A qualitative study of the impact of the COVID-19 pandemic on women seeking pelvic organ prolapse surgery in Alberta, Canada

Erin Knox Master's Student | Kaylee Ramage PhD | Natalie Scime PhD2,3 | Ariel Ducey PhD1 | Erin Brennand MD, MSc, FRCSC2,3

1Department of Sociology, Faculty of Arts, University of Calgary, Calgary, Alberta, Canada
2Department of Obstetrics & Gynecology, Cumming School of Medicine, University of Calgary, Calgary, Alberta, Canada
3Department of Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, Alberta, Canada

Correspondence
Erin Brennand, 2500 University Drive NW, Calgary, AB T2N 1N4, Canada.
Email: erin.brennand@albertahealthservices.ca

Funding information
M.S.I. Foundation; Canadian Institutes of Health Research, Grant/Award Number: 433250 and 442148

Abstract
In addition to altering public infrastructure and social patterning, the COVID-19 pandemic has delayed many pelvic organ prolapse (POP) surgeries. POP-related stigma, symptomology and the experience of waiting for POP surgery can negatively impact women's quality of life and mental health. The experience of preoperative POP patients during the pandemic thus entails a new intersection of gendered, stigmatic and medical realities. Qualitative interviews were conducted with 26 preoperative POP patients as part of a larger qualitative study, 20 of whom spontaneously volunteered information about how the pandemic coloured their experience living with and awaiting surgery for POP. Interviews occurred between January and July 2021, which coincided with the second and third waves of the pandemic in Alberta, Canada, and before full immunisation was available for all Albertans. Pandemic-related interview excerpts were thematically analysed, and four main findings emerged. (1) Though surgical delay meant living with unpleasant symptoms for longer than anticipated, some sought this out in order to protect vulnerable loved ones from possible hospital-acquired infection, (2) shifting and unclear hospital policies and logistics resulted in intense preoperative stress, at times causing women to temporarily cease treatment, (3) decreased access to public restroom infrastructure caused women to reduce their outings and (4) the imperative to minimise social gatherings made it easier for women to engage in POP-related, shame-based self-isolation without the notice of friends and family. As they can influence postoperative outcomes and treatment adherence, trends observed should be of interest to clinicians and policymakers alike.

KEYWORDS
COVID-19 pandemic, hospital policy, pelvic organ prolapse, self-isolation, stigma, surgery, urinary incontinence

1 | INTRODUCTION

In efforts to reduce viral transmission and reroute resources to ICUs during the COVID-19 pandemic, Alberta Health Services (AHS)—the publicly funded healthcare system in the Canadian province of Alberta—cancelled and postponed elective surgeries and the majority of in-person examinations. Due to its largely non-emergent nature, urogynaecology was acutely affected. In addition to postponed surgery and cancelled urodynamic tests, surgical consultations took place over the phone and intervals between assisted pessary
changes were extended (Alberta Health Services, 2021). The repercussions of these changes were keenly felt by women with pelvic organ prolapse (POP)—a pelvic floor disorder in which pelvic organs (i.e. bladder, uterus, small bowel, rectum) descend into or out of the vagina. Common symptoms include pelvic pain, sexual discomfort and urinary or faecal incontinence (Bump & Norton, 1998).

Research suggests that delay in the assessment and treatment of POP can have significant, negative effects on patients’ quality of life. Indeed, a Toronto-based study recently found that, despite experiencing less pain and physical impairment than osteoarthritic patients, women awaiting POP surgery reported levels of vitality, emotional role functioning and mental health similarly low to those reported by patients awaiting hip and knee replacement surgery (Leong et al., 2017). This may be due to the body-image issues (Jelovsek & Barber, 2006) and embarrassment (Lynch et al., 2021) associated with POP symptomology.

Women feel shame regarding prolapse symptoms because they are stigmatised. Conditions are stigmatised when they run counter to collective expectations of what certain kinds of people—in this case women—do and are like (Goffman, 2009). Research suggests that conditions and procedures involving the female urogenital system—like endometriosis (Krsmanovic & Dean, 2022), hysterectomy (Bossick et al., 2018), menorrhagia (Komaladin et al., 2019), pelvic floor disorders (Cox et al., 2021) and vulvodynia (Hintz, 2019)—are more stigmatised than those concerning sex-nonspecific systems of the body. The fear of being seen and treated as ‘less-than’ can make stigmatised individuals reluctant to disclose their condition in both interpersonal and medical contexts (Link & Phelan, 2006).

The literature regarding the experience of women with pelvic floor disorders during the pandemic is scant. To our knowledge, no qualitative accounts exist. In terms of quantitative reporting, Carlin et al. (2021) found that the degree to which pelvic floor disorders reduce the quality of life remained constant or worsened during the pandemic, while Mou et al. (2020) noted that most women were upset by pandemic-related postponements of pelvic floor surgeries.

Emerging data suggest that the pandemic has impacted men and women differently, one way being that women have suffered more mental health issues than men (Zheng et al., 2021). This may be linked to sociocultural factors, specifically the foundational changes in family and work patterns (Yavorsky et al., 2021). Since the advent of the pandemic, women have reported engaging in more domestic labour, feeling obliged to do so while working from home (Islam, 2021). The loss of institutional and informal childcare support also means that the burden of informal care work has increased (Ranji et al., 2021). Additionally, social distancing mandates mean that emotional support from outside the home becomes harder to come by.

