Pregnancy and Childbirth During the Covid-19 Epidemic in Poland: Qualitative Evidence From Expert Interviews.

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Research article

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Abstract

Background

The Covid-19 outbreak has significantly altered the provisions and shape of medical services for expecting mothers worldwide. In Poland, the country where pregnancy and childbirth are subject to comparably greater medicalization, those shifts are particularly tangible. This study aimed at capturing the responses of the maternal health professionals, highlighting possible long-term implications for the expecting and new mothers, as well as the reproductive health sector.

Methods

This is a qualitative and rapid-response study which addresses the themes around the emerging implications of the viral outbreak. Semi-structured expert interviews were conducted with 46 individuals, all highly-skilled, working in either medical or adjacent sectors connected with reproductive medicine, as well as varied antenatal and postpartum care services. In this analysis, 7 digital experts were excluded as observers rather than field practitioners Among 39 interviews, 5 have been conducted with OB-GYNs, 13 with midwives, 7 with doulas, 14 broadly-conceived category of maternal support experts including psychologists and physiotherapists. The recorded data were input into thematic grids and meticulously transcribed prior to being subject to an inductive, thematic analysis.

Results

The findings revealed that the context of the heightened medicalization of pregnancy and hospital care during birth in Poland, resulted in strong restrictions and immediate fall back to a clinical care model. The majority also claimed that the Covid-19 pandemic exacerbated the implications of the decades of Polish maternal health recommendations contradicting the WHO regulations. Professionals’ anxieties concern limited access to services assisting women during pregnancies. While those linked to hospitals pointed out physiological risks, other maternal support experts drew attention to the effects of stress and uncertainty on maternal mental health.

Conclusions

Experts believe that the pandemic will have multifaceted consequences. Negative impact on well-being of expecting and birthing mothers, as well as new-borns, is already observed and highly anticipated to increase further. The professionals underscore both the information chaos surrounding recommendations and procedures, and see the pandemic as a moment of reflection, mostly being vocal in their critiques of the over-medicalized Polish care model.

Background

The novel coronavirus (Coronavirus disease 2019 - COVID-19) is a global public health emergency with no end date in sight. Since early 2020, we have been witnessing a variety of restrictions that governments
imposed as a means to limit the spread of the virus and protect citizens (1,2). Corollary to other sectors and groups, the COVID-19 outbreak has significantly altered the provisions and shape of medical services for expecting mothers worldwide. Guidelines on delivery and care are constantly evolving as we learn more about the illness (3,4,5,6,7). COVID-19 reinvigorated the debates on telemedicine, agility of healthcare systems, as well as overcrowding and under-financing of healthcare workers, all having an impact on expectant and first-time mothers as a particularly vulnerable group. This is because overlapping medical and social shortcomings affect pregnant women in particular ways, introducing a condition of uncertainty and hindering women's ability to receive medical or social support during pregnancy, childbirth and in terms of new-born care (8,9,10,11).

While the virus is not under control globally as of July 2020 (12), in Poland the situation has been tackled head-on, with the government-introduced lockdown and strict policies for medical facilities taking effect in early March 2020. Importantly, pregnancy and childbirth have been subject to comparably greater medicalization in Poland than other EU/OECD countries (13,14). Thus, the COVID-19 shifts are especially tangible through greatly limited availability of support and growing fears of the expecting mothers. In this article, we seek to highlight these risks from the perspective of reproductive health experts.

As regards global context, it should be stated that early on in the COVID-19 epidemic, the issue of maternal health, particularly in the context of safety of delivery and vertical transmission, has been discussed in rapid response reactions (3,4,5,6,7). Based on the lessons of previous epidemiological threats, experts underscored that each case of a COVID-19 maternal infection will make subsequent prenatal, perinatal and postnatal care challenging, therefore sternly recommending emergency protocols, isolation and new-born quarantine (3,5,6). In early studies, clear guidelines on delivery were explicitly in focus, both to optimize the prognosis for mothers and children, and to prevent additional adverse outcomes. In sum, studies on the one hand supplied conflicting evidence on delivery timing, advice on the type of delivery and medical interventions during childbirth (e.g. anaesthesia), maternal ward organization and new-born care, including breastfeeding (5,7). On the other hand, little attention was paid to the wellbeing and psychological condition of the expecting and birthing mothers, foregrounding a very narrow view of medical safety.

