

Seeking mental health support for feelings of perinatal depression and/or anxiety during the COVID-19 pandemic: A qualitative descriptive study of decision-making

Women's Health
Volume 20: 1–14
© The Author(s) 2024
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/17455057241282258
journals.sagepub.com/home/whe



Katrina Shen¹ , Cassandra Kuyvenhoven¹, Andrea Carruthers¹,
Manisha Pahwa², Dima Hadid², Devon Greyson³, Hamideh Bayrampour⁴ ,
Jessica Liauw⁵, Caroline Mniszak³ and Meredith Vanstone¹

Abstract

Background: Rates of perinatal depression and anxiety increased during the COVID-19 pandemic. It remains unclear how the COVID-19 pandemic influenced risk perception and help-seeking behaviours among pregnant and postpartum individuals.

Objectives: To explore pregnant and postpartum individuals' decision-making process about when and how to seek support for feelings of depression and/or anxiety during the COVID-19 pandemic.

Design: A qualitative descriptive design was used.

Methods: The current study is a secondary analysis of qualitative data collected for a larger mixed-methods project that recruited participants who gave birth from 1 May 2020, to 1 December 2021, in Ontario and British Columbia, Canada, using maximum variation and purposive sampling. Seventy-three semi-structured interviews were conducted over Zoom or telephone. This analysis focuses on 56 individuals who discussed their self-identified feelings of prenatal or postpartum depression and/or anxiety. Conventional (inductive) content analysis was employed with iterative stages of open coding, focused coding and cross-checking themes.

Results: Most participants recognized their need to seek help for their feelings of depression and/or anxiety through discussions with a mental health professional or someone within their social circle. Nearly all participants accessed informal social support for these feelings, which sometimes entailed social contact in contravention of local COVID-19 public health policies. Many also attempted to access formal mental healthcare, encountering barriers both related and unrelated to the pandemic. Participants described the pandemic as having the dual effect of causing or exacerbating their feelings of depression and/or anxiety while also constraining their ability to access timely professional care.

Conclusion: Participants struggled to address their feelings of perinatal depression and anxiety during the COVID-19 pandemic, with many describing a lack of readily available resources and limited access to professional mental healthcare. This study highlights the need for improved provision of instrumental mental health support for pregnant and postpartum populations.

¹Department of Family Medicine, McMaster University, Hamilton, ON, Canada

²Health Policy PhD Program, McMaster University, Hamilton, ON, Canada

³School of Population and Public Health, University of British Columbia, Vancouver, BC, Canada

⁴Midwifery Program, Department of Family Practice, University of British Columbia, Vancouver, BC, Canada

⁵Department of Obstetrics and Gynaecology, University of British Columbia, Vancouver, BC, Canada

Corresponding author:

Meredith Vanstone, Department of Family Medicine, McMaster University, David Braley Health Sciences Centre, 100 Main Street West Room 5001F, Hamilton, ON L8P 1H6, Canada.
Email: vanstomg@mcmaster.ca



Plain language summary

Seeking mental health support for feelings of perinatal depression and/or anxiety during the COVID-19 pandemic: A qualitative descriptive study of decision-making

It is not unusual for pregnant and postpartum individuals to experience feelings of depression and/or anxiety. Studies have shown that this became more common during the COVID-19 pandemic. Depression and anxiety can be challenging to recognize and treat in pregnant and postpartum individuals but may lead to long-term negative effects if not addressed. The COVID-19 pandemic brought on public health measures, including social distancing, which created barriers to accessing mental health professionals or social interactions. In this study, we wanted to understand when and how pregnant and postpartum people chose to seek support for their feelings of depression and/or anxiety during the COVID-19 pandemic. We interviewed people who gave birth during the pandemic in either Ontario or British Columbia, Canada and asked them about whether they experienced feelings of perinatal anxiety or depression, and how they chose to seek help for those feelings.

Most participants acknowledged their feelings of depression and/or anxiety through discussions with a mental health professional or someone within their social circle, even though many experienced barriers to accessing these supports. Nearly all participants interacted with friends or family outside of their household to cope with their feelings, which sometimes meant acting against local COVID-19 public health policies. Although some participants talked about facilitators for accessing mental health professionals, many who tried also encountered challenges, and a few were unsuccessful. Participants in this study shared that the pandemic sometimes caused or worsened feelings of depression and/or anxiety while also making it harder to access the support they felt was necessary to cope with their feelings. These findings show that there is a need for more frequent conversations about mental health during healthcare appointments and more readily accessible mental health resources for pregnant and postpartum people.

Keywords

pregnancy, peripartum period, mental health, help-seeking behaviours, COVID-19

Date received: 12 April 2024; revised: 17 August 2024; accepted: 23 August 2024

Introduction

Rates of self-reported depression and anxiety were elevated during the COVID-19 pandemic among pregnant and postpartum individuals.^{1,2} The COVID-19 pandemic is an example of an unforeseen, persistent and severe stressor³ that disproportionately impacted the mental health of pregnant people compared to their non-pregnant counterparts.⁴ The disproportionate burden experienced by pregnant and postpartum individuals may stem from an increased vulnerability to severe illness from COVID-19 infection, inequities accentuated by the pandemic and novel stressors brought upon by public health measures, including disruptions to the provision of perinatal healthcare, transition to virtual care and social isolation.^{5–8} Structural and socioeconomic inequities were intensified by the pandemic as marginalized groups (i.e. women, low-income, gender-diverse, racialized and Indigenous people) were more susceptible to poor mental health, COVID-19 infection, food and housing insecurity and precarious employment.^{9,10} Indirect consequences of the pandemic, including income loss and resulting financial stress, increased rates of sex-based violence and increased caregiving responsibilities, were also felt more acutely by women

and may have contributed to the increase in mental health concerns.⁵

Perinatal depression and anxiety are not unusual; pre-pandemic, the prevalence of perinatal depression was 15%, whereas anxiety affected approximately 29% of perinatal individuals.^{2,11–14} During the first wave of the pandemic in Canada, rates of perinatal depression and anxiety rose to 40% and 72%, respectively.² While the rates of depression and anxiety were higher during the pandemic, accessing necessary support to mitigate stressors was challenging due to the impact of public health infection prevention and control policies, which restricted access to essential support services, including vital mental health resources.^{2,3,5,15,16}