The overlap of negative mental and physical health outcomes instilled by POP (Cox et al., 2021; Jelovsek & Barber, 2006; Melville et al., 2005), the pandemic (Zheng et al., 2021) and lengthy surgical wait times (Ackerman et al., 2011; Casson, 2009; Leong et al., 2017) could mean that women awaiting POP surgery during the pandemic are experiencing a uniquely compounded hardship. Though the physical symptoms of prolapse remain the same, pandemic-related changes in environment are affecting the experience of prolapse.

As healthcare systems begin to address the backlog of surgeries caused by COVID-19 and the prioritisation of surgical procedures is re-assessed, qualitative accounts can help fill the gaps left by standardised prioritisation tools—revealing areas that are foundational to well-being, yet often overlooked in narrowly defined definitions of health (Gross et al., 2020).

Through a thematic analysis of semi-structured interview data, this article seeks to provide an account of the unique experiences of women awaiting elective urogynaecological surgery for POP during the COVID-19 pandemic. Specifically, this article discusses the relational nature of the decision to delay surgery, procedural uncertainty as a cause of preoperative anxiety, the increased difficulty of navigating public life with symptoms of POP and the compounding self-isolating effects of the pandemic and POP stigma.

2 | MATERIALS AND METHODS

2.1 | Study design

Feminist theory informed researchers’ desire to explore potential sites of injustice for those seeking surgery for pelvic organ prolapse, a female-specific condition with no male equivalent. The researchers’ experiences navigating patienthood as cisgender women, combined with their time researching and providing female pelvic health care, provided a standpoint from which it was clear that, during this time of reduced surgical access and urogynaecological care, POP patients were at risk of being forgotten, marginalised and ‘othered’. Rigid a priori theory was not applied. It has been argued that to do
so risks blinding researchers to meaningful phenomena that fall outside a framework’s expected findings (Smith, 2006), and that theory can be used later in the analytic process as a basis for comparison (Anfara & Mertz, 2015). Informed by interpretivist epistemology, this study sought to understand the intersecting lived experience of pandemic, prolapse and preoperative patienthood, as told by those who occupied this unique position (Schwandt, 2003).

Qualitative semi-structured interviews were conducted with 26 preoperative POP patients taking part in a larger longitudinal cohort evaluating outcomes after multi-compartment POP surgery (Scime et al., 2021). This qualitative subsample was recruited to explore the intersection of a broad range of topics such as sexuality, surgical decision-making and gender with the lived experience of POP. Ethics approval was granted by the Conjoint Health Ethics Research Board at the University of Calgary (REB 19-2134) and all women provided informed written consent.

2.2 | Recruitment

Women were eligible for the cohort, and thus interviews, if they were ≥18 years, desired no future pregnancy, and were able to communicate in English.

Women with surgeries between February and July 2021 were invited via e-mail to participate in the qualitative portion of the study. Recruitment for this portion of the study was ongoing and ceased when researchers deemed saturation to have taken place. Saturation refers to the point in data collection at which new interviews stop yielding new themes, and instead repeat those which have been previously identified (Hennink et al., 2017). Interviews occurred between January and July 2021, which coincided with the second and third waves of the pandemic in Alberta and before full immunisation was available for all residents.

2.3 | Data collection

Interviews were audio-recorded with permission and conducted via Zoom or via telephone. Each interview was transcribed verbatim, with transcripts then anonymised and coded using NVivo 12. Two researchers—K.R., a PhD candidate in epidemiology, and E.K., a master’s student in sociology—conducted the interviews and transcription. Each transcribed the interviews they conducted (10 by E.K. and 16 by K.R.). An open-ended interview guide was developed for interviews, with structured prompts to assist the conversation. Participants were able to spontaneously offer information beyond the premade questions, and interviewers were instructed to follow the conversation’s natural flow (Table 1).

2.4 | Data analysis

Interviews were analysed thematically using the Framework Method (Ritchie et al., 2014), a qualitative analysis method that is particularly suited for health and health policy research, as it does not adhere to any single theoretical or conceptual ideal (Gale et al., 2013). The systematic approach of Framework Method has five key stages: familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation (Gale et al., 2013; Ritchie et al., 2014). Familiarisation entails the review of transcripts and audio files to ensure that the researcher(s) are familiar with the available data and was achieved through E.K. and K.R.’s thorough reading of audio transcriptions. Recurring themes were noted at this time, one being that in 20 of the 26 interviews women spontaneously volunteered information about how the pandemic coloured their experience living with and awaiting surgery for POP. Following this, we constructed a thematic framework using an iterative process based on the emergent theme of the COVID-19 pandemic. The researchers then met to refine the themes and framework, which was then applied to the 20 interviews that explored the intersection of COVID-19 with women’s upcoming surgery. The researchers assessed meaning and significance, assigning information to the appropriate theme or code with each passage of the data. The first four transcripts were coded together to ensure comparable data interpretation. The remaining 22 were coded individually. Thereafter, we charted the data, extracting the themes across all respondents by synthesising the information from each quote. Finally, during the mapping and interpretation phase, E.K. and K.R. worked with EAB, NVS and AD to further analyse the data, providing investigator triangulation (Denzin, 2017).