In this perspective, emerging studies of pregnant women treated for COVID-19-related diseases offer mixed results and translate to those considering or experiencing pregnancy being ill-informed (15). One study found that pregnancy did not aggravate pneumonia caused by the virus and recovered expectant women delivered children scoring high on the Apgar scale (16). Conversely, Rasmussen and co-authors (17) indicated that novel coronavirus led to preterm delivery and foetal distress. In a meta-review of the available small-scale studies, Panahi with team (18) argue that there is no evidence of vertical transmission of COVID-19 from infected mothers to new-borns (see also 19) and the symptoms of the infection do not significantly vary between pregnant and non-pregnant women. At the same time, the review suggested that COVID-19 might in fact result in heightened risks of foetal distress, respiratory distress and even miscarriage. Liu and co-authors (19) underlined that women in first and third trimesters are in a special pro-inflammatory state, i.e. the cytokine-storm connected to COVID-19 might correspond
to the seriousness of symptoms and proneness to infections. Another scoping review by Elshafeey and team (20) looked at a total of 385 pregnant women infected with COVID-19 across various countries, concluding that nearly 96% experienced mild symptoms, while only 0.8% were deemed critical. An important issue was the type of delivery with the rate of caesarean sections standing at a staggering 69.4% (20), even though the clinical presentation and illness severity in non-pregnant adults was comparable, weakening the argument about COVID-19’s impact on poor maternal or perinatal outcomes (see also 4).

With the prevalence of clinical recommendations, people alter their reproductive plans. In an Italian case study, Micelli and co-authors (15) showcase that 37.3% of those who planned to have a child before the pandemic have changed their mind. Their decision was related equally strongly to economic worries and possible health consequences of COVID-19 on the pregnancy. In a subsample of those who started to think about parenthood during the lockdown - reportedly as a way to find more positivity during the crisis - only a very small fraction (4%) actually tried to get pregnant.

Changing one’s mind, however, is not available to those already pregnant. Clinical recommendations, albeit crucial, might obscure the fact that stress during pregnancy is a highly concerning public risk exaggerated by the COVID-19 outbreak. Corbett and co-authors (21) found that pregnant women experience increased anxiety about their immediate family, older relatives and unborn baby, while Viaux and team (22) explicitly expect the rate of postpartum depression in the general population to rise up from the current 15% in response to the lockdown measures, especially since psychosocial stress is a key risk factor for preterm birth (8). As argued by Mirzadeh and Khedmat (11), ‘in nulliparous pregnant women, the adverse mood symptoms accompanied by childbirth fear may have irreversible effects on mother and child health’, thus health management and monitoring of wellbeing should not only concern late pregnancy but also the first two trimesters. Arora and co-authors (9) similarly call for less restrictive hospital visitor policies and enabling homebirths when possible, while recommendations by Rocca-Ihenacho and Alonso (23) favour decentralized midwife units and community birthing support.

Durankus and Aksu (24) surveyed 260 pregnant women in Turkey and found that 70% believed that the pandemic will impact on their pregnancy, with 35% scoring higher than average on three depression and anxiety scales. Topalidou with co-authors (8) specifically criticize early responses and clinical interventions in the form of separating mothers from infants post-birth and discouragement of breastfeeding. This is because feelings of inadequacy and shame about motherhood cause increased self-blame and make young mothers even more prone to postpartum depression (e.g. 25). This was confirmed for the COVID-19 times in a qualitative study by Das (10) who interviewed 14 women in Britain during their perinatality in May 2020. She notes instances of blanket social distancing measures due to virus-related anxiety, resulting in missing routine care appointments. The interviewed women felt cheated and devoid of the joy of motherhood, reporting feelings of guilt and sole sense of responsibility caused by partners’ exclusion from antenatal preparations, often linked to mental struggles of young fathers. While digital support provided respite, it was often deemed insufficient.
Few studies focused on the perspectives of health professionals. A quantitative, international and non-representative survey of 714 maternal and new-born healthcare providers was conducted by Semaan and team (26) in April 2020. These voices from the field expectedly indicate that professionals in high-income countries had a higher likelihood of being informed about guidelines, as well as better access to infrastructure (e.g. dedicated COVID-19 maternity suites). Across the board, stress levels of professionals increased, often because of staffing shortages and commuting challenges. Main concerns related to adverse outcomes caused by limited antenatal care provisions, fewer outpatient visits, cessation of having birth companions’ support, mother-new-born separations and postponed immunizations for babies. At the meta-level, studies (8,26) emphasize that hard-won victories in empowering birthing women can easily be lost by a high susceptibility of maternity care services to the clinical protocols during emergencies. While the effectiveness of this approach in terms of limiting the spread of the virus is not contested here, we draw attention to the possible implication of a complete isolation of birthing women and babies.

