maternity care systems and practice against obstetric violence. Finally, I will discuss the limitations of this study and areas for further research.

2. Implications for Practice

a. Less bureaucratic healthcare systems

This study shows that perinatal care provider discretion is a significant resource for ensuring the implementation of policies in practice. However, as this study and others show, discretion, specifically care providers advocating for clients, is also constrained by occupational demands, bureaucracy, and structural relations of power (Finlay & Sandall, 2009; Nunes & Lotta, 2019). Theorizing the "dilemma of street-level bureaucracies," Lipsky (1980) wrote that "the very nature of [the street-level bureaucrat's] work prevents them from coming even close to the ideal conception of their jobs" (p. 82). Indeed, my analysis shows that care providers were constrained by bureaucratic pressures and the imperative to process clients in an efficient and impersonal manner; however, this depends on care provider interpretations of such structures as real and constraining or not (Findlay & Sandall, 2009). Some care providers resisted such constraints and exercised advocacy ("*I am not one of those nurses that would for you [to put a mask on]*"). Many respondents felt "stuck between a rock and a hard place" deciding whether to advocate for patients where it did not converge with organizational priorities. From this perspective, there appears to be a need to re-construct maternal health, at the systems, organization, and practice level, towards less bureaucratic and more person-centred ends (Finlay & Sandall, 2009; Rudebeck, 2019; Tiderington & Stanhope, 2018). This, as other scholars also argue (McCrae, 2013; Kruger & Schoombee, 2009), must be met with efforts to eliminate

workplace hierarchies and empower frontline health workers, from an occupational, educational, and interpersonal standpoint, to provide person-centred maternity care.

b. Democratizing the policy process

The findings of this study have demonstrated a need for involving birthing people and client-facing care providers in multiple levels of policy processes. Respondents in this study described being able to speak with their managers regarding policy implementation, but none had the opportunity to contribute to the formal policy writing process. Furthermore, there existed no patient committee or representatives specific to the obstetric ward to assess the acceptability of policies for the specific patient population. This issue is reflective of the broader power hierarchies in the bureaucratic organization of hospitals, where nurses, residents, and general practitioners are at the bottom of the hierarchy of the medical system, and patients are expected to be passive and cooperative (Whitelaw et al., 2020). This fundamental assumption is deeply problematic and in conflict with the goals of respectful, person-centred care, and ought to be replaced with models that are conducive to team-based, collaborative models of medical care, as asserted by other scholars (Wilson, 2012; Fox & Reeves, 2015; Whitelaw et al., 2020; Belrhiti et al., 2021). As this study has shown alternative discourses of "essential" perinatal care do exist, albeit in the frontlines and margins of policy within bureaucratic healthcare organizations. Client-facing physicians and nurses, for example, may be better suited to advocate for client interests than unit and division management.

Scholars of intersectionality-based policy analysis have suggested that including diverse, intersectional perspectives in policy decision-making processes is fundamental to the development of policies that address health inequities and ultimately, more just healthcare systems (Fridkin, 2013). Thus, healthcare organizations should work to create various patient committees to oversee policy-making processes. For example, the BC Women's Hospital offers different ways to provide feedback on services, one being their Patients as Partners initiative (Patient Experience, BC Women's Hospital, 2022). Another example in Canada, although not in maternity care, is the Holland Bloorview Kids Rehabilitation Hospital's Family Advisory Committee, consisting of youth and their families who contribute to decision-making within the hospital. This committee played a role in the creation of the "Family Caregiver Presence Policy," alongside the hospital ethicist, the Director of Client and Family Integrated Care, and various other organizational leaders. Ultimately, the policy assessed visitors on a case-by-case basis and

in collaboration with the family, with a specific focus on equity, considering the differential impact of policies along the lines of health condition, race, class, im/migrant status (Menna-Dack & Sium, 2021). While there are vast differences between rehabilitation care and childbirth, such a participatory policy process, alongside significant levels of discretion, is a resource and aspirational model for other healthcare organizations to better include clients and their social networks in decision-making. Furthermore, given the structural nature of obstetric violence, it is also important that women's groups, birthing rights activists, and community organizations are involved in the policy process, the design, delivery, and evaluation of obstetrics care, and continuing medical education for healthcare professionals.