3 | RESULTS

Twenty of the 26 women (77%) interviewed for the main qualitative study spontaneously volunteered varying detailed accounts of how the pandemic impacted their experience of living with POP while navigating the road to surgery. Two women were interviewed shortly after their surgeries, and the rest were interviewed 1 day to 1 month before their procedure. Participants ranged from 32 to 75 years old, with a median age of 57. Just one participant identified as non-white (mixed-race), and more than half reported an annual household income of CA$80,000 or more. The vast majority had completed at least some post-secondary education, and most were partnered. Respondent demographics can be found in Table 2.

While women’s experiences were idiosyncratic and informed by the specificities of their lives, common themes emerged regarding the intersection of prolapse and COVID-19: surgical delay, hospital protocol and logistics and the exacerbating effects of the pandemic on life with POP.

3.1 | Surgical delays: Protecting others at the expense of prolonged symptoms

Surgical delay for the women in this study ranged from approximately 2 to 5 months. The majority of women had no say in whether
or not their surgeries were delayed. These participants were generally displeased, but tolerant to the extent that they recognised the extraordinary and unanticipated circumstances that necessitated such measures. No one expressed concern that their condition would deteriorate as a result of surgical delay. Rather, women’s frustration came from having to live with the symptoms of POP, which drove them to pursue surgery in the first place, for longer than anticipated. Patients who had originally been prioritised or fast-tracked for surgery due to the severity of their prolapse were particularly perturbed.

Some, however, were offered the choice of whether or not to postpone, and others ceased their treatment and delayed surgery on their own initiative. The self-postponing category consisted mostly of women over the age of 70. Often, these choices were presented as self-evidently pragmatic, and no rationalisation was offered. Others cited a sense of unease over fluctuating and unclear protocols, thinking it best to resume treatment when operations had stabilised.

And then… the pandemic had started. And I just kind of did not pursue [treatment]… I know the clinic itself wasn’t open for quite a while there, or my appointments kept being delayed.

Participant 19, age 75

Although some women mentioned the possibility of contracting COVID-19 in hospital, none voiced explicit concern regarding the risk this posed to their health. However, that nosocomial infection loomed large in women’s minds was apparent in their considerations of family members, in which questions of vaccine availability and moral responsibility played decisive roles in when and if they would proceed with surgery. Indeed, one younger participant requested her surgery be postponed by 4 months so that her parents could be vaccinated and safely provide the informal childcare support that she required to properly recover from surgery.

Well, it was my decision to wait until September, and that was really because we do not have any family or kind of support system in Calgary. And so I was offered to have that surgery in May but requested to push it back so that my parents could be immunised for COVID-19.

Participant 5, age 40

Even when childcare was not a problem, concern for at-risk family members like parents and spouses ultimately took precedence over the timely treatment of POP. Three days before her scheduled operation, another participant’s surgeon informed her that a COVID-19 case had been reported in her scheduled recovery ward and presented her
with the choice to proceed or reschedule. She decided to reschedule, and thus added an additional 4 months to her wait time.

So, there had been a COVID-19 outbreak. I had not been immunised by then at all. And, between [my surgeon] and I, we decided to postpone, being that I’ve got elderly parents. My dad had a triple bypass two and a half years ago. My husband is in sort of a high-risk category. He got COVID-19. And so, we just decided to postpone it.

Participant 12, age 60

### 3.2 Hospital protocol and logistics

For others, stress induced by pandemic-era surgery came not from the prospect of infection, but hospital protocols put in place to lessen this risk. Sometimes, it was the substantive implications of these protocols, like not being able to be accompanied by loved ones, that participants found upsetting. However, more often than not, it appeared to be the inconsistent nature of these restrictions that were experienced as particularly distressing. Inconsistency in this context could be related to changing protocols or the lack of clarity arising from incongruities between official sources of information.

| Participant ID | Age | Ethnicity          | Parity | Marital status | Education level          | Household income (CAD)                        |
|----------------|-----|--------------------|--------|----------------|--------------------------|-----------------------------------------------|
| 1              | 32  | White              | 3      | Married        | Completed High School    | Prefer not to answer                          |
| 2              | 34  | White              | 2      | Married        | Completed Post-Secondary | $80,000–$100,000 per year                    |
| 3              | 39  | White              | 2      | Married        | Completed Post-Secondary | $100,000–$200,000 per year                   |
| 4              | 40  | White              | 2      | Married        | Completed Some Post-Secondary | $100,000–$200,000 per year                  |
| 5              | 40  | White              | 2      | Married        | Completed Post-Secondary | $80,000–$100,000 per year                   |
| 6              | 40  | White              | 3      | Married        | Completed Some Post-Secondary | $80,000–$100,000 per year                  |
| 7              | 41  | White              | 3      | Common-Law     | Completed Post-Secondary | $80,000–$100,000 per year                   |
| 8              | 49  | White              | 2      | Married        | Completed Some Post-Secondary | $100,000–$200,000 per year                  |
| 9              | 52  | Mixed Race or Ethnicity | 2    | Married       | Completed Post-Secondary | $100,000–$200,000 per year                   |
| 10             | 54  | White              | 2      | Married        | Completed Some Post-Secondary | Over $200,000 per year                      |
| 11             | 60  | White              | 2      | Married        | Completed Post-Secondary | $80,000–$100,000 per year                   |
| 12             | 60  | White              | 2      | Married        | Completed Post-Secondary | Prefer not to Answer                          |
| 13             | 63  | White              | 2      | Separated      | Completed Post-Secondary | $30,000–$50,000 per year                    |
| 14             | 67  | White              | 2      | Married        | Completed Post-Secondary | $30,000–$50,000 per year                    |
| 15             | 68  | White              | 1      | Married        | Completed Post-Secondary | $100,000–$200,000 per year                   |
| 16             | 71  | White              | 3      | Married        | Completed Some Post-Secondary | $50,000–$80,000 per year                    |
| 17             | 73  | White              | 3      | Married        | Completed Post-Secondary | $50,000–$80,000 per year                    |
| 18             | 74  | White              | 1      | Widowed        | Completed Post-Secondary | $30,000–$50,000 per year                    |
| 19             | 75  | White              | 3      | Married        | Completed High School    | $80,000–$100,000 per year                   |
| 20             | 75  | White              | 4      | Widowed        | Completed Post-Secondary | $30,000–$50,000 per year                    |
It’s so shitty. Cause like, the restrictions are changing all the time. Like, three weeks ago, I talked to someone, and they were like, “Oh, you might be able to have someone.” So, literally up until yesterday... when they called and said, “Yeah, no support people.” That’s when my anxiety flew through the roof.