In terms of specific context, Poland generally stands out in Europe regarding reproductive health and reproductive justice (27). While the maternal mortality ratio is extremely low (28) and perinatal mortality of children is decreasing, Poland’s care standards are still strongly rooted in a clinical model. This is exemplified by the percentage of caesarean sections (C-sections) which has been stably growing from 1 in 5 in 2000 to reaching a pick of 44% all deliveries in 2017 (29). Only 1 in 4 births ends in C-section in Europe (30 p10), thus nearing the 1-in-2 ratio globally places Poland in third position, just behind Turkey and Korea (31). Medicalization is also evident from the rate of episiotomies which were carried out on 57% of women in Poland in 2015, whilst the rate stood at 9% and 12% for Sweden and the United Kingdom, respectively (30).

Notably, home births and birthing centres are still a rarity in Poland, with only 136 out of 370 706 (32) of all new-borns delivered outside of hospitals. The costs of non-hospital childbirth are relatively high (ca. 800 EUR) and are not covered by insurance. Simultaneously, Polish women are also used to paying for the so-called ‘nonessential’ hospital care out-of-pocket. They privately finance their midwives, pay for ‘family’ rooms and so forth. This causes social cleavages, as only those with significant economic capital can afford better care during labour. Only in 2011, following two decades of advocacy efforts, Polish Ministry of Health introduced the first national Perinatal and Postnatal Care Standard (PPC Standard). This was in line with World Health Organization (WHO) recommendations, especially in relation to birthing companions, avoiding separation of mothers and new-borns post-birth, as well as giving women the right to choose a method and place of labour (13,33). Governmental control nevertheless confirmed that numerous wards were still not following the guidelines five years later (30 p10). The mistakes ranged from infrastructural inadequacies like overcrowding, missing equipment or staff shortages, to issues related to women’s dignity. Women’s privacy and intimacy rights were not being observed and even though women should have access to childbirth anaesthesia covered by insurance since 2015, not having an anaesthesiologist on staff makes this pain management option unavailable for many women (30).
The Polish PPC Standard was then expanded in 2019, with the now imposed duty to monitor the mental state of women during pregnancy and in the postpartum period. This falls on healthcare providers, mainly midwives (14). At the same time, a large-scale study by Baranowska et al. (34) found that 81% of women in a sample of 8378 experienced violence or abuse during their childbirth-related hospital stays, long after the Standard was put in place. Most recalled physical discomfort during procedures, inappropriate comments and violations of privacy. Exemplifying how medicalization rooted in a checklist-like and particularistic care approach work against the WHO’s recommendations, a longitudinal study of 1679 women by Królak-Olejnik and colleagues (35) found that nearly all Polish women (97%) initiate breastfeeding after birth, however, they rapidly cease to exclusively breastfeed during a new-born's early life, with the rates of breastfed babies falling to 43.5% at 2 months, 28.9% at 4 months and only 4% at 6 months. Together with the fact that only 17% of infants were breastfed for 12 months, the data demonstrates that WHO recommendations are largely not followed, largely due to maternal support being too pricey or otherwise inaccessible.

It appears that the epidemiological threat exacerbated tensions between WHO recommendations and more women-centred care led by midwives, and hospital/OB-GYN (obstetricians and gynaecologists) care bounded by legal frameworks. WHO recommendations (36) focused on ensuring high-quality antenatal, intrapartum and postnatal care, inclusive of safeguarding well-being of mothers and new-borns. Moreover, the WHO guidelines called for skin-to-skin contact post-delivery, encouraging breastfeeding for so-desiring women. They did not speak to the cessation of family member’s presence, however, WHO still left the final decision in the hands of national and local consultants. In the latter realm, state-run clinics and private practices in Poland were subject to a national lockdown as of March 13., A ban on hospital visitations was introduced shortly after on the 20th of March 2020, with family births forbidden as well. Poland quickly fell back to a narrow model of the clinical rather than a holistic antenatal and perinatal healthcare. According to the Childbirth with Dignity Foundation (37), which has been at the forefront of fighting for granting subjectivity and agency to birthing mothers in Poland since 1994, this was a sudden imposition, traumatizing women who were not at all prepared for this shift.