In Canada, where this study was conducted, there is limited publicly resourced mental health support, and mental health specialists reported a particular strain on services and struggled to meet needs during the pandemic.^{15,16} Feelings of depression and anxiety may be particularly difficult to identify and address in pregnant and postpartum people, as approximately 70% of those who screen positive for perinatal mental health disorders choose not to seek support, and less than 15% receive formal mental healthcare.¹⁶ Information about how perinatal individuals addressed their feelings of depression and/or anxiety during the COVID-19 pandemic is still

emerging, with remaining questions about how people made decisions about accessing mental health support during the perinatal period and their experiences of trying to access support. To help address this knowledge gap, we sought to understand how people who experienced feelings of perinatal depression and/or anxiety made decisions about seeking mental health support, and their experiences throughout the process.

Methods

Study design

This study was part of a larger parallel convergent mixed-methods project about how people who gave birth during the first 2 years of the COVID-19 pandemic made pregnancy-related health decisions.¹⁷ The project was conducted in Ontario (ON) and British Columbia (BC), two large, populous, and demographically diverse provinces in Canada.¹⁸ Semi-structured interviews were conducted with 73 people who gave birth from 1 May 2020 to 1 December 2021. This study focuses on responses from the 56 participants who reported feelings of depression and/or anxiety while pregnant or in the year after birth. Ethics approval was obtained from the Hamilton Integrated Research Ethics Board (#14632) and the University of British Columbia Behavioural Research Ethics Board (H22-01905). Written informed consent was secured from all participants in advance of the interview, with additional verbal consent affirmed immediately before data collection.

Methodology

We used a qualitative descriptive approach to stay close to the participants' explicit meanings and words with minimal abstraction or interpretive inference, allowing us to portray their experiences in their own words.^{19,20} Five people with lived experience of pandemic pregnancies (MP, NS, CM, SK, JL) participated as members of the primary study research team as either co-investigators (MP, SK, JL) or paid research assistants (NS, CM). We reported our study following the Consolidated Criteria for Reporting Qualitative (COREQ) Research Guidelines.²¹

Recruitment

The eligibility and exclusion criteria, sampling and recruitment strategies for the larger study have been previously reported.¹⁷ Briefly, people over the age of 18 who gave birth to a live baby between 1 May 2020 and 1 December 2021, in ON or BC and were able to complete an interview in English were eligible. Excluded participants include those who gave birth outside ON or BC, had a stillbirth or were unable to participate in an interview in English. ON and BC were chosen as the two provinces of interest for this

study as they both had a large number of live births and high rates of COVID-19 infection during the pandemic.^{22,23} Potential participants were recruited via advertisements placed on social media and in public places frequented by parents of young children (e.g. libraries, pharmacies, child-care centres). The advertisements directed potential participants to an online consent-to-contact form that collected basic demographic information, which was used to determine eligibility and to operationalize purposive and maximum variation sampling as the study progressed. This analysis was a secondary focus of the larger study. While the data on mental health has not been analysed in any other publication, identifying potential participants who experienced feelings of depression and/or anxiety was not a recruitment goal for the larger project.

Data collection

We developed a semi-structured interview guide (Supplemental Material) that focused on understanding perceptions of COVID-19 risk as they related to health decisions in three areas of interest: mental health, vaccination and prenatal care. Our published protocol¹⁷ provides more information on interview guide development, piloting and content. Further refinement to the guide occurred to respond to insights from preliminary data analysis, which occurred iteratively with data collection.

Interviews were conducted by multiple female interviewers of reproductive age with training in qualitative research and varying levels of educational attainment, including a BSc, master's degree, MD and PhD (KS, MS, NS, ST, AC, CK and CM). Participants completed a single one-on-one semi-structured interview over Zoom or telephone from July 2022 to August 2023. The participants had no previous relationship with the interviewer. However, they were aware that the interviewer was a female employed as health science research staff investigating how pregnant and postpartum people's perceptions of COVID-19 risk and pandemic circumstances influenced their healthcare decision-making related to pregnancy. Interviews lasted approximately 19–60 min (average: 44:48 min). Audio recordings of interviews were transcribed verbatim and de-identified for data analysis. To maximize the diversity of perspectives collected, interviews continued past thematic saturation when they no longer provided new information about areas of interest.²⁴ Additional data were collected to affirm that the findings continued to hold in additional participants who exhibited diversity in age, family composition and race.

Data analysis

We employed a conventional (inductive) approach to content analysis, adapting the staged coding methods of qualitative description to iterate data collection and analysis.^{19,20} One researcher (KS) open-coded all transcripts

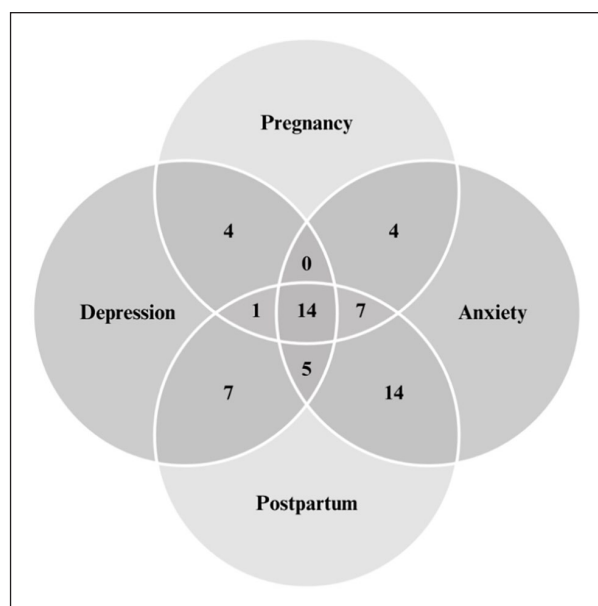


Figure 1. Feelings of depression and/or anxiety ($n=56$).

to identify and organize recurring themes in the data relevant to experiencing and seeking support for feelings of depression and/or anxiety. Initial insights were discussed with the larger research team, who offered suggestions for a refined coding framework. KS conducted two additional rounds of focused coding. Then, two researchers (CK and AC) co-coded the transcripts and cross-checked the themes to prompt critical dialogue and ensure consistent application of the codes. Constant comparative analysis was conducted across participant groups,²⁵ such as those who discussed their first pregnancy or those who intended to become pregnant during the COVID-19 pandemic. Triangulation was achieved across analysts and across participants.²⁶ Written memos were recorded after conducting each interview and reviewed throughout the analytic process to foster reflexivity and assist in recalling initial interpretations of participants' experiences. Regular meetings were held with the broader research team to share preliminary findings and receive feedback. NVivo 14 (QSR International, Melbourne, Australia) was used to manage data. Transcripts or findings from the final analysis were not returned to participants.