Participant 1, age 32

In the information [provided by the Pelvic Health Clinic] it says to have somebody with you three hours before surgery, but this is in the time of COVID-19 and... You know, the hospital website says not to have other people accompany you, if possible.

Participant 11, age 60

While the presence or absence of a support person is understandably emotionally charged, discussions of uncertainty regarding more mundane logistical matters took on a similar emotional valence and gravitas. In a context where previously taken for granted certainties (surgery dates, the presence of a support person, etc.) had become contingent, patients sought assurance and stability in the nuts-and-bolts protocol that would order their hospital stay. For some, breakdowns in communications regarding matters like allowable personal items were potent sources of anxiety.

Even like, what are you allowed to bring? Where are you dropped off? Should I be dropped off?... It says, “Oh, and we have no place for your things, and don’t bring an iPad or your phone or whatever.” And I’m thinking, “OK, well, that’s for day surgery, but what about your stuff if I’m going to spend the night?” Right?

Participant 11, age 60

All participants emphasised their trust in the technical skills and knowledge of their surgeons and anticipated their procedures would go smoothly. However, some reluctantly expressed discontent with what they saw as abdications of good quality or standard medical care in the name of COVID-19 safety through the provision of virtual care instead of in person visits.

My [doctor’s] appointment might have been a bit quicker than normal because I went in during COVID-19 times. I was actually supposed to have a phone consult and they were like, “No, can you come in instead?”

Participant 7, age 41

I know that six weeks later you have a checkup, which, by the way, they offered me by phone, and I’m thinking, “Really?” They said, “Well, because of COVID-19, we’re not seeing as many people and...” And I’m thinking, “Nobody’s going to look up there and see if everything's healed well?”

Participant 11, age 60

3.3 | Pandemic as exacerbating negative elements of prolapse: Navigating public life with urinary incontinence

In addition to complicating the pre-surgical terrain patients had to navigate, the pandemic amplified some of the more negative experiences associated with POP. At various points in the pandemic, retailers barred customers from using their bathrooms in an effort to reduce COVID-19 transmission. While the availability of public restrooms may be taken for granted by healthy populations, they are an integral component of the public infrastructure that allows women with POP to manage urinary incontinence.

So, with COVID-19 and stuff, finding a washroom, I mean it’s better now than the first lockdown, but to try and find a washroom is a real challenge... I plan my life around my bathroom breaks if I’m in the city.

Participant 12, age 60

Errand-based outings thus became considerably more stressful. Some women responded to the heightened risk of public bladder voiding by reducing fluid intake, avoiding diuretics and acidic foods and wearing pads. In other cases, these stressors were simply too much to bear, and women forewent these outings. Further, these tactics were of little use to the contingent of women who relied on public bathrooms as a private area to readjust vaginal bulging.

I could not go anywhere because it was, you know, go to the grocery store and you expect you’d probably be an hour... and that just does not fit in well unless you have a bathroom nearby.

Participant 20, age 75

3.4 | Pandemic as exacerbating negative elements of prolapse: Isolation

It was not unusual for participants to describe their experience with prolapse in lonesome and atomised terms. The psychological burden of POP was, for the most part, borne alone. Though these women were comfortable discussing their experiences to interviewers, they often refrained from doing so with friends and family.

It is not exactly the thing that when you are having coffee with your friends you say, “So what do you think? How do you think my pessary's working? How’s yours working?” [Laughs].

Participant 19, age 75
And it does sound gross, like... It's not something that you would talk about it at a dinner table.

Participant 10, age 54

In addition to concerns about being perceived as grotesque or impolite, women sensed that awareness regarding POP was low and that disclosing one's prolapse could force the choice between being misunderstood or bearing the burden of explanation. They often felt it easier to keep things vague or elide such discussions altogether. Indeed, for one participant, the pandemic-era imperative to reduce social contact served as an excuse to engage in shame-based self-isolating behaviour.

