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Kuurne (Ketokivi), Kaisa

2022

Kuurne (Ketokivi), K & Leppo, A 2022, A battle over birth : Contestations, lived experiences and the restrictive policy of Finnish birth care in the Covid-19 pandemic. in M Hellman, T Kettunen, S Salmivaara & J Stoneham (eds), Governing Human Lives and Health in Pandemic Times : Social Control Policies. Routledge, Abingdon. https://doi.org/10.4324/9781003241157-7

http://hdl.handle.net/10138/565343
10.4324/9781003241157-7

unspecified
acceptedVersion

In Hellman Matilda, Kettunen Tom, Salmivaara Saara and Stoneham Janne (eds.) Governing Human lives and Health in Pandemic Times. Social Control Policies (2022). London: Routledge

Chapter 4

A battle over birth: contestations, lived experiences and the restrictive policy of Finnish birth care in the Covid-19 pandemic

Kaisa Kuurne **0000-0001-5854-4308** and Anna Leppo **0000-0002-4745-5534**

Abstract

Objective. This study examines the governing of personal and family life during the pandemic through analysing the new restrictions applied in Finnish birth care, their contestation by parents and their influence on the experience of pregnancy and childbirth. In the spring of 2020, Finnish birth facilities restricted the presence of birth partners in hospital obstetric units in various unforeseen ways. The logic behind the restrictions was to ensure patient safety in the midst of a global pandemic. Design. The study is based on a case study approach. It draws on a systematic analysis of various qualitative materials, including institutional and media documents, birth narratives and interviews with activists, midwives and obstetricians. Contribution. The concept of belonging frames parents' contestation of the restrictions as a battle over the right to childbirth as a personal and family event: to whom does childbirth belong – to the birth-giver and her family or to the hospital? Moreover, despite good intentions, the restrictions had numerous negative consequences to people in the fateful and vulnerable event of giving birth.

Keywords

Finland; Covid-19; Belonging; Childbirth

1 Introduction

When the Covid-19 pandemic spread across the world in early 2020, governments and local authorities worldwide started implementing restriction policies that aimed at preventing and slowing down the transmission of the virus. Healthcare services were key places where new control policies were created in the face of great uncertainty regarding the future trajectory of the virus. For example, to ensure patient and work safety, visits and the presence of birth partners were restricted. The restrictions were placed with the intention of making sure the health services would not be overwhelmed. Highly specialised birth care staff are very difficult to substitute. The key concern was to ensure the continuation and safety of birth care in the midst of the pandemic. Some birth scholars, however, were concerned about the effects the restrictions may

have on the well-being of women in the vulnerable situation of giving birth. Rocca-Ihenancho and Alonso (2020), for example, noted that history shows that women's and children's needs are easily side-lined during difficult crises.

The pandemic quickly changed the logic of political power. In advanced liberalism, power is typically 'indirect': people's conduct is aligned with socio-political objectives via the use of 'expertise' and self-regulation (Miller & Rose, 1990, p. 2). Not long ago, the Nordic welfare states had the moral authority to regulate, for example, family life and reproduction with interventionist and even forceful measures (Sulkunen, 2009, 2011), but, since the 1960s, such normative state control has gradually lost much of its mandate. This development can be characterised as the victory of the principle of individual autonomy over the authoritarian or normative state (Sulkunen, 2009, p. 139).

The principle of autonomy poses a problem for social coordination in times of a crisis: how does a society that places high value on freedom of choice deal with a global pandemic, which calls for strict interventions into people's lives in the name of avoiding severe illness and unnecessary deaths? How do citizens react when their taken-for-granted freedoms and autonomy are unexpectedly limited as authoritarian modes of rule are set in motion? Public discussion in Finland focused on protection of the elderly from contracting Covid-19. Soon after the first social distancing policies were implemented, concerns were raised concerning vulnerable people in fateful situations and their right to stay connected with their intimates.

In developed countries, it has become the norm to give birth in a hospital under medical care and surveillance (De Vries et al., 2001; Rothman, 2016). In Finnish birth facilities, the presence of a birth partner, typically the father, has also become a norm. Especially in the case of first-time birth-givers, the partners' involvement in post-partum care has become significant as many post-partum wards rely on 'rooming-in' care where the parents take the main responsibility of their baby. The absence of the parent who is not the birth-giver, especially for first-timers, caused great anxiety in numerous expecting parents during the restrictions (Kuurne et al., 2020). Dramatic changes occurred in hospital birth practices across the world as a result of the pandemic (Davis-Floyd et al., 2020; Sadler et al., 2020). For example, in New York many hospitals excluded partners and doulas completely, which, based on birth professionals' testimonies, was very stressful for the expecting mothers. Professionals argued that the lack of support in childbirth may have negative long-term consequences, such as an increase in post-partum depression, not to mention the negative impact on hospital staff, who rely on the support of birth partners (ibid.).

