MOTHERFIGURE

FLASH REPORT ON MATERNAL CARE IN THE TIME OF COVID-19

JUNE 2020

Photo credit: Stock Image

Introduction

The effort to stem the impact of the novel coronavirus in the United States in the first half of 2020 dramatically reshaped day-to-day lives. Many local governments issued shelter-in-place orders that have lasted up to 12 weeks. Travel ground to a halt, social distancing became the norm, and masks became part of our everyday wardrobe. On top of all this, coronavirus has had a particularly transformative impact on the pregnancy, birth, and postpartum periods for new mothers, as hospitals and other maternal care providers adapted to comply with recommendations, leading to unprecedented changes in the way maternal care and labor and delivery proceed. These changes — and their unintended consequences — are the focus of this flash report.

At the time of writing, comprehensive research has not yet been published on the impact of COVID-19 on birth outcomes, perinatal well-being, and more. Although studies are now underway, the National Center for Health Statistics typically does not finalize national vital statistics data for two years post-year-end, though it may elect to release studies publicly more quickly, and many scientific studies are themselves not expected to be complete or published until well into 2021 or 2022.

But birth does not wait, and parents and providers are struggling now. As such, we see value in sharing the qualitative and quantitative insight we have gathered today.

By the numbers

1 in 5

of the 106 postpartum mothers surveyed by Motherfigure who had given birth amid the pandemic rated their satisfaction with their birth experiences as poor to very poor, compared with 1 in 7 or 1 in 10 In ordinary times

1 in 4

of the 38 mothers surveyed by Motherfigure who said they wanted lactation support during the pandemic but reported being unable to receive it

72.6%

of the 106 postpartum mothers surveyed by Motherfigure who had given birth amid the pandemic who self-reported anxiety and depressive symptoms when asked questions typically used for screening patients for mental health challenges

10 of 10

doulas who reported massive disruptions in their business and depressed demand through the duration of 2020

70.6%

12 of 17 mental health providers focused on serving the perinatal population who said they are seeing an increase in severity of PMAD conditions compared to what they typically see in their practices

Key findings

The priority in a public health crisis, naturally, is to funnel appropriate resources toward addressing it. Given the possibility that COVID-19 cases could overrun our healthcare system, coupled with a shortage of PPE and other lifesaving equipment, strict social and other measures have been implemented. But in protecting people — including mothers and babies — there have been a number of unintended negative consequences, which may be especially acute for vulnerable populations. In particular, this period has seen increases in postpartum depression and decreases in birth satisfaction, breastfeeding success, and access to providers.

- The support of doulas or other labor companions has been shown to decrease the rate of medical interventions in birth, including pain medication and C-sections, while increasing labor satisfaction. Before the pandemic hit, an estimated 11 percent of births included doulas. In the first half of 2020, however, most doulas were unable to deliver in-person services due to visitor restrictions and told Motherfigure their businesses have been adversely impacted. The inverse of the positive impact of continuous labor support is expected to be true: Denying women companionship in labor has been hypothesized to increased interventions. In a survey of 106 mothers who gave birth during the pandemic, Motherfigure found that 20 percent reported birth experiences they would describe as poor or very poor, compared to an estimated 10-15 percent in normal times.

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- Birth is extremely physical, and many women need time and support to heal physically from the experience. In ordinary times, more than half of women experience issues with urinary incontinence or prolapse after giving birth, one in three have C-sections, and thousands have perineal tears — all issues that can be helped by women's health physical therapists, especially those who specialize in treating the pelvic floor. This treatment is best conducted in person, but the pandemic led to relaxed insurance and technological restrictions, enabling providers to offer services virtually for the first time. Yet, awareness of this treatment — and appreciation for the possibility of virtual support — remains low among the general population.