I do not know where to draw the line where if it's lockdown and social distance restrictions and all of that nonsense going on, or if it's me pushing people away because I'm uncomfortable [with prolapse]. I do not want to talk about it. I do not want to tell them, you know? Like, walking at the zoo with my girlfriends and, "Oh, can I just sit down for five minutes? Because if not, I think something's going to fall out." I'm ok with this lockdown. As terrible as that is... It gives me an excuse not to go.

Participant 1, age 32

Some respondents reported that pandemic-related changes in communication methods, such as the use of videoconferencing, resulted in new barriers to disclosing and discussing their experience with POP. Participants found that the mediating effect of the computer and its associated audio-visual glitches decreased the quality of emotional connection possible in any given conversation. Further, the physical cordoning of all conversations to the home meant that domestic roles and tasks, particularly those associated with childcare, interfered with their ability to have a conversation. Our participants thus saw this as an undesirable substitute for face-to-face conversation.

Like, even if I wanted to go talk to someone about how this is affecting... Like I do not do well on Zoom or anything. Cause I have three kids and they are jerks. And when you want to talk about something serious, you cannot and... It's just... Zoom does not work. But if I was able to go in person, maybe this would not have been so bad, you know?

Participant 1, age 32

4 | DISCUSSION

This qualitative study describes the experiences of 20 women awaiting surgical treatment for pelvic organ prolapse during the COVID-19 pandemic in Canada, finding that the pandemic affected women's lives in complex ways. Four key themes emerged, related to surgical delay, frustration with hospital policies, washroom inaccessibility, and the exacerbation of POP's isolating effects. This study adds to the timely body of literature documenting the myriad ways Canadians have been impacted by COVID-19 and provides further evidence of sex and gender-based differences in pandemic experience from a sociological viewpoint, given that POP is a condition that affects only those with a female urogenital tract.

Almost all of the women interviewed had their surgery delayed due to the pandemic. While most did not have the choice of whether or not their surgery was postponed, the elements that informed those who did are interesting and worth examining. Our main findings regarding the decision to postpone concerned the prioritisation of others' wellbeing and vaccine availability. Despite an age range of 32–75, women consistently appeared unworried about their risk of nosocomial infection. They were, however, acutely aware of the hazard that their own infection could pose to vulnerable others in their social networks. While other research has shown women to privilege familial relationships, dynamics and responsibilities over their own interests in medical decision-making (Lewis et al., 2021) the highly communicable nature of COVID-19 likely amplified this tendency, in a sense making the effect one's choices have on those to whom they are responsible more material and tangible.

Interviews took place before both doses of the COVID-19 vaccine were available for all Albertans. As such, the risk COVID-19 posed for vulnerable populations was particularly high. The women quoted in our results section cited concern for at-risk parents and a husband. It could be argued that there is a gendered element to this phenomenon, that is on the aggregate level we might expect such reasoning to be undertaken by women more than men. On average, in North America, the responsibilities of childcare are still disproportionately taken on by women (Alon et al., 2020). This means that the 6-week recovery period of women with young children could necessitate childcare support. Grandparents are likely a common source of help. Advanced age is one of the most significant risk factors for severe COVID-19 outcomes (Albitar et al., 2020), meaning that there is a high likelihood that individuals old enough to be grandparents will be old enough to be considered at-risk for COVID-19. In the case of husbands, heterosexual pairings still tend to consist of older men and younger women (Syrett, 2021). While further quantitative research would be needed to definitively say, it is possible that women have been more likely than men to voluntarily delay surgery during the COVID-19 pandemic, or other times of communicable illness, for reasons related to keeping others safe. The fact that these choices were made before province-wide vaccine availability was established is also significant. Women may have made a different decision if they or their vulnerable loved ones had been fully vaccinated. This opens up interesting avenues for future research. When thinking about matters of equitable vaccine distribution and triaged access, it would behove policy makers to consider these less obvious implications of vaccine availability.

Uncertainty and upheaval in hospital policies appeared to be a source of anxiety and fueled decisions to delay surgical treatment. Organisational scholars Doherty and Saunders (2013) argue that putting oneself in the vulnerable position of surgery patient necessitates a belief in the technical competence of surgeons and...
the professionalism of hospitals. In these instances, the hierarchi-
cal and bureaucratic nature of hospitals is a source of comfort. For
all its negative associations, bureaucracy can be reassuring insofar
as it promises order and fair treatment. If these are the qualities of
healthcare systems that make patients feel safe, it is logical that the
perceived ambiguity, inconsistency and rapid changes in AHS proto-
col and messaging caused distress. It was not nosocomial infection
that these women feared, but the chaos and uncertainty surrounding
a (likely) once-in-a-lifetime event in which they are extraordinarily
vulnerable. This resulted in heightened preoperative anxiety—which
has been shown to have negative impacts on surgical outcomes
(Geoffrion et al., 2021; Vileikyte, 2007)—and the voluntary cessa-
tion of treatment. That treatment cessation was only temporary
cannot be considered representative of the larger POP population,
as having a scheduled POP surgery was a precondition of participa-
tion in this study. It is possible that some women ceased treatment
for these reasons and never returned. Cognizance of the specificities
of preoperative stress unique to the pandemic era is thus a matter
of concern for clinicians, administrators and policymakers concerned
with postoperative outcomes and treatment adherence.