Neither Polish Society of Gynaecologists and Obstetricians, nor the National Neonatology Consultant issued changes to their recommendations in the face of emerging evidence from the medical community worldwide. This signified a growing dissent from non-profit organizations and the Polish Ombudsman Office. At the beginning of May 2020, Polish Society of Gynaecologists and Obstetricians slightly revised restrictive recommendations to allow one birthing companion (38). However, there have been reports about difficulty in actually meeting the requirements for the birth partner who is supposed to have an up-to-date (not older than 5 days) and negative outcome of the Covid-19 PCR test (Polymerase Chain Reaction test). This is hard to do not only in the light of the unpredictability of the exact labour date and, more importantly, due to the limited accessibility of PCR testing in Poland. After two months of the aforementioned limitations, the National Health Fund (NHF, 39) announced that women have a right to a birth companion regardless of the epidemic. In July 2020, the authority conceded that requiring an up-to-date Covid-19 PCR test is irrational. To meet the upheld recommendations, NHF guarantees additional money for protective gear. In addition, the accompanied birth can only happen if the hospital facility has
enough single-occupancy en-suite delivery rooms. If granted the right to accompany a birthing woman, one person may stay for up-to two hours after birth only. Nonetheless, no other rules concerning hospital visits, skin-to-skin contact or breastfeeding have been altered by mid-July 2020. Furthermore, for pregnant women who either test positive for the novel coronavirus or are suspected of having contracted the virus, Polish National Consultant continues to enforce maternal and new-born isolation, as well as no breastfeeding.

Methods

Study design and participant recruitment

The study represents one of the components within a broader qualitative research program focused on motherhood and underway at the the at the Youth Research Center of the SWPS University since 2018. Specifically, a qualitative longitudinal GEMTRA project (full title Transition to motherhood across three generations of Poles. Intergenerational longitudinal study [GEMTRA]) is complemented by the Mother 360 project on (Mother 360 degrees – A journey to motherhood in contemporary Poland according to experts). Sharing topical focus and methodological premise, the two studies cross-sectionally address the process of becoming a mother from a number of perspectives, ranging from expecting mothers, through their relatives and antenatal non-medical support providers, to health professionals. We utilize qualitative research to gain more nuanced and in-depth understandings of how people make sense of the changing social realities (e.g. 40,41,42). The analysis is undergirded by the wider project, yet here empirically limited to the interviews with experts – practitioners in the field of reproductive medicine, as well as antenatal, perinatal and postpartum care services.

As we were preparing guides for expert interviews with three types of maternal support professionals, the first Covid-19 cases were being reported in Europe. During early days of the lockdown, we have decided to revise our study goals and include the question block on the effect of the pandemic on expectant mothers and various sectors where those providing mothers with support operate. While we maintained key research questions about the changing nature of maternal expertise in modern Poland, we have focused on the epidemiological crisis in relation to its both immediate and forecasted long-term effects.

Study participants were selected deliberately, with attention being paid to heterogeneity of the interviewees with regards to profession, age and, most importantly, place of work. The sample is biased towards women, given the gendered labour market sectorization. The recruitment techniques were reliant on letters to prominent figures of maternal support, adverts on social media, as well as personal contacts of the research team, followed by a snowballing strategy.

Data collection and analysis

With a lockdown in place, the participants were interviewed through digital methods, with semi-structured, individual interviews conducted online (e.g. via Skype Whatsapp, Messenger) or - in some cases - over the phone. A team of experienced qualitative researchers followed the interview guide when collecting the
empirical material. The interviews were carried out in April and May 2020 and lasted 1.5-hours on average.

Besides receiving an information package, prior to the commencement of each interview, the researchers have informed participants once again about the study, as well as acquired consent through verbal confirmations in response to statements about anonymity, right to withdraw etc. Data was audio-recorded and then input to framework grids by the researchers, as well as meticulously transcribed verbatim by an external subcontractor bound by a dedicated NDA (Non-disclosure agreement). Framework grids and transcripts were subject to thematic and cross-sectional analysis (41, 43), with a data dig-out workshop attended by the entire research team to ascertain intersubjectivity and cross-validation of the emerging saturation and patterns of meaning. Data relevant for this particular topical analysis was extracted with extended excerpts for subsequent recoding, then refined and finalized by the authors.

Participants

In total, 46 interviews were carried out across various categories of experts: medical, digital and supporting professions. 5 OB-GYNs, 13 midwives, 6 doulas and 14 professionals including psychologists and physiotherapists were interviewed. All but four participants were women. The respondents were born between 1960 and 1991 (average age 38,2), and had higher education. For this analysis, we excluded the digital experts as those are seen as observers rather than practitioners in the field.