- Before the pandemic, 60 percent of women said they didn't meet their own breastfeeding goals — goals often met through successful initiation and follow-up support. In the U.S., there are only 10 lactation consultants for every 1,000 live births — an obstacle in itself. The majority of such specialists are white. This service is typically delivered in person, although many lactation consultants transitioned their services to virtual amid the pandemic. In theory, this might broaden access, but many lactation consultants shared they had struggled, and in a survey conducted by Motherfigure of 51 women who gave birth in the pandemic, 36 wanted lactation help. 5 reported being unable to get it; 13 received help virtually; and 18 got help in person.

- Pre-pandemic, 15 percent of women experienced postpartum depression, and 4–10 percent experienced post-traumatic stress disorder after birth. Meanwhile, COVID-19 is widely understood to have contributed to a mental health crisis among the general population. According to a survey conducted by Motherfigure of 106 women who gave birth during the pandemic, 72.6 percent of respondents self-reported anxiety and depressive symptoms during the postpartum period. In a separate poll of more than 15 Motherfigure mental health providers, all of whom are practicing virtually in light of COVID-19, many said they are not necessarily seeing an increase in the prevalence of PPD, but many said they are seeing an increase in the severity.

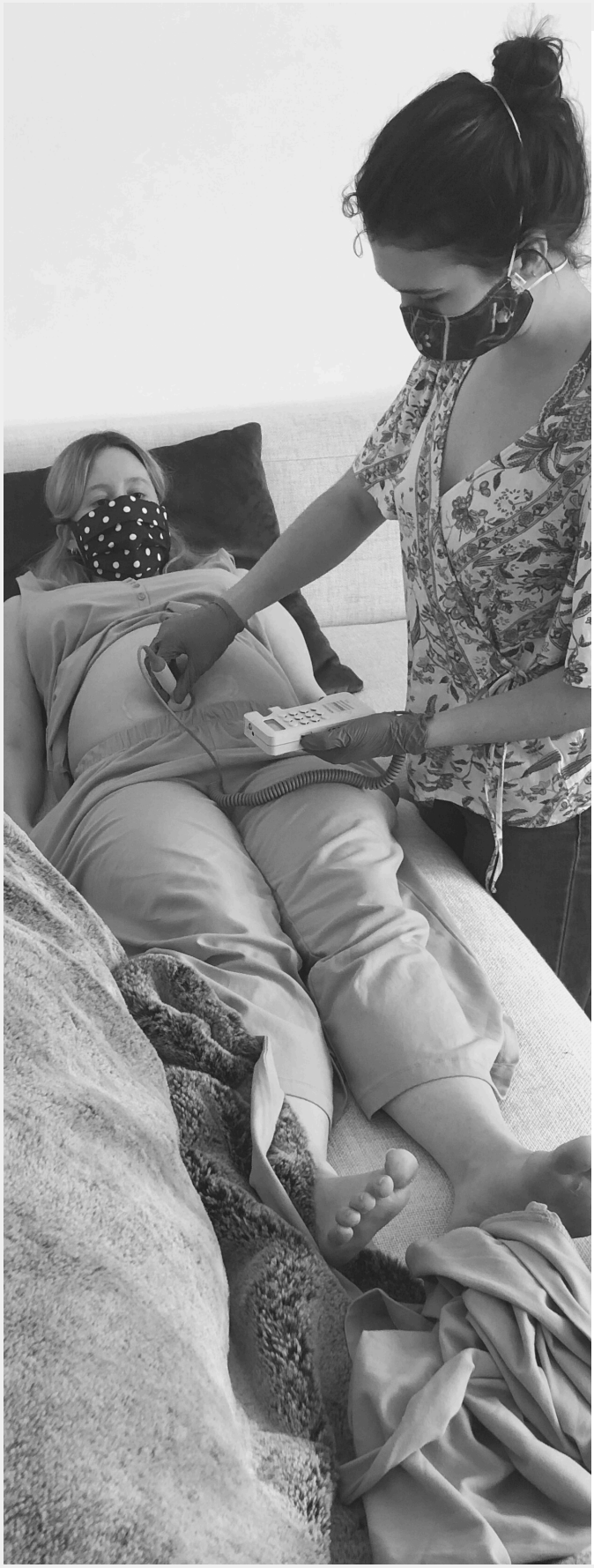


Photo credit: Britt Teasdale

Prenatal care

Typically, a pregnant woman has about 14 in-person prenatal visits. Amid the pandemic, however, many practices have reduced these by as much as half, with in-person touchpoints reserved for blood work and anatomy scans and telemedicine in between. This is helpful in mitigating the broader public health risk, but raises concerns about providers' abilities to pick up on more subtle hints of problems.