c. Humanistic perinatal care model

This study shows that care providers exercise discretion and make policy implementation decisions based on constructions of "essential" perinatal care that are grounded in technocratic and, on the other hand, more person-centred, humanistic paradigms. Notably, constructions of "essential" care differed among managers and client-facing care providers, with the latter drawing on biomedical discourses to justify the "most conservative" policy implementation approach. Scholars have since conceptualized the need for more humanistic healthcare, one that views birth as a "biopsychosocial" process wherein the birthing subject is conceived as relational, embedded within the family, community, and broader society (Davis-Floyd, 2001). The humanistic model allows for a more equitable balance of the needs of the individual and the needs of the institution which, in the context of perinatal care, requires birthing people have the flexibility to labour as they choose, the right to a chosen birthing companion, and access to midwife birth attendants and doulas (Davis-Floyd, 2021). The need for more humanistic healthcare is made even more evident in the case of the COVID-19 pandemic, where birthing people and newborns are conceived as "discrete individuals and disease vectors who must be isolated" in hospitals (Rice, forthcoming).

d. Working towards ending obstetric violence

The pandemic has exposed deficiencies in the technocratic model of birth that dominates healthcare systems. Studying policy implementation and care provider discretion during the pandemic, in the face of immense strains on the healthcare system, reveals the deeply entrenched assumptions behind "essential" and "not essential" perinatal care, the "reflex reactions" that prevent the practice of obstetrics from evolving with scientific evidence, association guidelines,

and importantly, the experiences and needs of birthing people. In addition to the steps outlined in the sections above, examining such taken-for-granted assumptions underpinning the technocratic model of birth is necessary epistemic work to examine and deconstruct the discourses and practices that cause harm to birthing people. This calls for more interdisciplinary scholarship in health research, with greater contributions from the social sciences, especially intersectional feminist perspectives. Creating space for decolonial, afro-feminist, and queer scholarship in health research will be essential for strengthening theoretical and empirical progress in characterizing the concept of obstetric violence (Chadwick, 2021a; Tamale, 2020).

3. Limitations and Future Research

a. Sample size, sampling site, and the wider applicability of findings

This study was site-specific to a tertiary care centre in Newfoundland and Labrador. As the maternity healthcare system is organized differently in each province and territory of Canada, the findings of this study are specific to perinatal care in Newfoundland and Labrador. To obtain a more comprehensive understanding of pandemic perinatal care in Canada, future research can expand the sampling site to include tertiary care centres in other provinces and territories. Considering that purposive sampling was utilized to contextualize the negative experiences of birth and postpartum in Newfoundland and Labrador (Rice & Williams, 2021a) and that the province experienced an overall low number of COVID-19 cases, this approach was overall advantageous to understanding how pandemic policies affected the provision of obstetrics care. Furthermore, despite its obvious limitations, the wider applicability of the findings is possible. For example, this study was designed to inquire about the experience of implementing pandemic policies surrounding perinatal care and making trade-off decisions, an experience that was universal in tertiary care centres across the country. This could serve as a useful comparative study with other provinces and territories in Canada where maternity care is structured differently, or where birthing people have had significantly different experiences during the pandemic.

Another point to discuss is the number of interviews conducted. As discussed in Chapter 4, the number of people interviewed for this study was expected to be modest given the specific sampling site, inclusion criteria, time constraints, and pandemic-related limitations. For this reason, critical case sampling and discourse analysis, as a theory and method, was utilized to

obtain a rich and nuanced understanding of care provider discourse surrounding policy implementation. The explanatory power of the study can be strengthened by interviewing more respondents from the sampling site to corroborate latent, higher-level codes and themes. Another limitation regarding this was that within my time and resource constraints, I was able to recruit only one obstetrician. Future research can interview more obstetricians and analyze profession-specific nuances in discourses surrounding policy implementation. Furthermore, as this study corroborates that care provider discretion is influenced by professional role (Lipsky, 2010; Evans, 2010; 2015), a larger study focusing on the relationship between occupational role and policy implementation would be valuable to understand how socialization into a professional role shapes the provision of perinatal care.