Results

In total, of the 65 participants in the original study¹⁷ who discussed their mental health, 56 participants reported feelings of depression, anxiety or both during pregnancy or within 1 year postpartum (Figure 1). These 56 participants were mainly White (70%), university-educated (72%) and primiparous (66%) (Table 1). The most common feelings reported were postpartum anxiety ($n=14$) and a combination of perinatal depression and anxiety

($n=14$). Overall, 44 participants experienced feelings of anxiety, and 31 participants experienced feelings of depression (Figure 1). Nineteen participants (34%) reported a diagnosis of depression and/or anxiety prior to becoming pregnant.

Four overarching themes were identified in participant interviews and are described here temporally in relation to the process of seeking mental health support. Participants' help-seeking processes typically began with identification and attribution of their feelings of depression and/or anxiety, followed by decision-making and experiences around accessing support for these feelings.

Identification of feelings of depression or anxiety

Identification is the process through which participants recognized that they needed to seek support to address their feelings of depression and/or anxiety. Most participants who experienced feelings of depression and/or anxiety came to identify their need for support from two main catalysts: receiving external feedback from family, friends or healthcare providers, and/or experiencing an adverse event.

External feedback. More commonly, participants were told to seek help by someone who showed concern for them, for example:

'One of my best friends [. . .] was concerned because of the way that I was withdrawing and the fact that some of the things that I was expressing that I was feeling were not normal. [. . .] She kind of stepped up and said, "No, you have to think about this, it's not just a normal sadness; this is like a grief that you need to address"'. (ON19, primiparous, 2021 birth)

Sometimes, healthcare providers played a pivotal role in helping participants identify feelings of depression and/or anxiety and encouraging participants to seek help.

'[. . .] [A]fter talking to my GP [General Practitioner] and showing signs he said, "No, what you're going through, you need medical help". So, he did share resources, and I voluntarily reached out to [a support organization] because I wanted to proactively deal with this my way'. (BC204, primiparous, 2020 birth)

Although many participants reported wanting more healthcare provider-initiated conversations about mental health or formal mental health screening, few recalled identifying their feelings through these methods. Instead, participants typically described spontaneously reporting behaviour or feelings to their healthcare provider, who then helped them name and recognize these feelings as depression and/or anxiety.

Table 1. Demographics table of participants.

Variable	Population of interest, <i>n</i> = 56 (%)	Entire study population, <i>n</i> = 73 (%)
Province		
Ontario	38 (67.9)	43 (58.9)
British Columbia	18 (32.1)	30 (41.1)
Intention for pandemic pregnancy ^a		
Intentionally became pregnant during pandemic	31 (55.4)	41 (56.2)
Did not intend to be pregnant during a pandemic	25 (44.6)	32 (43.8)
Race or ethnicity		
White	39 (69.6)	47 (64.4)
East Asian	6 (10.7)	9 (12.3)
South Asian	4 (7.1)	5 (6.8)
Middle Eastern	3 (5.4)	3 (4.1)
Black	2 (3.6)	4 (5.5)
Southeast Asian	1 (1.8)	1 (1.4)
Multi-racial	1 (1.8)	2 (2.7)
Indigenous	0 (0)	1 (1.4)
Latin American	0 (0)	1 (1.4)
Level of education		
Completed high school	1 (1.8)	1 (1.4)
Some college or trade school	4 (7.1)	4 (5.5)
Completed college or trade school	11 (19.6)	15 (20.5)
Some university	1 (1.8)	3 (4.1)
Completed university	24 (42.9)	29 (39.7)
Some postgraduate or professional studies	5 (8.9)	6 (8.2)
Completed postgraduate or professional studies	10 (17.9)	15 (20.6)
Parity		
Primiparous	37 (66.1)	44 (60.3)
Multiparous	19 (33.9)	29 (39.7)
Delivery date		
1 May 2020 to 31 December 2020	26 (46.4)	31 (42.5)
1 January 2021 to 1 December 2021	30 (53.6)	42 (57.5)
Employment		
Yes	40 (71.4)	52 (71.2)
No	16 (28.6)	21 (28.8)
Partnered with co-parent		
Yes	55 (98.2)	71 (97.3)
No	1 (1.8)	2 (2.7)
Place of residence		
Urban	29 (51.8)	40 (54.8)
Suburban	18 (32.1)	23 (31.5)
Rural	9 (16.1)	9 (12.3)
Remote	0 (0)	1 (1.4)
Age at time of delivery		
19–24	6 (10.7)	6 (8.2)
25–29	12 (21.4)	16 (21.9)
30–34	25 (44.65)	30 (41.1)
35–39	11 (19.65)	17 (23.3)
≥40	2 (3.6)	4 (5.5)
Previous diagnosis of depression and/or anxiety		
Yes	19 (33.9)	19 (26.0)
No	37 (66.1)	54 (74.0)

^aParticipants who conceived before the beginning of the COVID-19 pandemic, or who conceived unintentionally during the pandemic are described as having 'unintentional pandemic pregnancy'. Those who conceived intentionally, within the COVID-19 pandemic are described as having 'intentional pandemic pregnancy'.

Adverse event. Adverse events triggered the recognition that support was needed for some participants. These adverse events typically involved intense feelings such as anger or intrusive thoughts about harming their baby. This prompted participants to acknowledge that they needed help managing their feelings.