Where we give birth

At the turn of the 20th century, almost all U.S. births occurred outside a hospital. For the past 50 years, most babies in the United States have been born in a hospital (98.4 percent).

In 2020, however, we have seen a surge of interest in both home births and birth centers — medical facilities that are either freestanding or part of a hospital that provides care for healthy, "low-risk" pregnant women. Many childbearing families have reported having anxiety about giving birth in a hospital during the pandemic, and wanted to avoid many of the changes that had taken root at hospitals, including birthing in masks and limiting visitors. Google searches for "home birth" and related terms reached their highest point in March, surging between 60 and 100 percent, and have sustained higher monthly averages since then. Likewise, inquiries to birth centers have more than tripled; in some states, the increase in inquiries has been closer to more than 10 times. During the height of the pandemic, some birth centers reported delivering four times as many babies as their typical volume.

But in these cases, demand dramatically outstrips supply — depending on the state, there are often fewer than a couple dozen home-birth midwives, and midwives take on more fewer than eight clients in a month. And as of 2020, there are just 384 freestanding birth centers across the United States, and nine states lack regulations for licensing birth centers at all.

One lasting impact of the coronavirus may be that more birth centers become accessible: As part of New York's response to the pandemic, the state's Maternity Care Task Force recommended a broad set of changes to improve access to birthing centers and midwifery care.

The choice of birthing facility — if such a choice exists — has a major impact on birth outcomes. For example, different facilities (and providers) have different practices and policies when it comes to birth. Some have policies that may drive higher C-section and episiotomy rates, including lower-volume rural hospitals, which tend to have higher rates of primary cesarean delivery. If given the choice, then, a woman who wants to labor vaginally may be better off going to a higher-volume facility. Granted, she may not know that: Hospital systems don't exactly spotlight such data, which should be part of a straightforward exchange of information between any consumer and provider of services. (This is why Motherfigure publishes these stats for thousands of hospitals and birth centers in our provider directory, the Motherlode.)

Though this 2020 surge in interest has been largely driven by COVID-19, and out-of-hospital births remain relatively rare, there has nonetheless been a marked increase in out-of-hospital births in the past 15 years.

Before the pandemic, the United States saw the highest proportion of

out-of-hospital births in the 30 years such data has been collected, at 1.6 percent. During that time, home births increased by 77 percent, while births at birth centers more than doubled.

Researchers suggest the trend speaks to “growing discomfort with the standard hospital-based system of childbirth in the U.S.” Women generally choose out-of-hospital births because they have fewer interventions and lower cesarean rates; after the fact, they also report feeling more empowered and in control of their experience.

If birth centers continue to rise in popularity and availability, they may fill an even more practical void. Currently, more than two-thirds of counties in the United States have at least one hospital, but more than half of counties don’t actually have a hospital that provides obstetric care, according to the March of Dimes. For 10 percent of women, the closest obstetric and neonatal critical care is actually in a different state. Women living in such deserts are unlikely to have much choice when establishing where to deliver. This phenomenon may get worse: It is no secret that coronavirus has decimated the profitability playbooks of hospitals nationwide. Fully a quarter of U.S. rural hospitals are at a high risk of closing, according to Guidehouse.

3.7M
U.S, BIRTHS, 2018

The birth rate reached a historic low In 2018

384
U.S. BIRTH CENTERS

Demand for out-of-hospital births amid the pandemic likely outstripped supply. as of 2020, there are just 384 freestanding birth centers across the United States, and nine states lack regulations for licensing birth centers at all. Depending on the state, there are often fewer than a couple dozen home-birth midwives.