Finnish hospital districts placed similar restrictions on maternity and birth care as they did in other hospital settings. The unique and particularly vulnerable moment of birth and the beginning of family life were not given a special status, and the presence of the birth partner was restricted

to the delivery room only. He or she was excluded from all other appointments before and after birth: monitoring the growth and well-being of the foetus and the post-partum care at the hospital. Expecting parents mobilised themselves to cancel these restrictions, claiming their right to experience birth and the arrival of their newborn together. The conflict concerned the right of the medical authority to control people's intimate lives and people's autonomy in the fateful moment of birth (Scamell & Alaszewski, 2012) in the name of safety and the public good. The parents did not give in and started a battle over birth.

The core of the battle between the hospital management and expecting parents was about *belonging: to whom does childbirth belong – to the hospital or the family?* What is the realm of birth supposed to be like? Is it supposed to be a technocratically oriented and risk-calculating 'birth factory', which does not recognise family attachments as they are lived (Scamell & Alaszewski, 2012) or a relational realm of ethical care which recognises the birth-giver's vulnerability and her constitutive need for support, suggesting alternative relational metaphysics (see, for example, Yuval-Davis, 2011, p. 181). The contestation concerned the politics of belonging (Yuval-Davis, 2011, p. 181) of birth, of the beginning of family life, and of the litigant persons who must be included.

The coronavirus pandemic can be seen both as a series of facts that are difficult to deny *and* a social reality that can be reinterpreted differently by social actors (Pleyers, 2020). In general, social movements were particularly active in the spring of 2020. The parents who mobilised themselves against the restrictions were in general *not* against Covid-19-based restrictions; instead, they made sure that they stayed at home in order not to catch the virus. At the fateful moment of birth, however, they felt that the restrictions violated their basic rights. Their action shaped a 'provisional consensus' on the narrative of Covid-19 and produced alternative ways of envisioning safety (Pleyers, 2020). How did the expecting parents get mobilised, and what was the moving force behind them? What about the medical authorities? How did hospital districts justify the restrictions and respond to the pressure from the demands of the parents (whose demands were also supported by the Finnish Government as well as the WHO)? Finally, what was the lived reality of birthing during the strictest restrictions?

In the following, we draw on a multimethod qualitative approach to study the battle over birth in the first spring of the pandemic. We will first briefly describe the Finnish maternity care system and the policy of joint parenthood. We then move on to analysing the restriction policies and their contestation. The second part of the analysis concerns birth-givers' experiences during the restrictions. In the conclusion, we crystallise our point about the contestation of the restriction policy, using this as a window to see two aspects clearly: first, the constitutive importance of the joint agency of the birth-giver and her partner and, second, the width and depth of the medical power manifested in the times of the pandemic.

2 Finnish maternity care in the social policy context

Finland provides publicly funded universal healthcare for all residents. Prenatal care in maternity centres is free of charge while the cost of hospital-based treatment is very low for the service user. Over 99% of pregnant Finnish women regularly attended municipal maternity centres during pregnancy, and 99.4% of them give birth in hospitals (Finnish Institute for Health and Welfare, 2020).

Finnish maternity and birth care is among the best in the world with regard to infant and maternal outcomes such as mortality. A two-tier maternity care system was designed in Finland in the 1970s. First, public health nurses, in collaboration with primary care physicians, were given responsibility for outpatient prenatal care during normal pregnancies. Second, hospital-based midwives, in collaboration with obstetricians, were awarded responsibility for pregnancy complications and all births (Hemminki et al., 1990). This development paved the way for the increased medicalisation of pregnancy and childbirth (Hemminki et al., 1990).
In the 1970s, Finnish health and social policy started to encourage fathers to become more active parents (Wrede, 2001). A short leave for fathers in association with the birth of a child was introduced in 1978. In addition, maternity care providers were encouraged to involve fathers throughout the process, including participating in childbirth (Wrede, 2001). These policies have been successful; in 2014, 78% of Finnish fathers took a short fathers' leave (Official Statistics of Finland, 2015). There are no statistics on how often Finnish fathers or other partners participate in childbirth, but according to our professional informants, at least 90% of women nowadays give birth with a companion.