'I went to my doctor – it was month three of being postpartum – and I said to her, "this is not working for me. I want to throw my baby [. . .] I hate it. I don't want to be around it". I was at a really bad place'. (P09, primiparous, 2020 birth)

Attribution

Many participants attributed their feelings of depression and/or anxiety to pandemic-related changes that strongly influenced their experience of pregnancy, birth and parenting. Those who gave birth in 2020 were more likely to attribute their feelings to the uncertainty of the pandemic and fears of COVID-19 infection, while those who gave birth in 2021 tended to attribute their feelings to isolation. No differences in attribution were identified between those who intended to become pregnant during the pandemic compared to those who did not plan to be pregnant during a pandemic.

Participants described four categories of pandemic-related factors that contributed to their experiences: COVID-19 infection risk and isolation, social tension due to personal beliefs around COVID-19 prevention efforts, missed baby celebrations and milestones due to physical distancing and pandemic healthcare policies that impacted birthing experiences (Table 2). Individuals who reported feelings of anxiety and/or depression typically attributed these experiences to one or more of these categories. Multi-parous participants provided particularly clear accounts of pandemic-related contributors to feelings of anxiety and depression, typically comparing with previous pre-pandemic pregnancies:

'My [pandemic pregnancy], I had postpartum depression – I've never had it before [with my 3 previous pregnancies], and I believe a lot of it was the isolation'. (ON35, multiparous, 2020 birth)

Parity. Primiparous participants reported feeling particularly isolated when other parents provided support or advice that did not apply to their pandemic circumstances.

'So, when other moms talked to me about the challenges and everything through that, I said I would divide my life into two phases: pre-COVID and during and post-COVID and all that phase. Because they said. . . things were hard for them. I would say it was 10 times harder [during the pandemic]'. (BC204, primiparous, 2020 birth)

Additionally, several multiparous participants expressed sympathy for primiparous parents during the pandemic

because they recognized how its associated circumstances might magnify the difficulties of pregnancy.

'I'm glad that this is our third and not our first because I think it would be really isolating and scary and sad to be doing this [becoming a parent] your first time during this [the pandemic]'. (BC205, multiparous, 2020 birth)

Experience of help-seeking

After identifying and attributing their feelings of anxiety and depression, all participants who reported feelings of depression and/or anxiety made decisions about whether and how to seek help for these feelings. Attribution was often linked to the type of help sought. While most participants sought mental health support from their social circles, some also sought formal support from different types of healthcare providers (see Figure 2). Similar help-seeking patterns between ON and BC participant groups were identified.

Social support. Almost all participants sought support from their social connections, engaging either in-person or virtual discussions with friends, family or online parenting groups. Most participants preferred in-person support as they found it helpful 'to just be present and have a conversation' (ON08, multiparous, 2021 birth), which could alleviate feelings of isolation for those who attributed isolation as an important contributing factor. Discussing challenges and concerns with these friends provided valuable encouragement and reassurance, ultimately reducing feelings of loneliness.

'they [friends with young children] were able to really help uplift me and not make me feel like I was alone in any of it. So that was really helpful'. (ON09, primiparous, 2020 birth)

Influence of public health policies. Nevertheless, some participants reported that accessing social support meant sometimes contradicting public health policies that encouraged physical distancing from non-household members. In some cases, the need for support prompted individuals to prioritize their mental well-being over strict adherence to provincial or municipal guidelines: 'I had no support aside from my mother-in-law down the street, and at that point, it was like, I'm going there. Like I need the help. I cannot do this alone' (ON37, primiparous, 2020 birth).

In contrast, some participants who experienced feelings of depression and/or anxiety became more socially withdrawn or isolated in an attempt to closely follow public health measures. For these individuals, fear of COVID-19 infection became a prominent barrier to accessing social support.

'No family, no friends, just me and my husband. [. . .] There was no village of support, and even [. . .] the few people that I could count in my village, we couldn't because we had to be super careful'. (BC204, primiparous, 2020 birth)

Table 2. Attribution factors for feelings of depression and anxiety.