98.4%
BIRTHS IN HOSPITALS

Though there has been a surge in interest in out-of-hospital births driven by COVID-19, and out-of-hospital births remain relatively rare, there has nonetheless been a marked increase in out-of-hospital births in the past 15 years.

With whom we give birth

For about a week in March in New York City, expecting moms at some hospitals were forced to labor alone. Though the state overturned that policy — intended to preserve needed PPE and address a lack of rapid COVID-19 tests — visitor policies in labor and delivery wards across the United States continue to be restrictive.

In a survey of 106 new moms who gave birth amid the pandemic, Motherfigure found that 11.3 percent had given birth without a support person. (Until the 1970s, this was the norm; fathers were not allowed in the delivery room.) An estimated less than 4 percent of people give birth without support in ordinary times, according to Listening to Mothers II.

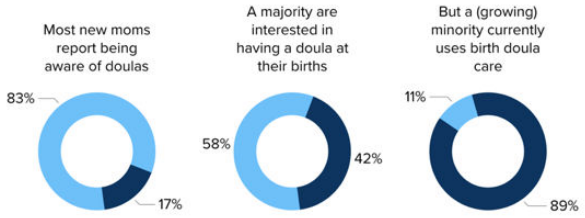
In addition, of 10 doulas Motherfigure contacted about this report, all 10 reported that their businesses have been adversely affected, with less demand expected through 2020, even after reducing fees.

According to a Motherfigure analysis, as of June, an estimated one-quarter of hospitals across the United States continue to limit labor & delivery visitors to one person only, thus banning doulas, even as shelter-in-place orders have been largely lifted.

Doula-supported women generally have lower rates of intervention compared to those without doula support. For some hospital systems where doulas are again permitted, they are now required to show evidence of certification, which could have a longer-term chilling effect.

In 2013, 6 percent of women reported having doula care during childbirth, and more than 27 percent of those who hadn't used one indicated that they would've liked to.

Since then, interest in doulas has increased. According to a 2020 study by Motherfigure, 83 percent of mothers of children under two years old were aware of doulas, 20 percent had doulas present at their most recent birth, and 76 percent said they were interested in having a doula physically present at the birth.



With so-called "doula bans" in place during the pandemic, however, this was not feasible. Doulas who have offered support virtually told Motherfigure that the medium has shortcomings: Labor support is hands-on and intimate, it is difficult to "read the room" remotely, and the advocacy work that doulas do on behalf of clients is harder remotely, where establishing a rapport is challenging, and the doula is often left to delegate suggestions to partners or an already overstretched nursing staff. The hospital visitor restrictions are especially likely to hurt BIPOC and others from marginalized groups, who may rely on doulas to advocate for them.

Moreover, many of the doulas surveyed by Motherfigure described their usual business as coming to virtual standstills. Many are focused on more education, and most have incorporated discounts to their packages. Even demand for fall has not recovered: Typically, expecting families book doulas months In advance, but even for families due to deliver then, doulas reported that inquiries are not at their usual volume.

How we give birth

Some providers on Motherfigure's platform, across specialties, shared concerns that COVID-19 might contribute to a spike in interventions during the labor process, and some shared that they are seeing an increase among the population they serve.

COVID-19 is not itself a reason for a cesarean, with no evidence to suggest that either vaginal birth or cesarean is safer than the other when it comes to mitigating the risk of transmission. So there may be no reason to suspect that cesarean births could spike. The C-section rate is already high: The United States low-risk C-section rate in 2018 was 25.0 percent, and 31.9 percent for all babies. The C-section rate is highest among Black women, at 36 percent. Although C-sections are necessary and literally lifesaving in certain situations, the data suggests that they are happening at a higher rate than should be medically necessary. According to Leapfrog, the rate of first-time cesareans should be no more than 23.9 percent.

However, during this time of quarantine, some best practices have been updated that could ultimately impact the mode of delivery. For example, experts have recommended the use of pitocin; higher doses of pitocin; and early intervention with pitocin and amniotomy to address or prevent slow labor. Such tools were common features of hospital labor to begin with, but the current moment may increase their prevalence.