Pandemic-related changes to the organisation of daily life ap-
peared to exacerbate the stigma-induced self-isolating tendencies
associated with POP. Throughout the course of the pandemic, public
and retailer washrooms have alternated between being open and
closed, sometimes remaining closed when they are not legally obli-
gated to do so (Jones, 2021).

Highly associated with depression (Melville et al., 2005) and
embarrassment (Lynch et al., 2021), incontinence is one of the most
stigmatised (Cox et al., 2021), and therefore mentally distressing,
symptoms of prolapse. These findings, in conjunction with our own,
support Lupton’s (2015) observation that stigma easily attaches to
conditions in which the body is leaky and uncontained.

Women in our study who had experienced public loss of bladder
control due to lack of restroom availability described the experience
as humiliating, and the spectre of such accidents haunted those
who had not experienced this. The closure of public washrooms
thus increased stress levels and reduced public outings. The harm
these closures inflict upon the elderly, homeless, and those with
incontinence-inducing disorders has been described as ‘discrimina-
tion by public design’ and a matter of health equity (Jones, 2021).
Though the technical severity of incontinence experienced by
women with POP is not affected by the pandemic, this readily over-
looked change in public infrastructure effectively makes it more de-
ilitating. While the women in our study foregrounded the impact
washroom closures posed to practical outings, it is likely that this
also truncated their social lives.

Finally, the pandemic-era imperative to minimise one’s social in-
teractions, while posing challenges to all, may have especially dele-
tious effects on those with stigmatised medical conditions like POP.
Almost all of the women in our study described some degree of dif-
culty discussing their condition with others. Typically, this was due
to both anticipation that their condition would be perceived as gro-
tesque and a sense that, despite its commonality, their interlocuters
possessed little awareness of POP. In addition to being regarded as
aberrant by others, our participants also seemed to fear that the dis-
closure of their prolapse, even if politely received, would strain inter-
actions between them and their ‘normal’ friends and family. These
findings mirror prior studies on the experiential components of uro-
genital conditions which foreground the communicative challenges
women encounter when discussing these conditions with romantic
partners (Hintz, 2019), coworkers (Krsmanovic & Dean, 2022), moth-
ers (Kamaludin et al., 2019), adult children, male family members and
physicians (Vardeman et al., 2022). Some participants reported self-
isolating in order to minimise negative reactions and situations in
which they would feel obligated to disclose their condition. This is
consonant with findings regarding the psychobehavioural impacts of
other stigmatised chronic conditions (e.g. Audet et al., 2013).

Pre-pandemic, it is likely that sudden social withdrawal would
elicit concern and outreach from loved ones. However, in a time
when self-isolation is encouraged, it is more likely that psychologi-
cal suffering of those with stigmatised conditions will go unnoticed.
Clinicians could address this by discussing the importance of social
support with their patients. In addition to providing resources out-
lining basic information on POP (including its population-level fre-
quency) for their patients’ family and friends, specialty clinics for
pelvic floor disorders could consider supporting the psychological
health of their patients through the development of support groups
and networks which can provide safe spaces for women to discuss
lived experiences. The results of this study highlight that the phys-
ical symptomology of POP (e.g. urinary incontinence, bulging) can
lead women to cease involvement in community activities, resulting
in intentional and unintentional self-isolation.

Strengths of our study include adding to a very small body of
literature related to how COVID-19 impacts those living with pelvic
floor disorders, particularly in a Canadian context. The results are
timely, as Alberta and other provinces have experienced recurring
need to restrict and delay surgical procedures since these interviews
were performed. This qualitative approach offers an in-depth view
of women’s experiences that quantified accounts of the number and
duration of surgical delays, while valuable, cannot. This study adds
women’s voices to the historical record and draws attention to addi-
tional ways women were impacted by the pandemic, particularly as it
intersects with an area of health that is shrouded in shame and might
not otherwise have been given consideration.

While it is recognised that qualitative research does not always
have representative samples due to design methodologies, one
limit of our study is that the sample consisted of primarily white,
well-educated, heterosexual, cisgender women. As such, it is pos-
sible that the intersecting experiences of the pandemic, POP and
preoperative patienthood may be markedly different for trans men,
non-binary individuals, and women of other ethnicities, sexual ori-
entations and economic strata. While this study provides valuable
preliminary qualitative insights to the unique experiences of this co-
hort of women, it is limited insofar as it relies on information that
was spontaneously volunteered during interviews on a range of top-
ics related to pelvic health. Further work in this domain could be
5 | CONCLUSION

The COVID-19 pandemic caused delays in the surgical treatment of POP, which in turn made women live with unpleasant pelvic floor symptoms longer than desired. When women chose to delay surgery, it was done for the promotion of family health and not concern about the risk nosocomial infection posed for themselves. Rapidly shifting hospital policies were a source of frustration and concern for women, and lead some to temporarily cease treatment. Women reported increased self-isolation due to the loss of public restrooms used to manage concomitant bladder symptoms and the challenges posed by videoconferencing in connecting with others, particularly for a stigmatised condition that is difficult to speak about under the best conditions. Given that future waves of COVID-19 may result in the need to ration hospital resources, it is important for decision makers to understand how women are impacted by the deprioritisation of pelvic floor surgeries.