Experience	Description	Exemplary quotes
COVID-19 infection risk and isolation	Many participants directly attributed their increased feelings of anxiety or depression to the COVID-19 pandemic, stating that it 'had a huge impact on [their] anxiety' (ON04, primiparous, 2021 birth), was 'a constant extra worry' (ON17, primiparous, 2020 birth) and increases feelings of isolation. These feelings of anxiety and depression were primarily driven by participants' fear of COVID-19 infection for themselves and baby. Some participants perceived prioritizing their child's health as part of their role as a new parent, which meant needing to navigate the ever-changing policies and lack of available information on child health outcomes after COVID-19 infection.	'[. . .] realizing how bad [the pandemic] actually was and that it wasn't actually going away, I felt terrible. Like I felt like we had made like a huge mistake, like should not have gotten pregnant, felt like what kind of awful world are we [. . .] bringing a baby into'. (ON30, multiparous, 2020 birth) 'I felt like if I got [COVID-19], then [my] baby wasn't going to live because it's just the way that it was coming across and the way that – even in the news and everything, just how bad it is, how people are dying'. (BC217, primiparous, 2021 birth)
Social tension due to personal beliefs around COVID-19 prevention efforts	Some participants who established social boundaries to protect their baby from COVID-19 infection also attributed their feelings of anxiety and depression to experiences of social tension from personal networks due to conflicting beliefs around these measures. These participants shared that others often thought their decisions were 'crazy' (ON01, primiparous, 2020 birth), and that remaining assertive about them caused 'a lot of strain on relationships' (ON22, multiparous, 2021 birth), 'tears' (ON17, primiparous, 2020 birth), and 'conflict' (ON16, primiparous, 2021 birth). When participants' loved ones opposed their decisions and boundaries, it aggravated feelings of social isolation and alienation.	'It was really hard to navigate. The first year was very hard. We had to just keep saying, you know, these are our beliefs, this is what we're doing. [. . .] it's nothing against you at all, it's to do with this virus, and right now, our belief is that we only [. . .] want her around mainly vaccinated people. So it was hard. It definitely caused [. . .] some family feud, for sure'. (ON07, primiparous, 2021 birth) 'I think that definitely caused some tension and concerns throughout the pregnancy – as they weren't on the same level, so there was definitely a lot of back and forth trying to request that they followed the restrictions'. (ON37, primiparous, 2020 birth)
Missed baby celebrations and milestones due to physical distancing	These efforts to strictly obey COVID-19 prevention measures impacted the appeal and feasibility of traditional social events during pregnancy. Most notably, primiparous participants attributed their feelings to the loss of important milestones and celebrations, stating that they were 'robbed' (BC204, primiparous, 2020 birth & BC205, multiparous, 2020 birth) or 'cheated' (BC204, primiparous, 2020 birth) of the moments that they have always 'pictured' (ON19, primiparous, 2021 birth & ON09, primiparous, 2020 birth) and 'dreamed of' (ON09, primiparous, 2020 birth). Participants commonly cited this as a contributor to their feelings of depression and anxiety during the lockdowns. For a few participants, this disconnect fostered 'feelings of resentment, [. . .] bitterness' (ON27, multiparous, 2020 birth) and 'anger' (ON08, multiparous, 2021 birth) towards their pregnancy experiences and, in some cases, their child.	'I felt very disconnected from the baby for the entire pregnancy [. . .] I think I just like put up a wall [. . .] I didn't like give him a name [. . .] I wasn't excited about it, and it's just obviously – I don't know, its just sad, there's no real like celebration'. (ON30, multiparous, 2020 birth) 'I've always wanted to be a mom. It's always been my dream. So, I remember saying to my mother-in-law this isn't how it's supposed to be, I was supposed to have a baby shower, and I was supposed to, you know, like have my baby and have people come and meet my baby'. (ON37, primiparous, 2020 birth)
Pandemic healthcare policies that impacted birthing experiences	Many participants also felt that pandemic policies, such as restrictions on hospital visitors and mandated COVID-19 testing prior to delivery, negatively altered their experience of clinical care, becoming a prominent source of their feelings of depression and anxiety. Participants primarily attributed these feelings to frequent changes in COVID-19 policies that would impact their labour and delivery plans, and access to prenatal health services.	'I feel for the people that are pregnant going through this because it is a very, ever-changing situation. Pregnancy is already stressful enough, and sometimes it's the policies that are scarier too, and the restrictions, than actual COVID. Like, my biggest fear was having to give birth on my own'. (ON07, primiparous, 2021 birth) 'So the first day of his entire life, his own mother was not able to be with him because a nurse made a poor choice and decided to COVID swab me while I was pushing a child out of me . . . so it really was an awful experience'. (ON09, primiparous, 2020 birth)

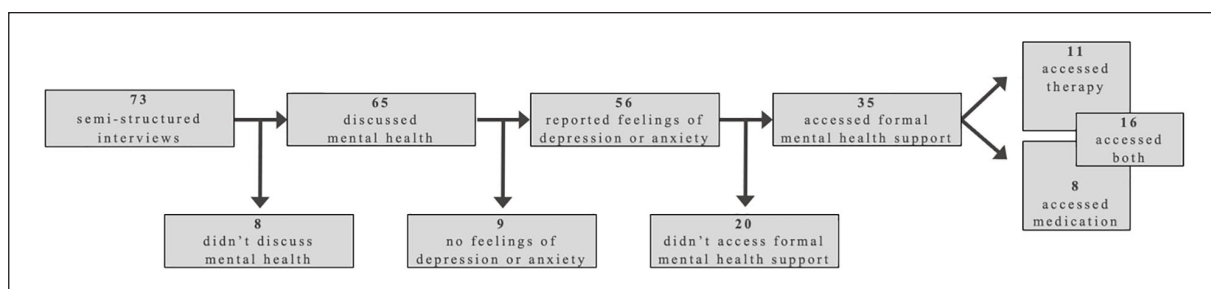


Figure 2. Types of formal support accessed ($n = 35$).

Loss of community. Participants reported that COVID-19 prevention measures affected their ability to seek face-to-face or hands-on social support, particularly for those with families living far away or those who lived in an area with high transmission rates.

‘Just like a lack of support because I felt like I couldn’t [ask for in-person support] because I would be putting my family at risk. So it was really just, it just felt like such a lonely, sad time, when I felt like should’ve been happy. I wished it would’ve been different’. (ON22, multiparous, 2021 birth)

Many participants also spoke about how closures of community social or recreational resources for new parents due to COVID-19 prevention measures meant missing out on ‘shared experience[s]... [as] it’s almost like therapy [when] sitting in a group of other moms’. (ON43, primiparous, 2020 birth) Regardless of whether participants chose to seek social support during the pandemic, all individuals discussed their desire to connect more than had been possible with family, friends or other new parents during this isolating time.

Formal mental health support. Of those who experienced feelings of depression or anxiety, 35 individuals proactively sought formal mental health support, which we defined as support provided by health or social care professionals. The forms of formal support reported by these participants were therapy, medication or both (see Figure 2 for more details).

Barriers. Of those who sought formal support, two individuals were unsuccessful in accessing their first choice of care provider due to barriers related to or exacerbated by the pandemic, including extensive waitlists, time-limited resources, lack of childcare, finances, previous negative experiences and delivery of services (see Table 3). One of these participants felt deterred from accessing counselling as an avenue of support as they felt it was too late to benefit by the time it was offered and instead pivoted to medication as an alternative while on the waitlist. Even when participants could access their first choice, some reported that it took longer than a year to receive an appointment.

As a result, a few participants only received postpartum mental health support because they anticipated these feelings before they arose and proactively sought these services during pregnancy.

One participant felt that they were fortunate to be prioritized for mental healthcare after experiencing a traumatic injury and surgery postpartum, as they were able to receive support immediately despite previously being on the waitlist for years. Many participants spoke about the decreased accessibility of mental healthcare due to pandemic closures and reported wanting more support and resources from their healthcare providers.