The Society of Obstetric Anesthesia and Perinatology (SOAP) also recommended early use of epidurals to minimize need for general anesthesia in the event of an emergency cesarean section. SOAP has also recommended against the use of nitrous oxide, which wasn't common in the first place, but is an alternative form of pain relief that has been on the rise in recent years.

In addition, experts have recommended against the use of peanut balls, which can be a feature of active, upright labor, given the possibility that their use may increase the risk of infection.

Further, some women are laboring in full or in part in a mask, which can make active, upright labor difficult.

It's worth noting that one contributing factor to the C-section rate (and the increase of interventions in general) has something to do with the so-called "cascade of interventions" that happens in hospital births, because there is little protocol differentiation between healthy pregnancies and those with problems that require acute care services. More than 90 percent of women delivering in American hospitals receive some form of medical intervention. And, as it happens, once one intervention happens, the more likely subsequent interventions tend to be.

The postpartum period

Prior to the pandemic, hospitals typically waited 48 hours to discharge patients following uncomplicated vaginal births and a few days for cesarean births. To limit the risk of inadvertent exposure and infection, the American College of Obstetricians and Gynecologists says discharge may now be considered after 12 to 24 hours. Some doulas noted that this discharge timing ultimately may have an impact on breastfeeding education and successful Initiation, as well as impede some elements of recovery.

Though 14 healthcare visits are typically a hallmark of prenatal care, there is usually just one postpartum visit: the six-week checkup. Already, there is widespread feeling that this is insufficient, and efforts to contain coronavirus may be limiting or postponing such a visit further, despite many of these postpartum visits, which include wound checks, are being arranged as telehealth. In Motherfigure's survey of 106 postpartum mothers, 15 reported that they had not yet had a follow-up visit either in-person or virtually with their providers but had passed the six-week mark.

These visits are important for numerous reasons. They enable the provider to check in on physical healing, detect and address new health concerns, as well as to pick up on important cues in terms of hygiene and maternal-infant bonding and signs of postpartum depression.

Given an estimated 1 in 3 pregnancy-related deaths occur 1 week to 1 year postpartum, and that a majority of pregnancy-related deaths are thought to be preventable, we need more postpartum check-ins, not fewer.

Checking in on maternal mental health is another important aspect of these visits, and the pervading feeling from most providers polled by Motherfigure was a fear that the pandemic could compound feelings of isolation and other challenges, especially for vulnerable women. As one mental health provider polled by Motherfigure said, "Many mothers are struggling at home all day alone with no breaks or others to come in and help. This leads to more anxiety and depression and feelings of isolation."

A lack of social support is a contributing factor to PPD, and our reality right now means that people cannot extend the same level of in-person support as they once might have.

One silver lining anecdotally seems to be that many people are finding ways to get support or are looking on the bright side — many partners are more present than they might otherwise be (given the poor state of parental leave in the United States) due to stay-at-home orders. When asked, the majority of new moms surveyed by Motherfigure said they would rate the support they received postpartum as good or very good.

The rise of telehealth

In an effort to decrease in-person medical visits, the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, and major private insurers relaxed telemedicine rules in March, establishing equivalent reimbursement for video telemedicine visits; relaxing enforcement of HIPAA violations related to delivering telehealth services; and approving new telehealth reimbursement categories, including physical therapy and mental health. In addition, some states relaxed medical licensure laws pertaining to the care of patients outside state boundaries.

These were welcome changes, despite the challenges. Virtual visits are not always substitutes for in-person care, and some providers noted that they see a gap between the need for virtual support and uptake of it: Job loss, loss of insurance, lack of awareness of or skepticism about telehealth, and unpredictable childcare has negatively impacted potential clients in reaching out for help. But access to maternal care providers is often a lifeline that can make or break the transition to new motherhood.

This opportunity was also critical for providers, who adapted rapidly as many specialties' in-person businesses disappeared virtually overnight.

For now, however, it appears that the impact of these updates may not be enduring. Aetna, for example, ended its cost-share waiver June 4, though it did extend waivers for outpatient behavioral and mental health counseling services through September.