AUTHOR CONTRIBUTIONS

Article conception and design (EB), data collection (KR, EK), data analysis and interpretation (EK, KR, EB, NVS, AD), manuscript development (EK), manuscript revision and final approval (EB, KR, EK, NVS, AD).

ACKNOWLEDGEMENTS

This study was funded by the M.S.I. Foundation. NVS is supported by a Canadian Institutes of Health Research Canada Graduate Scholarship Doctoral Award. EAB is supported by a Canadian Institutes of Health Research Early Career Investigator in Maternal, Reproductive, Child and Youth Health award.

CONFLICT OF INTEREST

None to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author (EB). The data are not publicly available due to containing information that could compromise the privacy of research participants. Access to data will require approval from relevant research ethics boards prior to release.

ETHICS STATEMENT

This study was granted by the Conjoint Health Research Ethics Board at the University of Calgary (REB 19–2134).

ORCID

Erin Knox https://orcid.org/0000-0001-9256-1080
Natalie Scime https://orcid.org/0000-0002-5811-7661
Erin Brennand https://orcid.org/0000-0002-0500-6060

REFERENCES

Ackerman, I. N., Bennell, K. L., & Osborne, R. H. (2011). Decline in health-related quality of life reported by more than half of those waiting for joint replacement surgery: A prospective cohort study. BMC Musculoskeletal Disorders, 12(1), 108. https://doi.org/10.1186/1471-2474-12-108

Alberta Health Services. (2021). Clinical guidance: Surgical services during COVID-19. https://insite.albertahealthservices.ca/tools/Page24550.aspx

Albitar, O., Balouze, R., Ooi, J. P., & Sheikh Ghadzi, S. M. (2020). Risk factors for mortality among COVID-19 patients. Diabetes Research and Clinical Practice, 166, 108293. https://doi.org/10.1016/j.diabres.2020.108293

Alon, T., Doepke, M., Olmstead-Rumsey, J., & Tertilt, M. (2020). The impact of COVID-19 on gender equality. (No. w26947; p. w26947). National Bureau of Economic Research. https://doi.org/10.3386/w26947

Anfara, V. A., & Mertz, N. T. (Eds.). (2015). Theoretical frameworks in qualitative research (2nd ed.). SAGE.

Audet, C. M., McGowan, C. C., Wallston, K. A., & Kipp, A. M. (2013). Relationship between HIV stigma and self-isolation among people living with HIV in Tennessee. PLoS One, 8(8), e69564. https://doi.org/10.1371/journal.pone.0069564

Bossick, A. S., Sangha, R., Olden, H., Alexander, G. L., & Wegienka, G. (2018). Identifying what matters to hysterectomy patients: Post-surgery perceptions, beliefs, and experiences. Journal of Patient-Centered Research and Reviews, 5(2), 167–175. https://doi.org/10.17294/2330-0698.1581

Bump, R. C., & Norton, P. A. (1998). Epidemiology and natural history of pelvic floor dysfunction. Obstetrics and Gynecology Clinics of North America, 25(4), 723–746. https://doi.org/10.1016/S0089-8545(05)70039-5

Carlin, G. L., Kimberger, O., Morgenbesser, R., Umek, W., Köhl, H., Bodner, K., & Bodner-Adler, B. (2021). Female pelvic floor dysfunction continues to negatively impact quality-of-life during the COVID-19 lockdown. Journal of Clinical Medicine, 10(5), 1075. https://doi.org/10.3390/jcm10051075

Casson, A. (2009). Waiting for surgery from the patient perspective. Psychology Research and Behavior Management, 107. https://doi.org/10.2147/PRBM.S7562

Cox, C. K., Schimpf, M. O., & Berger, M. B. (2021). Stigma associated with pelvic floor disorders. Female Pelvic Medicine & Reconstructive Surgery, 27(2), e453–e456. https://doi.org/10.1097/SPV.0000000000000961

Denzin, N. K. (2017). The research act: A theoretical introduction to sociological methods. Taylor and Francis.

Doherty, C., & Saunders, M. N. K. (2013). Elective surgical patients’ narratives of hospitalization: The co-construction of safety. Social Science & Medicine, 98, 29–36. https://doi.org/10.1016/j.socscimed.2013.08.014

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multidisciplinary health research. BMC Medical Research Methodology, 13(1), 117. https://doi.org/10.1186/1471-2288-13-117

Geoffrion, R., Koenig, N. A., Zheng, M., Sinclair, N., Brotto, L. A., Lee, T., & Larouche, M. (2021). Preoperative depression and anxiety impact of COVID-19 on gender equality. (No. w26947; p. w26947). National Bureau of Economic Research. https://doi.org/10.3386/w26947

Goffman, E. (2009). Stigma: Notes on the management of spoiled identity. Simon and Schuster.

