

COVID Reflections

Childbirth Education During the Pandemic

COVID-19 safety measures required creativity and innovation in childbirth education. While in-person classes have resumed, telehealth continues to provide many unique opportunities for those with limited access to childbirth education.

Introduction

Childbirth education has been shown to build confidence, self-advocacy, increased shared decision-making, maternal birth satisfaction, improved breastfeeding efficacy, and use of family support services such as Lamaze. Childbirth educators help to close the gap of health information by creating a nonjudgmental space in which to ask questions in a safe social environment of birthing people who are experiencing similar concerns related to pregnancy. At least one recent *American Journal of Obstetrics & Gynecology* article suggests that childbirth education may reduce the rates of adverse delivery outcomes [1]. The COVID-19 pandemic upended our traditional approach to childbirth education.

In March 2020, as the Centers for Disease Control and Prevention (CDC) began to announce guidelines for managing COVID-19, health care systems began restricting hospital access to visitors. As access was limited, prenatal visits were affected, and most in-person childbirth education classes were canceled. Expecting parents were uneasy about what they would experience during their hospital stay and how their baby would be affected, and pregnancy-related prenatal clinic visits dropped dramatically [2].

During the pandemic, we helped design and deploy two types of responses aimed at maintaining access to critical childbirth education services during the pandemic.

Virtual Childbirth Classes

One of the first responses to the lack of access to in-person childbirth classes during COVID-19 was to adapt to providing them virtually. Health

systems and childbirth educators began offering childbirth classes via Zoom rooms. This required significant adaptations: childbirth educators were faced not only with creating an engaging curriculum, but also with addressing sincere fears and social exclusion. Health systems made many of these classes free, which increased some levels of access and diversity but also had the effect of increasing class sizes from 12 couples to 50 couples, with multiple teachers sharing the tasks of presenter, chat monitor, and technical support. Educators had to work simultaneously to make every person feel heard and that their pregnancy was important.

Creative workarounds included hands-on virtual guidance for support partners regarding comfort techniques during labor, including using Zoom breakout rooms for competitions among parents to see how many comfort measures they could list. Anatomy and physiology props, such as the female pelvis model used to show the changing position of the fetus based on a birther's posture, seemed like a distant idea, as did passing around a flexible pelvis for each person to understand how it moves in support of birth. Parents were anxiously engaged in virtual classes, but showed signs of burnout from virtual fatigue.

Providers, nurses, and educators were fatigued as well, and staff members became ill or lost loved ones to COVID-19. Working longer hours or multiple shifts and functioning within the highest scope of practice was the call to action. Our patients, families, and community needed us, and we also needed each other.

Electronically published January 4, 2023.

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NC Med J. 2023;84(1):42-44. ©2023 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2023/84115

Remote Helpline Support

Another approach taken during the pandemic was to provide virtual on-demand support for expecting parents through helplines.

While parents with access to hospital systems were impacted by COVID-19, that impact was compounded among vulnerable North Carolina parents who struggled to access pregnancy care even before COVID-19, including parents in “maternity deserts” in rural counties, Spanish-speaking parents with language barriers, uninsured or financially insecure parents, or people who feared they wouldn’t get equitable treatment in the formal health system.

We launched BirthCompass (formerly the COVID Moms Helpline) in May 2020 to support pregnant and birthing people across North Carolina—regardless of race, age, and education level—with a free text helpline staffed by knowledgeable experts and perinatal educators, available by SMS text or Facebook messenger. This initiative was launched as a project of Jacaranda Health, a maternal health nonprofit working in Kenya whose founder is based in North Carolina; we borrowed tools from Jacaranda’s digital health platform, which reaches over 2 million parents in Kenya. Text-based responses imposed some limitations on childbirth education, but improved access for the many people in our state who could not access broadband or video streaming, or who wanted anonymous virtual support. Pregnant women and new mothers responded to Facebook ads and could freely ask questions about pregnancy or postpartum care during COVID-19 and get rapid responses and empathetic support from perinatal educators. Conversations started with queries such as:

“Hi I’m six months and living in a hotel in Raleigh. The shelters are closed – please help me bring my daughter into a stable home.”

“I’m six weeks and I lost my job and I don’t know where to get prenatal care.”