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Results

Relatively little is known about pregnancy care in Poland from a qualitative perspective of experts, thus it is valid to first highlight the broader context of medicalization from the perspective of healthcare professionals:

*At a big conference in Poland, there was a comparison of pregnancy care in Poland versus (...) some rich countries in Western Europe (...) We do so many tests! A lot of ultrasound exams, while there are some countries where there are only two throughout the entire pregnancy. Midwives manage pregnancies. I think our model is highly and strictly medicalized (3_KE, OB-GYN[1])*

Our study shows that Polish experts vary in their awareness and evaluation of medicalization of pregnancy and birth. On the one hand, OB-GYN respondents were expectedly keen on leading pregnancy as sole decision-makers. They saw privatization and medicalization as underpinnings of optimal care and outcomes, especially during birth:
In Poland we continue to have this inflated medical aspect (...) I think there is this massive need to medicalize, the inducements of births, redressing normal labour into frames where two hours pass and then there goes a caesarean and the thing is over. I think we should draw more from the evidence-based Western medicine, knowledge based on scientific facts about perinatal care. In Poland we are really so behind. This is evident also with the pandemic situation. In the interest of women, we need to look more to the West (14_KE, midwife)

According to experts who interact with pregnant women on a daily basis, the COVID-19 outbreak brought on a lot of anxiety among expecting mothers and those who have been planning pregnancies. Uncertainty and information chaos are pervasive, especially as recommendations and practices vary between WHO, national experts and local practitioners. Inconsistencies are the source of nervousness:

There is so much news in the media, it's a giant mess. In Poland we do not cope with information well and we have recommendations differing from what is happening abroad, not in line with WHO. If someone reads English and has friends abroad, they might get completely lost, ask themselves what does it mean that someone else could do something but they can't, each doctor says something different. We're feeling lost, it's a giant mess (5_KE, midwife/ breastfeeding advisor)

The experts in the Mother 360 project have been observing growing fears that impacted on the preconception processes (see also 15). OB-GYNs, following the Ministry of Health recommendations, stopped provisioning fertility treatments and urged postponement of pregnancy plans during the epidemic. They drew on the fear stemming from the unknown consequences of this virus for mothers and unborn children (e.g 19, 44):

Women who planned to have a child are scared. Doctors simply advise them not to get pregnant because not much is known about the virus. It is impossible to say how it could influence the foetus during the orthogenesis, when all organs are formed. One does not know if the baby would be healthy. Both pregnant women and those who planned on getting pregnant, and the birthing women, they are all negatively affected by this situation (48_KW, physiotherapist)

Importantly, interviewees anticipate that the pandemic might get worse and there is no end date in sight. This especially holds as the impending recession factors begin to overlap with the weakening conviction
about the economic viability of one's reproductive plans (15), on which one interviewee claims that “many women will alter their plans due to economic reasons” (39_MW, physiotherapist). At the same time, experts argued that not all women have a privilege of holding off, referring especially to those struggling with infertility and being in their late 30s or early 40s. While they might be in the risk group, the desire to have a baby appears stronger than COVID-19 fears:

There are these women who are older, born in the 70s and 80s. When it comes to pregnancy, especially the first one, they feel a breath of time on their necks and don't believe they can wait. They have been trying for a while and they simply think that - virus or no virus - they will get pregnant. This is their decision and even though our recommendations are clear on discouraging getting pregnant, it is also true that our experiences with corona-virus in early pregnancy are non-existent (10_KE, OB-GYN)

Similar to Semaan and team (26), our study shows from a qualitative perspective that experts are stressed and confused, calling for more research on the risks associated with COVID-19 and pregnancy. Moreover, it demonstrates that Polish experts seem to have limited access to knowledge, so the distributed information and soundness of recommendations varies on a case-by-case manner:

The national consultants for midwifery and neonatology issued a peculiar update last week, saying that there was never a ban on accompanied births at all. It seems that the restrictions were introduced by the hospitals, which is not true because these came from the consultants’ recommendations. Factually, we followed ‘recommendations’ though no legal, banning act was introduced. At the same time, the advice from regional and national consultants was to stop allowing birth companions (13_KE, midwife)

The confusion about decisions and their ownership does not change the experts’ perception of women as facing an injustice. Recommendations aside, expecting women are portrayed as made highly vulnerable by the epidemic, also because their carefully planned antenatal activities have been upended from one day to the next:

This is very stressful. I see young women being completely cut off from doctors, from consultations, from ultrasounds, various control visits. They are really affected by this and the fact they cannot see anyone, can’t access (services), everything was cancelled (34_KW, sling advisor)

Decisions connected with cancelling visits at doctor’s offices are perceived through a dual lens: the well-being and medical consequences for a woman and her unborn child, and possible implications of a lockdown on the maternity support sector and professionals more broadly, i.e. when specific practice or specialist might not be able to run their business for a longer time during the lockdown. The tensions between doctors, midwives, doulas and other experts are more vivid during the pandemic, yet also, collaterally to the market lockdown and closing of outpatient clinics and on-site services, telemedicine and online provision of classes has blossomed quickly (see also 10):

Pandemic resulted in a speedy development of telemedicine, which is how I work now. It turns out that even pregnancies can be managed through telemedicine (...) Even though we were critical of those
methods, the pandemic shows the usefulness of digitalization, introducing e-prescriptions and medical leave confirmations online. We might not yet realize the benefits it gives us, the fact that it is (now) permitted. Even my private practice can be run this way because I have all documentation online (3 KE, OB-GYN)

In a peculiar manner, the lockdown challenges the typical overmedicalization of pregnancies in Poland, wherein women usually visit their managing doctors every 2-3 weeks. For some of the experts, pandemic served as a means to reflect on what is truly needed, limiting personal visits only to absolute emergencies:

*It is indeed easier not to drag the patient for a face-to-face examination, it is enough to give some advice or consult about the results of a test online (...) The patients are no longer trying to push for a hospital stay, we don't see one million consultations in the ER. From this perspective, it became much calmer. A woman would think 'OK, I am not dying, nothing serious is happening. So maybe there is no reason to run to the hospital or the doctor's office' (10 KE, OB-GYN)*

While midwives, doulas and psychologists/therapists tended to worry about women's fears, they also proclaimed interesting benefits of the pandemic re-empowering Polish women, who typically feel disenfranchised during pregnancy and birth (14, 34, 35). They posit that expecting mothers have stronger convictions about their own capabilities:

*Women gained more self-confidence and trust towards their own judgement, observing their bodies, their pregnancies and their babies, it's all very common-sensical now (10 KE, OB-GYN)*

Yet, this optimism has not been common among all experts. There was an observable pattern that the closer the expert was to clinical care (e.g. working in a hospital ward), the more concerns for adverse outcomes they voiced. Particular attention was drawn to those who require specialist care but were left alone without any options, abandoned in the middle of the process:

*Women have restricted access to doctors and examinations. There are those who have high-risk pregnancies, need to be overseen by a diabetologist, endocrinologist - these visits were made much more difficult (...) Some things cannot be done well in an online visit. For instance, the half-point ultrasound, it would be unthinkable to have it not happen at the right time. Cancelling those visits, I don't know but I think that we will see women suing because their right to healthcare is being restricted. I do not believe these key appointments should be cancelled (7 KE, midwife)*

The overmedicalization before epidemic was an everyday experience, so it can be argued that women were not accustomed to self-reliance This means that the experts' perspectives might not be shared by the expecting mothers. Without any preparation, pregnant women were left alone without any options, nor knowledge about norms:

*It was very difficult at the beginning when it suddenly turned out that family births were suspended and it became a massive problem. Doctors simply closed their clinics from one day to the next, which for me*
was really unacceptable. I simply cannot imagine leaving a pregnant patient, just saying that well, it’s closed now, go find yourself someone else (41_KW, doula)

As Polish medical professionals work with very tight and extensive schedules as regards pregnancy care, they underline possibly serious health implications. Moreover, the professionals indicate that both sudden decisions and a prolonged social lockdown might affect parturition:

If a woman is pregnant and already has small children that she needs to isolate and they cannot go out, then I’d imagine that the perinatal risks are going to be higher for the new-born. This pregnancy is then exhausted. It is not a physiological pregnancy, even if it has a physiological presentation. The environmental factors have an incredible bearing on how the pregnancy unfolds, the well-being of a foetus and the birth itself (44_KW, physiotherapist)

Confirming findings of other studies (21, 22, 24) in the Polish context, the interviewees predict that the upcoming waves of births and new-born cohorts will be negatively affected by the pandemic:

I see my patients and in August and September we will have a brood of crying children, children hard to regulate because women are loaded with cortisol. I understand that birthing classes happen (virtually) but we are social beings and this online relationship is simply not sufficient for critical situations (44_KW, physiotherapist)

They also seem to predict a new wave of medical interventions resulting from the increased anxiety and stress:

It is very difficult now. More so because pregnancy and the perinatal period should not be marked by anxiety. The births will not start, they will not begin and they will need to be induced. We will have thousands of C-sections. From C-sections, we will have children separated from mothers. This will be terrible. As usual, women will be the victims (45_KW, doula)

Decisions about caesareans were, subsequently, connected with predicted or real problems with physiological childbirth and tied back to the explicit fallback to a clinical model. Experts - medical and support professionals alike - asserted that hospital doctors regained absolute power, undoing the work towards safeguarding women’s dignity during birth (see also 37):

Situation of pregnant women changed dramatically because we have horrendous consultants, useless, 60-year-old geezers who decide how women are supposed to birth children (...) And they completely ignore WHO recommendations. (Pandemic) changed women’s situation because their visits are cancelled and this causes anxiety. Everyone was already taking away their competence, now they suddenly have none left. (45_KW, doula)

This critique was not unequivocal among our interviewees, yet midwives and other experts who participated in the research pointed out that a clinical model not only does not improve outcomes but actually implies that non-evidenced-based actions are allowed during a national lockdown perceived as
an emergency. As such, non-hospital-based experts foregrounded possible violations (see also 34), underscoring mental health and wellbeing concerns:

_The (birthing companion ban) will have a tremendous impact. I have a patient who cannot imagine giving birth in a different setting, without her husband present for this crucial moment. (Women) are at the hospital wards alone, nobody is allowed to visit them. If a woman experiences something bad, encounters a difficult event at the hospital in connection to birth, then she will be facing a much more difficult situation due to being alone with it. I think this is the main negative impact, (pregnancies and births) became psychologically harder (6_KE, midwife)_

Corollary to what Arora with co-authors (9) and Rocca-Ihenacho and Alonso (23) argued in the face of the pandemic more broadly, Polish experts also wondered about the potential to challenge medicalization:

_Women who wanted to give birth at home, those who are very aware and have their own midwives, well, they are still well taken care of, nothing has changed. This really shows the dissonance as to how a hospital was supposed to be this safest place, but now we see it is absolutely not. Women who rely on midwives, they have continuous care and will give birth at home, naturally (5_KE, midwife/ breastfeeding advisor)_

In this context, the epidemiological situation may once again reframe the debate on what the best place and model for giving birth might be.

[1] Every quote is described with interview number and interviewee profession.

**Discussion**

This paper offers qualitative evidence from 39 expert interviews conducted at the key period of 2020, immediately following the introduction of social and healthcare access restrictions linked to the pandemic. As the presented results stem from a qualitative study conducted early on during the Covid-19 epidemic, it is highly recommended to pursue further research on this topic. Firstly, a quantitative and ideally cross-country approach is needed to gauge prevalence of the noted themes, as well as to check how the Polish over-medicalized system compares to other country-contexts. Secondly, a longitudinal lens is advisable for checking whether the described attitudes are maintained or shift over time as the epidemiological situation unfolds into the late 2020. While the project has limitations rooted in the qualitative nature of the work, it uses rich and saturated data to highlight main concerns and themes raised by the maternal health experts in relation to pregnancy and birth during COVID-19 in Poland.

The presented voices from the frontlines contribute to the emerging evidence about the medical professionals worldwide reacting to the COVID-19 pandemic, focusing specifically on maternal health and wellbeing (8,26). It does so for a specific case of Poland, typifying a regime marked by strong medicalization of pregnancies and births, still often pinpointed as an example of a country where progress in general indicators and introduction of the Standards did not translate to ensuing reproductive
justice and guarantees of rights and dignity for birthing women (30,34). Like elsewhere in the world, COVID-19 necessitated a revision of the established protocols (1,2) though new evidence about the disease in the context of maternal health (3,4,5,6,7) did not result in alleviation of uncertainty and fears among Polish experts. On the contrary, our findings support the predictions about the negative consequences of the information chaos (22,26), especially in relation to the imposed clinical restrictions and reservations of a highly medicalized system towards the revised WHO (36) guidelines centred on women and new-borns’ wellbeing (see also 9).