In a poll of more than 15 mental health providers across the United States who focus on the perinatal period, all said that they've transitioned their practices to virtual/telehealth, if they weren't doing so already. They reported feeling adequately able to serve their clients needs through this medium.

Half of doulas Interviewed by Motherfigure said they thought virtual support might become a sustained part of their practice, particularly for prenatal visits, but others were emphatically against it. Though virtual visits are "better than nothing," as one doula put it, another noted that "It is challenging to meet the needs of those in labor virtually — it is difficult to read the room, it is slightly more difficult to offer suggestions of position changes/comfort measures in labor, virtual support is not typically continuous which means clients are having to fill me in on anything that happened while not connected."

Birth recovery

Few women emerge from birth physically unscathed—and complications lead to myriad physical and mental difficulties months or even years postpartum. Getting support during this period has been made more difficult during the pandemic.

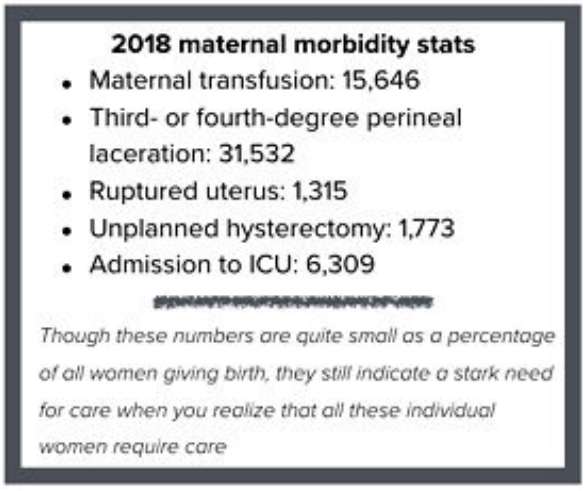
Perineal lacerations during childbirth affect more than 65 percent of women in the United States. Moderate to severe perineal lacerations can lead to chronic pain, pain during sex (dyspareunia), bowel and bladder incontinence, postpartum depression, and poor sexual readjustment (those with a second-degree tear were 80 percent more likely than those with minor tearing or none at all — and those with a third-degree injury 270 percent more likely — to report pain with intercourse at three months postpartum).

An estimated 58 percent of women who had spontaneous vaginal delivery have some form of pelvic floor disorder, compared with 43 percent who have C-sections. Urinary incontinence is common in the immediate postpartum period. Research from 2002 also found that at six weeks postpartum, 83 percent of people had pelvic organ prolapse, in which one or more of the pelvic organs drops into or out of the vagina.

Pelvic floor issues are often best resolved by pelvic floor physical therapists, but there are fewer than 500 women's health physical therapists with this designation practicing in the United States, and awareness of this specialty among the general public remains low. Several states have no such providers at all, and no state has more than 0.5 specialists per 1,000 births.

In addition, many are in private practice and not in network with insurance providers. The broader field of physical therapy is dominated by white people. Among members of the American Physical Therapy Association (APTA) as of 2010, only 2.1 percent of physical therapists were Hispanic, 4.7 percent were Asian, and 1.4 percent were Black. In 2015-16, just 5 percent of applicants to The Physical Therapist Centralized Application Service were Black.

Although pelvic floor problems are exceedingly common among women giving birth, access to care for the issues themselves and the complications that arise from them is hard to come by, leaving women enduring physical and mental health challenges needlessly.
Though strategies can be pursued via telehealth, this work is best conducted in person.