b. Directions for future research

Site ethnography can also be a valuable opportunity to understand policy implementation processes to understand the culture, behaviours, and norms of obstetric care providers within the organizational setting. Ethnographic discourse analysis (Pun, 2020), for example, can be used to study care provider discretion and interactions. This is a useful approach for contextualizing interview data to understand how interprofessional collaboration, managerialism, and the physical spatiality of obstetrics wards contribute to policy decision-making and the construction of "essential" perinatal care. My findings suggest that care providers request exemptions from policies on behalf of their patients; investigating patient agency within provider-client interactions is a rich area for inquiry to investigate how power operates within the therapeutic relationship. Furthermore, eliciting the narratives of birthing people and analyzing how they construct "essential" perinatal care is an important aspect of characterizing biomedical discourse and its effects on agency.

The finding that more client-facing care providers utilize their discretion to advocate on behalf of their clients is also significant. While care-provider advocacy is valuable, it is not a reliable or consistent process to ensure that the needs of birthing and postpartum people are met. This raises concerns regarding how such processes may exacerbate inequities in access to respectful, person-centred maternity care, as individual care providers are afforded the power to decide, as was in the case of the pandemic, who gets to be advocated for, and why. In their study of equitable access to health services, Nunes and Lotta (2019) find that Brazilian community health workers exercise power over which policies they implement in practice, how, and for

whom, using unofficial classification schemes for clients. Community health workers describe clients based on health conditions, their worldviews, expectations of their occupational role, and moral factors, creating the subject position of the "ideal patient" who is "worthy" or "not worthy" of healthcare services. As scholars of intersectionality-based and critical policy analysis have shown, policy processes exist within a historical context, wherein intersecting and oppressive systems such as racism, sexism, and colonialism operate through policy processes to reproduce social inequalities (Hankivsky et al., 2014; Lotta & Pires, 2019). Thus, further research on care provider advocacy is necessary to characterize its outcomes on the provision of perinatal care. Importantly, characterizing how race and racism plays a role in shaping care provider advocacy is crucial, given research coming out the pandemic showing that policies had a disproportionately harmful impact on racialized birthing people, who were afforded fewer exemptions and accommodations (Altman et al., 2021a;2021b).

How conversations surrounding exemptions unfold between the client and the care provider, which requests and *whose* requests are getting taken up to management, and how managers process exemptions are areas of inquiry for intersectionality-based and critical policy analysis. Further, how policy processes evolve, including "unofficial" systems of client advocacy into common practice ("*there's really no one that wouldn't be granted an exemption to come in and be a visitor*"), could be a fruitful study of the dynamic and interrelated relationship between care, policy, and institutional culture. As this study has shown, discourse analysis is a theoretical and methodological tool to analyze advocacy and highlights the discursive nature of policy implementation and conceptions of "essential" perinatal care. As discourse is both powerful and transformable, researching advocacy is foremost an investigation of "bottom-up" resistance to bureaucratic structures and biomedical discourse. This research holds transformative potential for innovation in maternity care for orienting organizational imperatives and healthcare systems towards the needs of the people it intends to serve (Walsh, 2007).

More pragmatically, research on how organizational structure and bureaucracy affect advocacy practices and person-centred maternity care is also a valuable area of study. Research has shown that maternity care providers in free-standing clinics exercised advocacy more frequently and to greater effects than maternity care providers part of a large healthcare organization (Finlay & Sandall, 2009). Such findings call for healthcare systems-level research on how maternity care is organized across the Canadian provinces and territories and how this

influences the provision of person-centred care. This research can provide further evidence to advocate for decentralized, midwifery-integrated, and person-centred maternity care models.

4. Conclusion

The pandemic has intensified health inequalities and exposed healthcare system inefficiencies in Canada. This study shows that in the face of resource shortages and pandemic-related pressures, many essential aspects of holistic perinatal care were de-prioritized as a necessary precautionary measure for COVID-19, even in regions like Newfoundland and Labrador where such risks did not materialize. Studying policy implementation revealed how care providers, afforded a great degree of discretionary power, made "unofficial" decisions based on conceptions of "essential" perinatal care. Ultimately, as reflected in manager narratives, the discourse of the Western technocratic model of birth were utilized to prioritize bureaucratic and organizational goals during the pandemic.