In an international comparison, there has been a lack of feminist debate around maternity care in Finland. Benoit et al. (2005) argued that this is linked to two trajectories. First, 'in a country where all women have had access to an extensive maternity service for practically no cost, and where infant and maternal outcomes are among the best in the world, other goals such as public day care, workers' rights and equality in the family have topped the feminist agenda' (Benoit et al., 2005). Second, the Finnish version of gender equality resulted in feminists emphasising similarities in the interests of men and women, and an emphasis on women's role as child bearers has been difficult to combine with this 'rhetoric of sameness' (Benoit et al., 2005). Benoit et al. (2005) concluded that, in Finland, a demand for choice in birth care was framed as an individualistic and even elitist issue, and reproduction and the organisation of maternity care remained surprisingly under-politicised.

However, since 2019 birth in Finland has politicised in a new way. First, #minämyössynnyttäjänä – campaign (#metooinchildbirth) came out with stories of obstetric violence in Finnish birth facilities (2019), followed by the movement studied in this paper (2020), and the politicisation of midwives' insufficient working conditions (2021).

3 The study

This study draws on a larger multimethod qualitative research project on birth and birth culture in transition in Finland. In this sub-study, we utilised a multimethod qualitative approach. *First, as background information* we followed a Facebook group 'Birthing during the Covid-19 pandemic', which had 2,100 members. We analysed the publicly available briefing materials produced by one large hospital district, a parents' public petition, blogs and media coverage, and we conducted 16 informant interviews with 12 midwives, two obstetricians and two activists in order to understand what happened behind the scenes.

Second, we gathered birth stories (48 written stories and 14 stories from interviews). We approached parents in various social media forums and invited them to share their experiences of birthing during the strictest Covid-19 restriction policies. The interviews were semi-structured. The average length of the written stories was four pages, and the interviews lasted between 50 and 90 minutes. Mothers wrote 44 birth stories while fathers wrote 4 stories. All interviewees were birth-givers. It seems that a negative birthing experience prompted most parents to participate in the study as the vast majority of the participants depicted difficult experiences. The battle between the hospital districts and the expecting parents was analysed following the case study method (Yin, 2003), which aims at understanding complex social phenomena and contributing to the knowledge of its individual, group, organisational, social and political aspects. The case study method was useful in studying the contestation at organisational and political levels (cf. Yin, 2003, pp. 2–13).

Interviews were transcribed verbatim. The parents' interviews and written narratives were analysed using qualitative content analysis (Schreier, 2012) with a narrative emphasis on understanding lived experience (Andrews et al. 2013; Squire, 2017). The key themes were systematically analysed in order to understand the narrators' experiences in all their variety and with all their nuances. The interviews with midwives, obstetricians and activists were only partially analysed as there was a pragmatic focus on the interviewees' take on the conflict over the restrictions.

4 The Covid-19-based restriction policies in Finnish birth facilities and their contestation

As the Covid-19 pandemic landed in Finland, Finnish birth facilities first allowed non-symptomatic partners to participate in all phases of birth. Our informants from birth facilities testify how the fear of the epidemic and especially the lack of capable staff were growing as many professionals had recently returned from a skiing vacation in the Alps and were placed in quarantine. Furthermore, in the face of the unknown virus, there was a fear that symptomatic birth partners may not disclose their potential symptoms in order to be included in the birth.

Early in April 2020, Finnish birth facilities implemented stricter policies and only allowed the presence of birth partners in the birthing room (and, in the case of a C-section, in the recovery room) and excluded them from all prenatal appointments, labour induction, post-partum care and postnatal appointments. The Finnish Society of Obstetrics and Gynaecology supported the restriction policies for birth facilities. Restrictions on birth partners lasted from early April to mid-June of 2020.

Many expecting mothers actively discussed birth-related issues in social media, and the restriction policies became the source of anxiety. Soon they started a private Facebook group for active contestation of the restriction policies. The group grew to 2,100 members and started to plan action against the restrictions. Active parents were (mainly) not already involved in (birth) activism and were 'ordinary' parents from all over the country, fighting for their right to both experience the birth of their child and spend the first days together as a family. The aim of the group was to take action to cancel the unequal policy by advancing their cause in the media, social media, politics and among the wider public. To advance their cause in social media, they used the hashtag #oikeuksiaodottaville ('#rightsforthoseexpecting'). Fathers mobilised themselves in unforeseen measures behind the cause.