High degree of medicalization makes it that much harder for the Polish expecting mothers to handle the ongoing epidemiological situation, both physiologically and mentally (see also 10,24). While telemedicine was said to offer some form of replacement, many experts - particularly doctors and those working in hospitals - remained sceptical about their usefulness. The interviewees in favour of a more holistic pregnancy care saw a value in women becoming more self-observant, yet nearly all worry about the weakening attention to birthing women's dignity in the current state of emergency. They also underscored that doctors regained full power over birth, especially when non-hospital births remain a marginal fraction of all labours and the Standards of care are not followed, even when no global pandemic rages (30,44). According to the interviewed experts, the already high number of medical interventions during childbirth is likely to increase as women are unable to benefit from advocacy done on their behalf by birthing companions, support caregivers or visitors and family members. Those are now forbidden from accompanying births and transitions to motherhood more broadly.

**Conclusion**

The epidemic acts as a litmus test of the healthcare services in Poland, both in terms of how the care and support for pregnant and birthing women is provided or organized, and as regards to identifying an element of a caring model that constitutes its base. First, the crisis demonstrated that a current antenatal and perinatal care system, characterized by a high-degree of medicalization, is by no means prepared for a condition of a prolonged hyper-uncertainty. While speedy progress in the field of telemedicine was noted as a positive side-effect, the epidemic paradoxically forced women to become experts in their own pregnancies, prompting the support services into reflecting about the benefits of adopting a woman-centred and more holistic model. As the interviewees underline, women were accustomed to constant control from doctors, yet had to face their sudden unavailability, which often resulted in significant anxiety and stress. At the very same moment of divesting women of support in the crucial antenatal period, the childbirth experience itself defaulted to women having no agency. In that sense, a period of de-medicalization during pregnancy is now followed by the reinforcement of the power ascribed to hospital personnel during a medicalized birth. As of July 2020, Polish women are affected by national guidelines that are not only largely noncompliant with the WHO (36) recommendations, but also bypass the Polish Standard of Perinatal Care. It can be said that the existing model rooted in a strong position of the OB-GYN and centrality of hospital as a birthing place, has been failing Polish women in the Covid-19 context. According to the experts, the system's inflexibility and lack of alternative options, paired with the already
considerable disregard towards the WHO guidelines on maternal wellbeing, are the reasons behind these negative opinions.

The majority of the interviewed experts concur that the national and ensuing hospital personnel's actions impact on the high degrees of stress which are likely to have wide-reaching and long-term effects for mothers, children and broader families (e.g. through disenfranchisement of fathers or kinship members during a transition to motherhood). The Polish maternal health experts believe that the pandemic’s multifaceted consequences will concern the entwined physiological and psychological effects. Negative impact on well-being of expecting and birthing mothers, as well as new-borns, has been widely observed by the informants and societal implications of pregnancy stress in the upcoming months and years are highly anticipated. The professionals underscore both the information chaos surrounding recommendations and procedures, and see the pandemic as a moment of reflection, being generally vocal in their critiques of the over-medicalized Polish care model.

**Abbreviations**

*Covid-19* Coronavirus disease 2019  
*C-section* Caesarean section  
*WHO* World Health Organization  
*PPC Standard* Perinatal and Postnatal Care Standard  
*OB-GYN* obstetricians and gynaecologists  
*PCR test* Polymerase Chain Reaction test  
*NHF* The National Health Fund  
*NDA* Non-disclosure agreement

**Declarations**

*Ethics approval and consent to participate*

The project received ethical approval from the Ethics Committee for Empirical Research with Human Participants at the SWPS University. Verbal, recorded consent to participate was given by participants, but written consent was not required by the ethics board since that would be the only documentation tying the participant to the study.

Consent details: participants were provided with a Study Information Summary and consent summary outlining the background and purpose of the study, background of the researcher, eligibility criteria, what participation in the study would involve, the right to withdraw from participation at any time, and the
storage and disposal of data collected. Contact details of the researcher along with clear guidelines on how privacy and confidentiality would be protected were also provided.

**Consent for publication**

All identifying information was removed and therefore permission to publish was not needed yet, interviewees were informed that collected data in anonymized form will be published.

**Availability of data and materials**

The datasets generated and/or analysed during the current study are not publicly available due to containing PIIs in raw transcripts. They are available from the corresponding author on reasonable request.

**Competing interests**

The authors declare that they have no competing interests.

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**Authors' contributions**

PP contributed to the design, coordinated and carried out the interviews and data analysis and drafted the manuscript. MB participated in the design, carried out the interviews and data analysis and supported the process of drafting the manuscript. Both authors read and approved the final manuscript.

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