“What should I expect when giving birth at this time? I don’t think I can provide a good life for my baby.”

These one-on-one conversations provided a different modality of childbirth education and support. Over the course of a year and half, the helpline served nearly 4500 pregnant people in

North Carolina (internal data). BirthCompass demonstrated that it could reach a population that was high-need and underserved, broadly reflective of the Medicaid population of the state. From chats with thousands of North Carolina people struggling to access care during pregnancy amidst the pandemic via text, Facebook, and phone, a few insights emerged:

Demand was high among the Medicaid and uninsured population, including some of the demographics facing highest barriers: rural moms, mothers of color, and Spanish speakers. The helpline saw queries from people in most counties of the state, both rural and urban. Over 40% of queries were from Spanish-speaking people. A culturally concordant team was critical in helping to create trust and empathy. The team received training in birth equity and justice, mental health, and nutritional awareness. They adapted all content into Spanish and maintained support from Spanish-speaking educators.

Barriers to care are diverse. Many of the needs and queries received during the pandemic were not actually COVID-19 related; they were the result of broken systems, access challenges, and deep inequities. Some of the most common themes were mental health, access to social services, and assistance finding primary pregnancy care providers or basic insurance. The team of educators needed to build content to reflect the diverse challenges pregnant people faced during this period. The team built a knowledge base with over 400 resources and answers, including pregnancy education to empower clients in triaging clinical risk factors and facilitating follow-up with health care providers; mental health resources and referral connections; and scripts and resources for people experiencing housing insecurity, unemployment, domestic violence, or challenges connecting to Medicaid; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); or other local social services.

Helplines can reach people uniquely early in pregnancy. Digital outreach engages people early—many queries came from parents before they had enrolled in Medicaid or seen a provider for their first prenatal visit. This is important, since nearly 40% of women on Medicaid in North Carolina do not get care in their first trimester [3].

Technology is an opportunity but also a limit-

ing factor to scaling childbirth education services. BirthCompass was supported by a competent tech team, but in conversations with other organizations supporting pregnant people during the pandemic, we found that technology was often a limiting factor in adapting service delivery in childbirth education.

Health care providers were able to use tools like Zoom for tele-consults in traditional health systems, but most of the social service organizations that served vulnerable populations had limited in-house technical capacity to provide virtual support and adapt it for clients who could not access streaming video or laptops. For example, the BirthCompass team provided technical support to a New York-based coalition called JustBirth Space, a partnership of organizations focused on birth justice, equity, and access to childbirth education for pregnant people in New York. BirthCompass helped JustBirth Space set up its helpline in New York, leveraging its North Carolina technology platform. To date, JustBirth Space has provided pregnancy support and education to over 5000 expecting parents.

Stories from BirthCompass Helpline

A Spanish-speaking mother was pregnant with her second child. She did not have insurance or a doctor, and she said that she was depressed and mentioned several concerning clinical symptoms. Our team talked through some of her concerns, recommended seeking urgent care, and walked her through the process of Medicaid enrollment. When she struggled to get a response about her eligibility, we connected her directly with state high-risk pregnancy coordinators.

A mom had just moved from out of state with a young child and was six months pregnant. She was without health insurance and feeling depressed and anxious. Our team talked her through her anxiety, connected her to pregnancy support groups, helped her link up with Medicaid, informed her about other resources for which she was eligible (like WIC), and put her in touch with state care coordinators to help manage her Medicaid eligibility.

A college student was pregnant with her first baby. Having to go to pregnancy appointments alone was making her depressed, and she was having panic attacks and failing her classes. Our specialists connected her with support groups, advised her on Title IX accommodations available from her school, and provided moral support.

COVID-19 demanded that the community innovate to provide virtual support to expecting parents and explore digital services that could improve access and build trust. Although hospitals have reopened to in-person childbirth education, there are still many people in the United States who face barriers to access and trust in the system. We believe that these lessons and tools for virtual pregnancy support can help us expand our portfolio of services and reach vulnerable populations as this community continues to work to make childbirth education universally accessible. NCMJ

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Acknowledgments

Disclosure of interests. Lugenia Grider is a pregnancy specialist with BirthCompass. Nick Pearson is a cofounder of the COVID Moms Helpline (now BirthCompass). No further interests were disclosed.

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