Soon after the restriction policies were implemented, the Finnish Minister of Equality appealed to the hospital management in media 'as a father of four', appealing for fathers to be allowed to be part of the birth. The same day, a medical superintendent of the hospital district responded that the policy was thought through and will not be changed. The Finnish Psychological Association supported the policy but emphasised the sense of safety, suggesting increased online support for the expecting parents should be arranged.

On 4 May 2020, the Finnish Government intervened and released a statement saying that non-symptomatic mothers and fathers *should* have the right to meet their child after birth and that parents should not be defined as visitors. It stated that birth-givers should have the right to the presence of their partners or other support persons in birth facilities through all phases of birth, from the opening phase to the actual birth (either vaginally or via C-section and the post-partum phase). Furthermore, WHO strongly recommended 'that the emotional, practical and health benefits of having a chosen labour companion are respected and accommodated. The pandemic must not disrupt every woman's right to high-quality, respectful maternity care.' The restriction policy held.

In the meanwhile, parents had composed a petition 'Oikeutta odottajille' ('Rights for those expecting') appealing to the hospital districts to allow the parent who was not the birth-giver (or another birth partner) to be present for the whole process. The parents behind the petition had different expertise, which they used to back the petition with legal perspectives and research evidence. As a result, the petition was evidence based in justifying why both parents should have

the right to participate in maternity and birth care. The gathered evidence pointed out that (1) breastfeeding is best accomplished with the early support of the father, (2) that the attachment bond with the father is based on the first days and skin contact, (3) stress and anxiety during pregnancy have adverse effects on the child, and, finally (4) postnatal depression occurs more often when the father is absent in the post-partum period.

The legal aspects raised the rights of the child to have both parents available, the full human rights of the birth-giver, supported by WHO and earlier legal cases. The petition was cooperative in tone and ended with an appeal: 'We ask that compromises will be made. The restriction policies have a good aim, but there must be a solution that is acceptable to all parties. For example, parents can acquire full protection apparel themselves. Let's ensure health for all!' Under the petition, there were 35 pages of comments for the hospital districts, a significant number of them written by fathers defending their rights as an equal parent and as providing indispensable support for the mother. Essentially, the petition rejected the idea that 'there is no alternative' and claimed that 'another world is possible' (cf. Pleyers, 2020).

Our professional informants testified that the protest forced the hospital management to use extensive amounts of time to justifying the policy. Mid-May, the large hospital district we studied, responded to the parents' critique by organising an online discussion for the public, taking up each concern raised by the parents, arguing for and justifying the restriction policy. In their justification for excluding the other parent who was not the birth-giver, the hospital management referred to psychological expertise that suggested there is no scientific evidence that the absence of fathers has a negative impact on developing an attachment between the father and the child. Regarding the post-partum ward, they ensured there were enough staff to care for the mothers and newborns. All in all, they emphasised the patient and work safety for which they alone were responsible.

According to our informants, in larger facilities there was initially a high consensus about the restrictions. This is easy to understand as the hospital districts were in a state of alarm in face of the unforeseen threat of Covid-19. Still, most of the midwives who we interviewed felt (afterwards) that non-symptomatic fathers could have safely stayed in a family room with the mother and newborn. Several midwives told us it was highly stressful to work during the restrictions. Usually, newborns are taken care of by the parents themselves in the post-partum ward, but, during the restrictions, the midwives had more workload. They had to face the anxiety and anger of birth-givers, even if many of them felt sorry for the families and would have preferred the partners to be there. Some felt that some mothers regressed, were righteous and did not understand what the pandemic required. Much like our birth-giver data show, midwives also suggested that first-timers suffered the most. Many midwives were pained to see how lonely the mothers were at the beginning of their motherhood. For instance, WHO (2020) has suggested

that health service workers may need psychosocial support during the pandemic in order to cope and be able to continue to provide high-quality care.

In early to mid-June 2020, the strict restrictions on birth partners were cancelled in most hospital districts. Despite the second and third waves, similar restrictions have not been implemented. Rather, the policies adopted later looked much like the policy the petition of the parents envisioned, focusing on masks and having rules for staying in family rooms as opposed to free movement in and out of the room. However, it is common that in regular patient rooms the amount of daily time of 'visitors' (including the parent who is not the birth-giver) is restricted to an hour. Older children have not been allowed to visit, which is hard on the children who may not have been apart from their mother before.