Facilitators. While many participants acknowledged the barriers that impacted their experiences accessing formal mental health support, some outlined potential facilitators, including strong relationships with support providers, history of successfully accessing care for depression and/or anxiety, and flexible or convenient modes of delivery for mental health services (Table 3).

Outcome of help-seeking

Thirty-three individuals described their overall experiences with formal mental health support as positive. Some participants described the process of seeking help as ‘life-changing’ (ON09, primiparous, 2020 birth), ‘a turning point’ (ON11, primiparous, 2020 birth) and wished they ‘wouldn’t have waited so long’ (ON13, multiparous, 2021 birth) to start.

‘I ended up going on depression medication, and it changed that time for me. It made me so much happier. I was able to be a good mom. I was able to get up every day and focus on my son and my health and caring for myself during that time’. (ON09, primiparous, 2020 birth)

Most participants were still accessing formal mental health support at the time of the interview. Four participants stopped seeking formal support because they felt their feelings of depression and/or anxiety had resolved over time, and three participants chose to discontinue treatments for other reasons (e.g. side effects of medication, unhelpful treatment).

Table 3. Experiences with barriers and facilitators to accessing support.

Experience	Definition	Exemplary quote
Barriers		
Extensive waitlists	Refers to a participant's long wait times before being offered a mental health consultation appointment with a healthcare provider.	'I did get to list for counselling. I got called a couple of months ago that my appointment was finally open. So, I was on the list for over a year. I just said no at that point, it had been over a year'. (ON12, multiparous, 2020 birth)
Continuity of care limitations	Refers to mental health resources that are only offered, or free, for a restricted period which limits the continuity of care.	'I was counselling with [hospital for women in BC] for a year, and then after that, they wrote a note to my family doctor on how to proceed with my meds. Yeah, and that's it, no more. I mean it's only one-year postpartum. [. . .] it doesn't go away after one year, that's not how. . . it's different for each person you know, I mean, there shouldn't be any time limit. [. . .] [I]t's very hard to switch like your healthcare professional when you're working with a counsellor or you know mental health social worker because you have to start all over again and it's very draining. You know, you'll feel like okay, I'm okay, I think I'm doing well and supported, and then you have to stop and switch and stay in a waitlist and, you know, it's, I feel like an ongoing process with the health worker'. (BC208, multiparous, 2021 birth)
Lack of childcare	Refers to childcare responsibilities that make it challenging for the participant to find time for mental health support.	'I have like two young kids at home. I don't really have childcare, and my husband works full-time. So, it was also like, when would I even have the time to go sit down and have a therapy session?' (ON13, multiparous, 2021 birth)
Economic	Refers to mental health support that required private payment which was a barrier to the participant.	'[. . .] at the time, I didn't have benefits, so I couldn't afford to pay for like a therapist because they're not cheap, and the free service, unfortunately, was about a one-year waitlist'. (ON12, multiparous, 2021 birth)
Previous negative experiences	Refers to a hesitancy to seek mental health support due to a negative experience with help received in the past.	'I was on medication in high school years ago and it always scared me to have to go back on something because that medication made me numb to the core. I didn't feel things for a long time'. (ON09, primiparous, 2021 birth)
Virtual care	Refers to the participant's preference for in-person mental health support, which was not widely available during the COVID-19 pandemic.	'I went through counselling and – well, to be honest, I didn't find it super helpful. Probably because I didn't have a good connection with my counsellor. [. . .] I think just like the face-to-face connection, like, seeing and being there, body gesture. [. . .] I'm just sharing my thoughts and personal things through a screen and not actually to a person. So, yeah, it just didn't feel right to me'. (BC201, primiparous, 2020 birth)
Facilitators		
Relationship with healthcare provider	Refers to a participant's long-term and trusting relationship with their provider that may make it easier to disclose feelings of anxiety and depression.	'It was extremely helpful, especially her having my history. Like I said, she'd been with me for so long, so she knew how I was. She knew way back when I first had issues with anxiety as a young kid. So, it was really helpful to have somebody who had been through that experience with me, and knew me, and understood me. [. . .] She's since closed her family practice, and I've switched to a new family doctor, and I'm pregnant again, and I kind of – if I was going through similar things I was going through then, it would've been a lot harder to manage this time around'. (ON04, primiparous, 2020 birth)
History of successfully accessing care for depression or anxiety	Refers to a participant proactively seeking mental health support before or early into the onset of feelings of anxiety and depression due to similar experiences in the past.	'[. . .] [T]his time around I knew that I had to be a bit more prepared with my relationships and what supports I might have in place and kind of like feeling like I have a plan. In case that postpartum depression or anxiety did creep up again. [. . .] [W]hen I found out that I was pregnant again and found out that we were having twins I was terrified, and then with the pandemic gearing up and all of these sort of unknowns, like, I just felt like that [counselling] was one thing that maybe could help me feel more prepared'. (BC206, multiparous, 2020 birth)

(Continued)

Table 3. (Continued)

Experience	Definition	Exemplary quote
Facilitators		
Support from healthcare provider	Refers to healthcare providers who the participant felt listened to them, and extensively supported their mental health needs.	'It was nice to have that conversation [about mental health support] ahead of time and feel my decision to reach out for help and just sort of plan for the long-term solution, was well-supported by both my doctor and my midwife. Which was a great feeling' (ON19, primiparous, 2021 birth)
Virtual care	Refers to the increased accessibility of mental health support when providers offer flexibility or alternative forms of care.	'My therapist was really understanding, she offered in-person sessions as well as virtual sessions, which was helpful. I could bring my toddler if I needed to, she was very easy going and if I was sick, I could do the appointment on the phone instead of coming in' (ON27, multiparous, 2020 birth)

Discussion

In this study, we report the diverse experiences of 56 individuals who described how the COVID-19 pandemic modified whether and how they sought support for their feelings of depression and/or anxiety during the perinatal period. These individuals cited COVID-19 infection risk, missed baby celebrations or milestones, social tension due to personal beliefs around COVID-19 prevention efforts and changes to policies that impacted birthing experiences as challenges and sources of stress that affected their mental health. These indirect and direct impacts of the COVID-19 pandemic changed their experience of these feelings of depression and/or anxiety; fear of infection contributed to participants' feelings and simultaneously increased their sense of isolation. Consequently, pandemic circumstances directly impacted how participants identified their feelings and the amount of informal and formal support sought for these feelings. Consistent with a systematic review of studies published before the COVID-19 pandemic, informal sources of help were more frequently accessed than formal support by those experiencing perinatal mental health challenges.²⁷