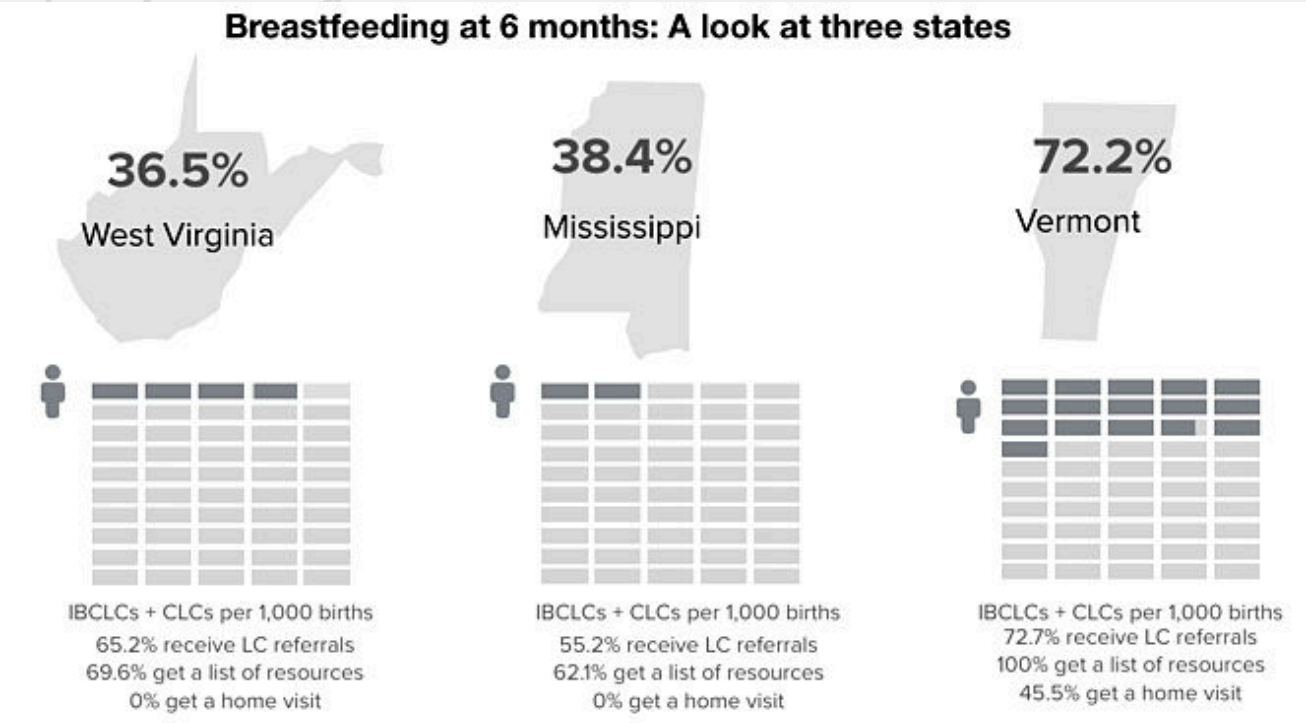
How we feed our infants

The 2010s saw steady increases in breastfeeding initiation and duration. In 2016, the most recent year for which data is available from the CDC, 83.8 percent of mothers initiated breastfeeding, up from 70 percent in the mid-2000s and from 22 percent in 1972.

The American Academy of Pediatrics recommends that children receive breast milk until they are at least a year old. But for many women, this is not realistic. While 57.3 percent of mothers continued to breastfeed at six months in 2016, in 2018, 60 percent of mothers reported that they did not breastfeed for as long as they intended to, for a variety of reasons, including:

- Issues with lactation and latching
- Concerns about infant nutrition and weight
- Mother's concern about medications while breastfeeding

This suggests that support is needed, which most commonly, or specifically, comes from lactation consultants. However, conservative estimates indicate that in the United States, there are about 10 lactation consultants (either International Board Certified Lactation Consultants or Certified Lactation Consultants) for every 1,000 live births—which means that demand vastly outweighs supply.



These challenges predate the pandemic; although the Affordable Care Act mandated coverage of breastfeeding support and supplies, in practice, actually receiving such benefits remains notoriously challenging. There is more work to do here, especially by facilitating virtual support.

But many lactation consultants and new moms have lamented limitations of the virtual format. Lactation consultants often bring sensitive scales to do weighted feeds, offering insight and reassurance that the Infant is successfully drawing out milk. Though some new moms can invest in home scales, this is not accessible for all. And latch and position challenges are easier to troubleshoot in person.