5 Restricted births: experiences of heightened vulnerability

Next, we will present the findings from the birth-givers' narratives and qualitative interviews. There were some positive experiences of giving birth during the restrictions, but the vast majority of the experiences in our data were negative. It looks like difficult experiences prompted birth-givers to share their story. Our analysis focuses on the negative experiences and explores how narrators depicted the effects of the restrictions on pregnancy, labour, birth and the post-partum period. The results will be presented chronologically – running from pregnancy, labour and birth to post-partum care.

5.1 Distress during pregnancy

All narrators reported that the pandemic caused considerable stress during pregnancy after hospital districts started placing restrictions on the presence of birth partners in hospitals. The mothers had expected that their partner, and in a few cases a doula, would support them throughout the birthing process. Numerous mothers reported that the restrictions triggered a fear of childbirth or intensified pre-existing fears. Many also found it difficult that partners could not attend prenatal hospital check-ups and that hospitals cancelled prenatal classes at short notice. The following quotation depicts the sentiments of shock and anxiety:

> My world collapsed at the beginning of April. Restrictions were placed on the partner's presence in childbirth. In the midst of all the uncertainty and fear, it felt unreasonable. Some people […] said that if the pandemic gets worse, fathers may be entirely banned, and every single day until my child was born I was afraid that this would happen. It became hard to prepare for the birth when all my energy was consumed by agonising about the birth: How will it go? Will my husband be there to support me and will he get the chance to attend the birth of his first child? For me, the prospect that I would have to give birth alone was the worst possible thing I could imagine.
>
> (Leena, 31, first child, written story)

For Leena, the worst scenario was that her partner would be banned from the hospital entirely. Leena describes being consumed by fear and anxiety. Leena's strong emotional reaction was not unusual in our data: for numerous mothers, the thought of only having their partner with them in the birthing room was very frightening. Some reported that they even started to consider home birth or travelling to another region that allowed partners' presence.

Many mothers also reported anxiety about the possibility of an induced birth, which could mean spending a long time (even several days) alone in the hospital. First-time mothers and those who had a history of a traumatic previous childbirth seemed to be most distressed. The incidence of Covid-19 was very low in Finland in an international comparison, and very few women in our data were worried about contracting the virus in the hospital.

In sum, increased stress, fear and anxiety during pregnancy were prevalent in our data. Our findings are in line with the work of Motrico et al. (2020), who noted that pregnant women in many countries have reported much higher levels of psychological distress – such as depression, general anxiety and pregnancy-specific anxiety – during the pandemic. High levels of depression and anxiety during pregnancy are some of the strongest risk factors for post-partum depression (Verreault et al., 2014), they are associated with negative obstetric outcomes (e.g. obstetric complications) and they have implications for foetal and neonatal well-being and behaviour (Alder et al., 2007).

5.2 Loneliness during labour and induction

Many women whose birth started with contractions at home reported trying to remain at home as long as possible despite increasing discomfort and pain. Their plan was that staying at home longer would make labour progress quicker and that, once in the hospital, they would get quick access to the birthing room. In some cases, the plan worked, and the women only waited a short time in the hospital before the couple had access to the birthing room. However, some had to part from their partner for several hours, until labour had progressed enough. These hours spent alone in the hospital were long, painful and lonely for many of the narrators, and it triggered feelings of loneliness and vulnerability.

About 20–30% of all Finnish births are induced. In our data, many women who had an induction in the hospital depicted extreme feelings of loneliness and vulnerability during labour. They had to stay in the hospital for hours or even days without their partner during induction. Below, one first-time mother depicts her experience of an induced birth:

> I had to get an induction a couple of weeks before the due date because there was a risk of infection […] My partner was not allowed to come with me, and I spent a day and a night all alone in the ward. This was the worst part of giving birth; the ward was full, and there weren't enough staff. Nobody was accompanied by a birth partner, but this had not been taken into

> account in the number of staff. The midwives were too busy to help me […] The ward had very little pain relief on offer and there wasn't any emotional support […] I was given oxytocin to stimulate the contractions and eventually the pain was insane, and I had one contraction after another without any break. All this time I had to cope on my own, crying and yelling. My whole body became tense because of all the pain and fear.
>
> (Iiris, 29, first child, written story)

Iiris links her negative experiences to the lack of staff. She experienced extreme pain alone, which was a very frightening experience. All in all, numerous birth-givers in our data had felt very lonely during labour. Support from the birth partner during labour would have had a well-established role in buffering the negative effects of stress (Reid & Taylor, 2015).

5.3 Togetherness in the delivery room

The experiences from the delivery room were fairly positive, and it was typically described as the best part of the experience despite severe pain and even some complications. Interestingly, in most of the written narratives, the actual delivery was only a small part of the narrative while negative experiences during induction or in the post-partum ward dominated the story. This is in stark contrast to our larger dataset of birth experiences collected prior to the pandemic. In them, delivery was typically the main focus of the story.