Although 33 out of 35 participants who sought formal mental health support reported positive experiences, many of them also had difficulties accessing these services. Extensive waitlists, economic restraints, continuity of care limitations, community program closures and inadequate mental health services were significant barriers to help-seeking cited by participants. However, several participants in this study and others also relayed facilitators to accessing care, including the availability of virtual appointments and flexibility from care providers who made extra efforts to arrange timely mental healthcare.^{28,29} The findings of previous research echo overarching sentiments shared by participants in the current study, with most emphasizing the amplified psychosocial burden on pregnant and postpartum individuals during

the pandemic^{1,30–40} due to the downstream effects of public health policies that decreased access to timely and adequate mental health services or community social resources.^{2,5,15,16,27,28} Pandemic circumstances further compounded existing inequities and barriers to culturally safe and trauma-informed mental health support, such as stigma, healthcare provider training, attitudes and screening practices, socioeconomic limitations and sparse publicly funded mental health resources.²⁹ These barriers to accessing perinatal mental health support existed before the pandemic,^{41–43} but reports from many regions emphasize the magnification experienced by many as a result of COVID-19.^{28,44,45}

This is the first qualitative study, to our knowledge, to examine whether and how pregnant and postpartum Canadians executed help-seeking for feelings of depression and/or anxiety during the COVID-19 pandemic. Our findings highlight important implications for clinicians and policymakers related to the provision and delivery of perinatal mental health support. Ontario and BC have established different protocols for perinatal mental health screening using standardized health records (ON, BC) and a formal perinatal mental health program (BC).^{46–48} In Ontario, universal perinatal mental health screening is not mandated, and individual health units develop independent protocols, most typically involving mental health screening during pregnancy and again at 6–12 weeks postpartum with validated screening tools.⁴⁷ British Columbia has established a strategy that strongly encourages mental health screening for all birthing individuals between weeks 28–32 of pregnancy and 6–8 weeks postpartum with validated tools.^{47,49} Despite the robust screening processes in ON and BC, few participants in this study recalled their healthcare providers initiating inquiries about their mental health or conducting mental health screening at the time they were experiencing feelings of depression and/or anxiety, suggesting potential low implementation during the early COVID-19 pandemic. One potential explanation for

these discrepancies was disruptions to in-person prenatal and postpartum care during the pandemic, which may have decreased opportunities for providers to execute mental health screening at a time when participants were actively experiencing feelings of depression and/or anxiety.^{5,50} Another is participant recall; perhaps the screening questions were asked in earlier perinatal care appointments when the questions were not yet relevant to their feelings, decreasing the likelihood they would be remembered during the time of the interview.

Overall, participants in this study reported wanting more healthcare provider-initiated conversations and screening for mental health; this finding is echoed in other literature investigating public and perinatal individuals' preferences for mental health screening.^{51–53} Universal perinatal mental health screening is controversial, with wide endorsement but also longstanding contestations of efficacy.^{46,51} The Canadian Task Force on Preventative Health Care (CTFPHC) recommends against universal perinatal mental health screening, suggesting providers conduct targeted screening only for individuals with evident symptoms.⁴⁹ BC has since published a provincial position statement in support of universal screening (opposing the CTFPHC's recommendation), further affirming participant narratives in this study about the value of regulatory screening protocols and implementation into practice.⁴⁹ Existing research has endorsed the efficacy of validated perinatal mental health screening tools in identifying and improving health outcomes related to depression and/or anxiety.^{54,55}

Implications

Healthcare provider-initiated screening and conversations about mental health can play a key role in the early identification of feelings of depression and/or anxiety while reducing the perceived stigma associated with addressing mental health concerns.^{12,56,57} The lived experiences of these study participants call attention to the shortcomings of perinatal mental healthcare infrastructure, the need for more readily accessible virtual and in-person resources, and the need to implement more frequent mental health screening throughout pregnancy and postpartum care appointments. While guidelines for perinatal mental health screening currently exist, they could be strengthened to ensure accessible and culturally safe screening occurs at multiple points in the care trajectory.^{16,44} In line with ongoing conversations about the value of universal screening, current guidelines could advocate for enhanced training for healthcare providers to appropriately target, conduct and follow up effectively on screening for perinatal depression and anxiety. This will facilitate the participation of healthcare providers in working with patients to identify the need for psychosocial support.¹⁶ Alternative delivery options for perinatal mental healthcare and screening, such as virtual,

home visitation or community-based interventions, may better meet the needs of this population and ensure support remains accessible during public health emergencies.^{44,58,59} Our findings extend beyond pandemic circumstances and offer valuable insight into everyday experiences of mental health during pregnancy, including the importance of social and instrumental support for new parents.

Strengths and limitations

With a qualitative descriptive approach, we capture pregnant and postpartum individuals' lived experiences navigating the help-seeking process and report themes grounded in their subjective perspectives and interpretations with rich detail. A possible limitation of this study is its retrospective nature and reliance on self-reported data. Recall accuracy and social desirability bias of participants could reduce the accuracy of the data. Nevertheless, the proportion of participants who self-identified as experiencing feelings of depression and/or anxiety is reflective of existing literature that reports high rates of these mental health conditions in perinatal populations, especially during the COVID-19 pandemic.^{1–3,16} The majority of participants in this study were White (70%) and university-educated (72%). While participant demographics in this study reflect the wider demographics of people of reproductive age in Canada (70% identify as White and 76% have a college or university education),^{18,60} it may be important for future work to focus specifically on the experiences of culturally and economically marginalized pregnant and postpartum people to understand potentially distinct experiences, equity issues and policy-relevant needs.⁶¹ Lastly, while we intended to collect self-reported genders of participants, an administrative error resulted in missing gender data for approximately one-third of the study sample.