However, that "essential" perinatal care entails heavy medical intervention use in hospitals, limited postpartum care and breastfeeding support, and bans on birthing support people is unacceptable given the vast body of evidence stressing the dangers of iatrogenesis and the successful outcomes of low-tech, person-centred maternity care practice. Considering the public outcry surrounding birthing support person bans, perinatal and postpartum mental health, and the ongoing inequalities in access to midwifery care, the demand for full-spectrum, holistic perinatal care is urgent and essential. As Davis-Floyd (2021) has highlighted, the pandemic is an opportunity to critically re-examine existing maternity care systems and work towards increasing access to and the capacity for out-of-hospital births, alongside the work to reframe out-of-hospital births as safe for low-risk pregnancies. However, given that many birthing people choose to give birth in hospitals (Chadwick, 2014), this effort must be met with reforming healthcare organizations towards a less bureaucratic and more client-centric ends. Harnessing the resistance and advocacy of care providers documented in this study will be a critical resource for strengthening healthcare systems against obstetric violence and future disease outbreaks.

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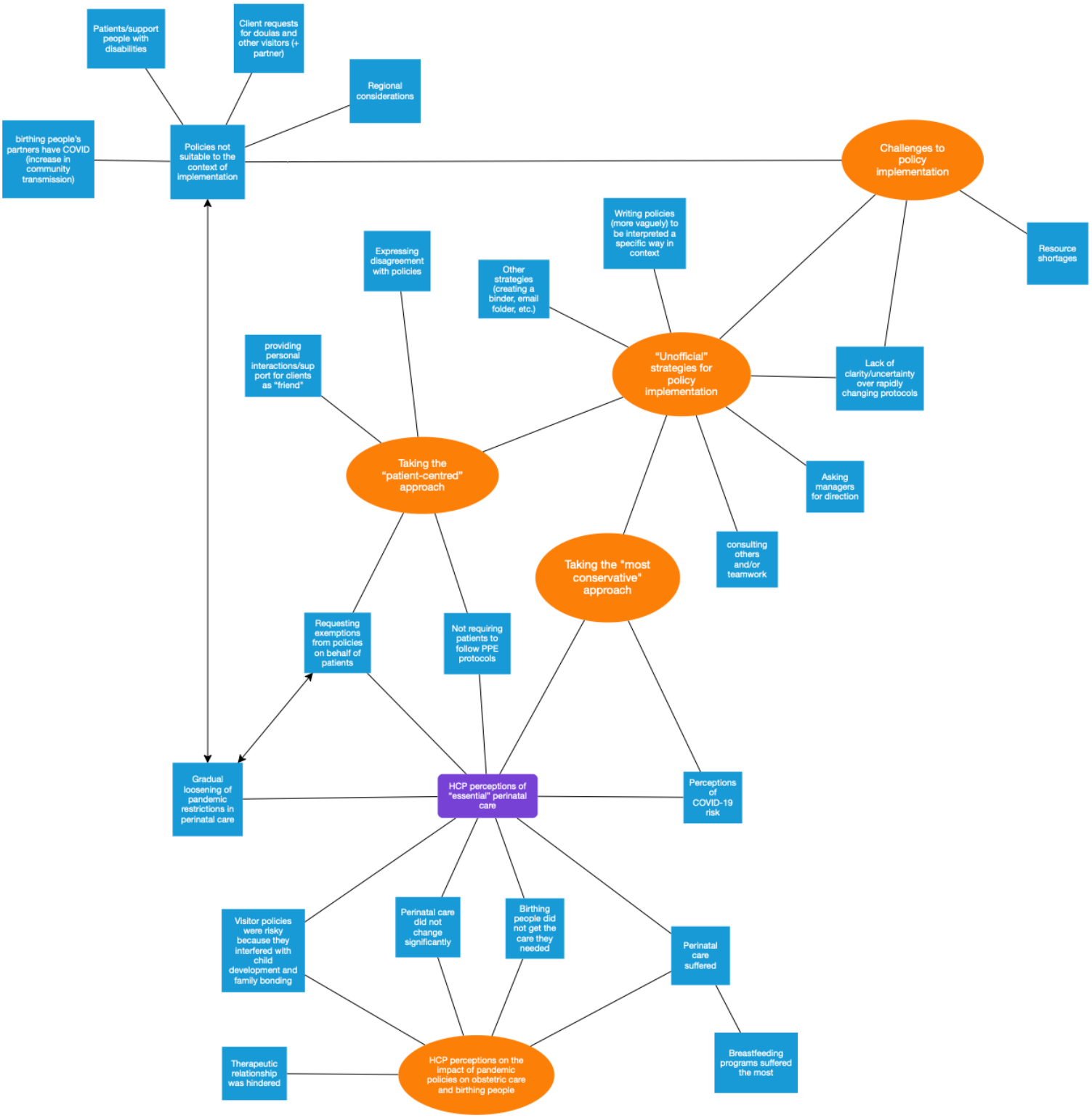
APPENDIX I: Thematic/conceptual map