Many mothers expressed great relief because they had been allowed to enter the delivery room soon after entering the hospital. Furthermore, the parents in our data cherished the short time (typically a couple of hours) that they were allowed to spend together in the delivery room with the newborn.

There were records of two planned caesarean sections and 16 emergency sections in our data. Partners were not allowed in the operation theatre, but they were allowed to spend some time with the newborn afterwards, while the mother was waking up from anaesthesia. Women's experiences of C-sections varied. Some experiences were negative as going to surgery alone or parting with the birth companion unexpectedly had been very stressful. This was the case for Ilona, who had an emergency C-section after first trying to give birth vaginally:

> The last midwife was amazing. She saw that I was totally exhausted (…) The C-section was a relief, but fear hit me when I had to leave. My partner stayed behind in the delivery room and I left in a hurry. In the theatre I was just shaking and crying with fear. I was thinking: What if something happens to me and I will never see my partner again nor see my child? I was completely alone; I've never experienced anything as frightening.
>
> (Ilona, 26, first child, written story)

Ilona's description of her mental state is a good example of how vulnerable women may feel during childbirth, and how the restrictions contributed to heightened fragility. Childbirth is a 'fundamentally fleshy' moment, during which one cannot escape the vulnerability caused by the human condition of being made of flesh and blood (Chadwick 2018; Huopalainen & Satama, 2020, p. 335).

5.4 Isolation, vulnerability and unmet needs in post-partum wards

Most of the very difficult experiences in our data took place during post-partum care in the hospital. Numerous women in our data had felt very alone, isolated and emotionally vulnerable, especially first-time mothers. In post-partum wards, the women typically had to stay in their own room and were only allowed to leave the room to fetch their meal trays at mealtimes. In the following extract, a first-time mother describes her experience of abandonment and exhaustion:

> No one was allowed to visit the post-partum ward, so I was alone the entire time with my firstborn baby (…) the experience was very lonely, and I've been to see a psychologist to get over it. I would have needed support and help with caring for the baby. I had been awake for two nights during childbirth and I needed rest, but on the other hand, I did not want to give the baby to the midwife's office because I was worried that they may transmit her coronavirus. As a result, I only had a few hours of broken sleep during the four days.
>
> (Kaarina, 30, first child, written story)

Kaarina's story depicts how her needs were unmet. She needed psychological help after birth to come to terms with her lonely experience. Many women described being in physical pain and feeling very weak after giving birth. Looking after themselves and their newborns was a real struggle. Below, Siiri – who had an emergency C-section after prolonged efforts at vaginal delivery – describes how hard it was for her to cope at the post-partum ward after major surgery:

> It was so hard for me to stay there [in the ward] alone. And the pain made everything so complicated: getting up from the bed, going to the toilet, getting up again from the toilet seat. There wasn't even a chair in my room so I had to lie down to breastfeed, but I was unable to lie down on the bed with the baby, so every time I had to ask somebody to lift the baby into the bed. I had no advice about breastfeeding; they [the midwives] just shoved the baby to my breast […] I felt so lonely (…) and I certainly did not fall in love with the baby there and then […] I was just thinking: How on earth can I cope with all this? […] I was scared to ring the bell after I had once done so and asked the midwife to lift the baby into my arms and she said that I shouldn't have rung the bell during the staff meeting […] and that I can surely manage by myself. That was the last time I rang for help.
>
> (Siiri, 30, interview, second child)

Siiri was one of the many mothers who reported that they decided to try to get home from the post-partum ward as soon as possible in order to get more help with the baby. Siiri described that

she did not have any warm feelings for the newborn because she was overwhelmed by the difficulty of her situation. Siiri and many others reported that they did not get enough support, for example, with breastfeeding. Numerous mothers in our data described how busy the staff had been, which made them feel like they should not ask for help. Siiri cried during her interview, as did many other interviewees. Many mothers had experienced difficulties coping with basic things (such as fetching one's meal tray from the lobby) as getting up from bed was a struggle. One mother reported that she had to wait too long for assistance to get to the toilet and had wetted her bed, which was humiliating.

Many narrated that they felt very isolated and had experienced 'a meltdown' at the ward. Some of them wrote that being isolated in a small room made them quickly feel like prisoners. Some described getting angry at the staff or having a panic attack due to anxiety. As our midwife informants explained, the situation at post-partum wards was very challenging for professionals as well. We could sense how the unique challenges posed by the pandemic in birth facilities resulted in increasing levels of distress and moral stress among maternity staff (see Horsch et al., 2020).