Moreover, perhaps because lactation is not a discipline commonly conducted virtually, and possibly due to a patchier reimbursement environment, some moms reported being unsure of how to receive help or unable to get it. Of 51 new mothers polled by Motherfigure, 38 wanted lactation support; but 5 were unable to get it.

What's more, given the ethnic and socioeconomic disparities in breastfeeding — women of color and women in low-income communities are more likely to stop breastfeeding before the one-year mark — the nature of support in the first place, even in the "best" of times, may be part of the problem. According to the 2019 Demographic Report of Current CLCs in the U.S. & Territories, the majority of lactation counselors are white.

Indeed, though strides have been made to improve women's ability to breastfeed — as of 2018, all 50 states had protections in place around a mother's right to do so — coronavirus may set these efforts back by limiting support. A lack of breastfeeding success can, in turn, contribute to stress, anxiety, feelings of disappointment, negative self-talk, and a mismatch of expectations and reality. And if moms plan or expect to breastfeed but find themselves unable to, they are the ones that the literature indicates have higher rates of postpartum depression.

How our mental health is faring

Postpartum depression (PPD) affects one in seven new mothers, according to the American Psychological Association, and symptoms can last up to a year postpartum. Post-traumatic stress disorder affects between 4 and 10 percent of women after birth.

Researchers note that plummeting postpartum hormone levels and sleep deprivation can have an impact on new parents' mental health. Previous history of mood disorders, life stress, poor social support, and low socioeconomic status are consistently reported as risk factors for PPD. Coronavirus concerns only exacerbate these challenges: For example, COVID-19 may increase isolation related to shelter-in-place orders; lead to a lack of access to care; create financial strain/stress; and contribute to unresolved or complicated grief and trauma — all of which can contribute to PPD.

Women of color experience PPD at a rate of close to 38 percent, and their particular experiences during the pandemic aren't helping. For instance, women of color are overrepresented in some of the industries experiencing the biggest job losses due to COVID-19, and many who are employed as essential workers have different challenges.

Even in ordinary times, less than 25 percent of the women who screen positive for PPD receive follow-up care, for reasons that range from social stigma to their providers not knowing where to refer them. This is where telehealth may be a boon, despite the mental health crisis that coronavirus has wrought. Many states that have the highest rates of self-reported postpartum depression — including Alabama, where the rate is 19.9 percent, and Arkansas, 19.2 — also have considerable mental health professional shortages. Relaxed licensing rules may help.

In Motherfigure's survey of moms who had given birth during the pandemic, 1 in 5 reported birth experiences they would describe as poor or very poor, and almost three-quarters of survey respondents self-reported anxiety and depressive symptoms when asked questions typically used for screening patients for mental health challenges. Indeed, almost everyone is at heightened risk for anxiety in this current climate — worries about health, job status and finances, loneliness, loss of routine, and more. And in that respect, distinguishing between "true" PMADs and more generalized anxiety and mood disorders may not matter — because both are important mental health issues to address.

In a flash poll of more than 15 Motherfigure mental health providers, all of whom are practicing 100% virtually in light of COVID-19, many said they are not necessarily seeing an increase in the prevalence of PPD. (Though they acknowledged there could be gaps in ability / willingness to seek help). But many said they are seeing an increase in the severity of symptoms. But all also noted they have found they are adequately able to hold space for their clients' challenges, again suggesting that more should be done to accommodate the tele modality from a reimbursement perspective.

Photo credit: Christine Junge

Conclusion

COVID-19 has had a transformative impact on our lives in America, with more than 100,000 lives lost at the time of this report. It has also recast the birth and postpartum experience of millions of new mothers who gave birth amid the pandemic.

In some ways, as we draw comparisons to the challenges inherent in the journey to motherhood in ordinary times, it underscores the ways in which our support of mothers today in general has fallen short.

Our hope with this flash report is to draw attention to these challenges — and spotlight the efforts of the many of people who dedicate themselves to supporting the motherhood journey, whose work we must do more to draw attention to and support.