APPENDIX II: Interview guide – revised March, 2022

Preamble:

Thank you for agreeing to participate in this interview. I am interviewing you to better understand your perspectives on implementing policies surrounding prenatal and postpartum care during the pandemic. The purpose of this interview is to gain knowledge that will support policy-makers, care providers, hospital staff, and relevant community groups in creating and implementing pandemic policies that ensure the provision of good care for pregnant people. Because I am interested in your perspective and experiences, there are no right or wrong answers to any of my questions.

You have signed the consent form and are aware of your rights as a participant. The interview should take approximately 30 to 60 minutes depending on how much information you would like to share. With your permission, I would like to audio record the interview because I don't want to miss any of your comments. All responses will be kept confidential. You may decline to answer any question or stop participating in the interview at any time and for any reason. May I turn on the digital recorder?

Interview Questions:

1. What is your professional role at the hospital?
    a. Prompts: what does a typical day look like for you? In what ways does this differ from prior to the pandemic?
    b. Do you work within a specific department or with a specific population? If so, please describe.

2. How are policies created and/or implemented at your hospital?
    a. Prompt: What are the processes or procedures for creating and implementing policies at your hospital?
    b. Probe: Who are the important people in terms of making decisions about pandemic policies in the hospital?
        i. Probe: Who is not included?

3. I would like to understand the relationship between supervisors, managers, and other staff in the hospital when it comes to implementing policies. Can you describe an event or interaction regarding policy implementation?
    a. Probe: concrete example

4. What is your role in regard to creating and/or implementing regional/hospital/birth centre policies?

    a. Prompts: can you give me an example of a policy you worked on regarding the birthing centre/maternity ward, either prior to or during the pandemic?
    b. What made you get involved in this role?

5. I am interested in your experiences with policies surrounding prenatal and postpartum care during the pandemic. How have you been involved in creating and/or implementing at the hospital/birthing centre/maternity ward?
    a. Prompt: What are your thoughts on these policies?

6. What are these policies intended to achieve?
    a. Probe: From your perspective, what should they achieve?

7. Could you walk me through the policy changes that have been implemented at your hospital/birthing centre/ward since the pandemic began?

8. What was it like implementing pandemic policies surrounding prenatal and postpartum care at the beginning of the pandemic?
    a. Probe: How has this changed compared to now?

9. What policy changes have worked well here since the pandemic began?

10. How are pandemic-related hospital policies implemented in the birthing centre/maternity ward?
    a. Probe: concrete example
    b. How are you and your colleagues aware of new policies?

11. Are there any supporting documents or guidelines being used to implement these policies?
    a. Probe: How do these documents or guidelines shape the way that policies are implemented in the birthing centre/maternity ward?
    b. How are they useful or not useful?
        i. Probe: concrete example for when they are or are not useful

12. Have you encountered any challenges in implementing pandemic policies surrounding prenatal and postpartum care?
    a. Prompt: concrete example

13. I am interested in understanding how hospital policies are implemented given an unanticipated situation. Can you describe to me a situation where implementing a policy was not straightforward?
    a. Prompt: concrete example

b. Probe: How were decisions made?

14. The women that my supervisor interviewed for our study had positive, negative, and neutral opinions and experiences with pandemic policies surrounding prenatal and postpartum care. From your perspective/experience, how do these policies affect birthing people?
    a. Probe: How are pregnant and birthing people considered in the policy process?

15. Do you have any suggestions for how pandemic prenatal and postpartum policies can be improved for professionals like you? For patients?

16. Do you have any other thoughts or concerns that you would like to share?