In sum, numerous mothers expressed that their practical and emotional needs were unmet during post-partum care. Similar experiences of loneliness, unmet needs and distress during post-partum care have also been reported internationally during social confinement (Motrico et al., 2020). Based on the narratives, we could see that there were simply not enough staff to take care of all the extra work to make up for the absence of birth partners.

While some parents accepted the restrictions on birth and found them necessary, many parents expressed a strong sense of injustice. The idea that birth belongs to both parents and that both parents have a right to participate was a common sentiment in our data. Many argued that there would have been an alternative way.

6 Conclusion: a battle over to whom birth belongs and the lived experiences of exclusion

We have analysed the contestation and lived experiences of Covid-19-based restriction policies at Finnish birth facilities during the first spring of the pandemic when birth partners were excluded from all phases of birth other than the actual delivery. Analysing the contestation shows how ordinary parents organised themselves and put considerable pressure on hospital districts. The lived experiences of high vulnerability, especially before and after birth, confirm the parents' message that they needed to be together or else the beginning of family life was filled with anxiety and other adverse consequences. Our study demonstrates that parents felt strongly that *birth and having a baby belong to both parents*. Gender equality in parenting has

been a central aim in Finnish family policy for decades, and our findings indicate that this policy has been successful and internalised by both parents.
The pandemic forced the government and medical authorities to make decisions very quickly and amid great uncertainty. At the beginning of the pandemic, there was very little knowledge about what the future trajectory of the virus was going to be and which safety measures were necessary. The unforeseen crisis gave the governments and medical authorities the mandate to use direct methods of social control unseen in contemporary times. The use of authoritative modes of power has, on one hand, been successful in protecting vulnerable citizens but, on the other hand, has shaken citizens' taken-for-granted rights and autonomy. Before the pandemic, most people were not used to authoritarian interventions into their intimate family lives as the legitimate use of power has long been more subtle in contemporary liberal societies (cf. Sulkunen, 2009, 2011). Our case study suggests that the global threat of a virus has the power to change the whole regime of executive powers and the legitimate ways of using them, but which authorities had the final say in the Finnish battle over birth?

In handling the pandemic, the Finnish Government explicitly based their recommendations and restrictions on health authorities' expertise. The strictest restrictions on birth partners took place between early April and mid-June 2020. What catches our attention is that WHO and the Finnish Government were both on the families' side in the battle, but the hospital districts had the final say. The Finnish Government and WHO emphasised the human rights perspective, while the hospital districts held on to assessing the medical risks of the pandemic. In justifying the restriction policies, the hospital districts relied on functionality, rational expertise and industrial efficacy in controlling risks, which can be seen as key justifications in the Finnish political system more generally (Luhtakallio, 2012, p. 183).

Following different authorities' recommendations for handling the pandemic, it seems that the medical superintendents have systematically been in favour of stricter safety measures than political actors. Looking at the pandemic from the viewpoint of medical risks is not always in line with the constitutional rights of the citizens. An early critic of medicalisation, Irving Zola (1972), suggested long ago that medicine was becoming a major institution of social control where judgements are made by 'morally neutral experts' in the name of health (see also Conrad, 1992, 2007). This is exactly what has been happening in the times of the pandemic. There have been some demonstrations against Covid-19-based restrictions, but we have seen very little wider public debate over the moral values, priorities and the ethics of care. Our case study suggests that in times of a pandemic, the hospital districts may have the final say on what happens within medical institutions. As the legal scholar Kostiainen (2020) suggested in a blog post, the medical superintendents may not be used to the contestation of their authority and executive power over patients. The pandemic has shown how we may all become citizens of a 'biomedical empire' that has intruded deep into our lives, especially at the two gates of life –

birth and death – (Rothman, 2021), and in the case of the female body (Chadwick 2018; Riska, 2003).

While the strict restriction policies showed the depth of medical power, they mobilised parents in unforeseen ways. The battle was about to whom does birth belong: To the family or the hospital? For expecting parents, the parent who was not the birth-giver was a litigant participant of birth and aftercare. For the hospitals, in the face of an exceptional threat, the only litigant person and patient was the birth-giver. At a more abstract level, the battle can be seen as parents' battle over their autonomy and rights and hospitals' battle over safety and control. Our analysis of this mobilisation presents three noteworthy aspects. *First,* the studied activism was based on social media participation that connected previously unknown people who had no earlier history of activism. The active parents protesting for the cancellation of restriction policies were *ordinary parents* from all over Finland.