Gross, M. S., Harrington, B. J., Sufrin, C. B., & Faden, R. R. (2020). Rethinking “elective” procedures for women’s reproduction during COVID-19. Hastings Center Report, 50(3), 40–43. https://doi.org/10.1002/hast.1130
Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research, 27*(4), 591–608. https://doi.org/10.1177/1049732316665344

Hintz, E. A. (2019). The vulvar vernacular: Dilemmas experienced and strategies recommended by women with chronic genital pain. *Health Communication, 34*(4), 1721–1730. https://doi.org/10.1080/10410236.2018.1517709

Islam, A. (2021). “Two hours extra for working from home”: Reporting on gender, space, and time from the Covid-field of Delhi, India. *Gender, Work and Organization, 28*(2), 405–414. https://doi.org/10.1111/gwoa.12617

Jelovsek, J. E., & Barber, M. D. (2006). Women seeking treatment for advanced pelvic organ prolapse have decreased body image and quality of life. *American Journal of Obstetrics and Gynecology, 194*(5), 1455–1461. https://doi.org/10.1016/j.ajog.2006.01.060

Jones, A. M. (2021). *Pandemic public washroom closures a critical issue for people with IBD, those experiencing homelessness*. CTV News. https://www.ctvnews.ca/health/coronavirus/pandemic-public-washroom-closures-a-critical-issue-for-people-with-ibd-those-experiencing-homelessness-1.5421311

Kamaludin, S. A. N., Zhang, X. R., & Shorey, S. (2019). Perspectives of women experiencing menorrhagia: A descriptive qualitative study. *Journal of Clinical Nursing, jocn.14856*, 2659–2668. https://doi.org/10.1111/jocn.14856

Krsmanovic, A., & Dean, M. (2022). How women suffering from advanced pelvic organ prolapse surgery versus hip or knee replacement. *Journal of Obstetrics and Gynaecology Canada, 39*(5), 341–346. https://doi.org/10.1016/j.jogcc.2017.01.005

L Lynch, R., Toozs-Hobson, P., Duckett, J., Tincello, D., & Cohn, S. (2021). Making a decision about surgery for female urinary incontinence: A qualitative study of women’s views. *International Urogynecology Journal, 32*(1), 127–133. https://doi.org/10.1007/s00192-020-04383-5

Melville, J. L., Delaney, K., Newton, K., & Katon, W. (2005). Incontinence severity and major depression in incontinent women. *Obstetrics & Gynecology, 106*(3), 585–592. https://doi.org/10.1097/01.AOG.0000173985.39533.37

Mou, T., Brown, O., Gillingham, A., Geynisman-Tan, J., Collins, S., Lewicky-Gaupp, C., Mueller, M. G., Kenton, K., & Bretschneider, C. E. (2020). Patients' perceptions on surgical care suspension for pelvic floor disorders during the COVID-19 pandemic. *Female Pelvic Medicine & Reconstructive Surgery, 26*(8), 477–482. https://doi.org/10.1097/SPV.0000000000000918

Ranji, U., Frederiksen, B., Salganicoff, A., & Long, M. (2021). Women, work, and family during COVID-19: Findings from the KFF Women’s Health Survey. KFF. https://www.kff.org/womens-health-policy/issue-brief/women-work-and-family-during-covid-19-findings-from-the-kff-womens-health-survey/

Ritchie, J., Lewis, J., McNaughton Nicholls, C., & Ormston, R. (Eds.). (2014). *Qualitative research practice: A guide for social science students and researchers*. SAGE Publications Ltd.

Schwandt, T. A. (2003). Three epistemological stances for qualitative inquiry: Interpretativism, hermeneutics and social constructionism. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed., pp. 189–213). Sage.

Scime, N. V., Ramage, K., & Brennand, E. A. (2021). Protocol for a prospective multisite cohort study investigating hysterectomy versus uterine preservation for pelvic organ prolapse surgery: The HUPPS study. *BJM Open, 11*(10), e053679. https://doi.org/10.1136/bmjopen-2021-053679

Smith, D. E. (2006). *Institutional ethnography as practice*. Rowman & Littlefield.

Syrett, N. L. (2021). Age disparity, marriage, and the gendering of heterosexuality. In R. L. Davis & M. Mitchell (Eds.), *Heterosexual Histories* (pp. 96–119). New York University Press. https://doi.org/10.18574/9781479852284-004

Vardeman, J., Spiers, A., & Yamasaki, J. (2022). “Things are happening that I don’t understand”: A narrative exploration of the chaos of living with pelvic floor disorders. *Health Communication, 1–9*, 1–9. https://doi.org/10.1080/10410236.2022.2040168

Vileikyte, L. (2007). Stress and wound healing. *Clinics in Dermatology, 25*(1), 49–55. https://doi.org/10.1016/j.jidermatol.2006.09.005

Yavorsky, J. E., Qian, Y., & Sargent, A. C. (2021). The gendered pandemic: The implications of COVID-19 for work and family. *Sociology, Compass, 15*(6), e12881. https://doi.org/10.1111/soc4.12881

Zheng, J., Morstead, T., Sin, N., Klaiber, P., Umberson, D., Kamble, S., & DeLongis, A. (2021). Psychological distress in North America during COVID-19: The role of pandemic-related stressors. *Social Science & Medicine, 270*, 113687. https://doi.org/10.1016/j.socscimed.2021.113687

—KNOX et al.—

How to cite this article: Knox, E., Ramage, K., Scime, N., Ducey, A., & Brennand, E. (2022). A qualitative study of the impact of the COVID-19 pandemic on women seeking pelvic organ prolapse surgery in Alberta, Canada. *Health & Social Care in the Community, 00*, 1–10. https://doi.org/10.1111/hsc.14020