Second, social media fostered the connection and empowered expecting parents to join forces. The mobilisation challenged the hospital management's idea that 'there is no alternative' to restricting the presence of the parent who was not the birth-giver and envisioned alternative ways of managing safety. According to Leong et al. (2019), social media holds a central role in enabling the powerless to voice widely shared grievances. In our case study, social media enabled grassroots involvement, rapidly connecting a large number of expecting parents with a common cause. Most of the activists never met each other in person. This kind of digital activism is better conceptualised as *connective action* than *collective action* (Leong et al., 2019) in which participation is based on private, rather than collective, interests.

Third, the number of active fathers was unprecedented when compared with any earlier birth movements in Finland. The mobilisation of fathers suggests that joint parenthood has become a taken-for-granted model for family formation. The restrictions were targeted at something that was held precious and self-evident by parents. Our analysis showed how fathers mobilised themselves to defend their personal right to fully participate in birth and in the first days of their newborns' life. Furthermore, they emphasised that their support for the mother was indispensable, which was easy to confirm from the narratives of high vulnerability.

Compared with other birth narratives we have collected for our larger study, the narratives of birth during the Covid-19-based restrictions were quite different. Whereas most other birth stories give the actual birth the central place in the narrative and the role of the partner is not emphasised, in the narratives analysed for this sub-study, the focus was not on birth but on the anxiety and vulnerability caused by the absence of the partner. Moreover, instead of focusing on birthing, these narratives focused on phases of birth when the partner was absent. The lack of partner's presence was central.

Our analysis showed that the absence of partners was very difficult for numerous birth-givers, generating experiences of loneliness, vulnerability and helplessness. In the narrators'

experiences, a sense of safety – which is generally seen as a prerequisite for a good birthing experience – was seriously jeopardised. Adverse effects on pregnant and post-partum women's mental health due to the social confinement measures in birth care should be recognised as a vital public health concern (Motrico et al., 2020). In the first months of the pandemic, this was not the case.

The analysed narratives testify that, exactly as the egalitarian Finnish family policy has hoped for, pregnancy and birth are strongly felt to belong to both parents. The ethos and the practice of the 'intimate and exclusive couple' (Ketokivi, 2012) has been internalised in relation to birth. Our informant activists testified how active parents had a sense that the unit of birthing is not the mother, but the couple themselves. What does this mean? To us, it suggests that birth-givers do not feel themselves to hold individual agency in birthing and rely heavily on the joint agency of the couple. As Bolt et al. (2016) suggested, a sense of joint agency is felt most in situations in which mutual coordination is required. Having a baby in Finland today has become an event of mutual coordination and joint agency. Covid-19-based restrictions challenged the young generation's taken-for-granted idea that having a baby does not happen in the individual physical body of the birth-giver but in the joint psychological body of the couple who belong together at birth. If we see the couple as the basic unit of birthing, it is easy to understand how constitutive the lack of 'the other half' must feel.

Hence, we suggest that the battle over birth was not only about support but also about the birthing body itself. While the hospital districts took a technocratic stance on the issue and focused on the birth-giver's physical body as the unit of birthing, the parents' view on the ontology of birth was different, focusing on the joint psychological body and the humanistic needs of the family (Davis-Floyd, 2001). Similar tensions between the viewpoints of birth hospitals and families were under the surface before, but the pandemic intensified and made the biomedical empire (Rothman, 2021) visible. The disagreement can essentially be seen to be about the worldviews and the paradigms of birth, hospitals basing their rationales on the technocratic paradigm, excluding birth experiences, and parents basing theirs on the humanistic paradigm in which experiences ought to be an integrated part of birth care (Davis-Floyd, 2001). Instead of health or safety, this places values and morals that are typically excluded from the neutral medical rationale (Zola, 1972) at the core of the dispute.

While the medical viewpoint initially dominated the battle, this domination mobilised an unforeseen movement for birth rights. According to the narratives of our informant activists, the active parents who mobilised themselves to fight for their rights during the pandemic are not leaving the scene but, instead, are forming an association to promote birth rights. This changes the power relations, providing a counter-power to the technocratic viewpoint. As elsewhere, it brings the humanistic paradigm and human rights in birth to the negotiating table (also Lokugamage et al., 2017).

Acknowledgements
We wish to thank the Kone Foundation for funding the research project “Battles over Birth – Finnish Birth Culture in Transition”.

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