Conclusion

Pregnant and postpartum individuals who gave birth during the COVID-19 pandemic experienced feelings of depression and/or anxiety due to a combination of factors, including isolation, fear of infection and uncertainty. Those who chose to seek formal support for their experiences encountered barriers to access that were likely pre-existing but amplified by the pandemic. Self-reported perinatal depression and anxiety were prevalent in this study and can potentially impact the well-being of pregnant and postpartum people as well as their children and families. The findings from this study highlight the importance of periodic mental health screening to improve the accessibility of mental healthcare and support. Recognizing how and why pregnant and postpartum individuals seek support for feelings of depression or anxiety can inform future health policy to better serve this population.

Declarations

Ethics approval and consent to participate

Ethics approval was obtained from the Hamilton Integrated Research Ethics Board (#14632) and the University of British Columbia Behavioural Research Ethics Board (H22-01905). Written and verbal informed consent was obtained from all participants prior to participation in the study.

Consent for publication

Written informed consent for publication was provided by all participants.

Author contributions

Katrina Shen: Conceptualization; Data curation; Formal analysis; Investigation; Writing – original draft; Writing – review & editing.

Cassandra Kuyvenhoven: Data curation; Formal analysis; Investigation; Writing – review & editing.

Andrea Carruthers: Investigation; Writing – review & editing; Formal analysis; Data curation.

Manisha Pahwa: Conceptualization; Formal analysis; Writing – original draft; Writing – review & editing.

Dima Hadid: Formal analysis; Writing – original draft; Writing – review & editing.

Devon Greyson: Conceptualization; Formal analysis; Funding acquisition; Writing – review & editing; Supervision.

Hamideh Bayrampour: Conceptualization; Formal analysis; Writing – review & editing.

Jessica Liauw: Conceptualization; Formal analysis; Writing – review & editing.

Caroline Mnizak: Investigation; Writing – review & editing; Formal analysis.

Meredith Vanstone: Conceptualization; Funding acquisition; Methodology; Formal analysis; Project administration; Resources; Supervision; Writing – original draft; Writing – review & editing.

Acknowledgements

The authors thank Sujane Kandasamy, Shipra Taneja, Njideka Sanya and Marina Sadik for their contributions to study conceptualization, data collection and/or participant recruitment.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by Canadian Institutes of Health Research grant number 179921. MV is supported by a Canada Research Chair (Tier 2) in Ethical Complexity in Primary Care. Neither funding source played a role in the research design, conduct or reporting.

Competing interests


The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Availability of data and materials

The interview data supporting these findings are not publicly available due to the potentially identifying nature of entire transcripts.

ORCID iDs

Katrina Shen  <https://orcid.org/0009-0000-4982-5204>

Hamideh Bayrampour  <https://orcid.org/0000-0003-3008-712X>

Meredith Vanstone  <https://orcid.org/0000-0002-7347-6259>

Supplemental material

Supplemental material for this article is available online.

References

1. Ahmad M and Vismara L. The psychological impact of COVID-19 pandemic on women's mental health during pregnancy: a rapid evidence review. *Int J Environ Res Public Health* 2021; 18: 7112.
2. Davenport MH, Meyer S, Meah VL, et al. Moms are not OK: COVID-19 and maternal mental health. *Front Glob Womens Health* 2020; 19: 1.
3. Lebel C, MacKinnon A, Bagshawe M, et al. Elevated depression and anxiety symptoms among pregnant individuals during the COVID-19 pandemic. *J Affect Disord* 2020; 277: 5–13.
4. López-Morales H, del Valle MV, Canet-Juric L, et al. Mental health of pregnant women during the COVID-19 pandemic: a longitudinal study. *Psychiatry Res* 2021; 295: 113567.
5. Lucas DN and Bamber JH. Pandemics and maternal health: the indirect effects of COVID-19. *Anaesthesia* 2021; 76: 69–75.
6. Jackson L, De Pascalis L, Harrold JA, et al. Postpartum women's experiences of social and healthcare professional support during the COVID-19 pandemic: a recurrent cross-sectional thematic analysis. *Women Birth* 2022; 35: 511–520.
7. Ali S, Asaria M and Stranges S. COVID-19 and inequality: are we all in this together? *Can J Public Health* 2020; 111: 415–416.
8. Mishra S, Ma H, Moloney G, et al. Increasing concentration of COVID-19 by socioeconomic determinants and geography in Toronto, Canada: an observational study. *Ann Epidemiol* 2022; 65: 84–92.
9. Ndumbe-Eyoh S, Muzumdar P, Betker C, et al. 'Back to better': amplifying health equity, and determinants of health perspectives during the COVID-19 pandemic. *Promot Educ* 2021; 28: 7–16.
10. Jenkins EK, McAuliffe C, Hirani S, et al. A portrait of the early and differential mental health impacts of the COVID-19 pandemic in Canada: findings from the first wave of a nationally representative cross-sectional survey. *Prev Med* 2021; 145: 106333.
11. Johnston C, Fairbrother N, Butska L, et al. Systematic screening or perinatal anxiety and why it matters. *J Obstet Gynaecol Can* 2024; 46: 102240.
12. O'Hara MW and Wisner KL. Perinatal mental illness: definition, description and aetiology. *Best Pract Res Clin Obstet Gynaecol* 2014; 28: 3–12.
13. Misri S, Abizadeh J and Nirwan S. Depression during pregnancy and the postpartum period. In: Wenzel A (ed.) *Oxford handbooks online*. 2014.
14. O'Hara MW and Swain AM. Rates and risk of postpartum depression-a meta-analysis. *Int Rev Psychiatry* 1996; 8: 37–54.

15. Ashcroft R, Donnelly C, Dancey M, et al. Primary care teams' experiences of delivering mental health care during the COVID-19 pandemic: a qualitative study. *BMC Fam Pract* 2021; 22: 143.
16. Hicks LM, Ou C, Charlebois J, et al. Assessment of Canadian perinatal mental health services from the provider perspective: where can we improve? *Front Psychiatry* 2022; 13: 929496.
17. Vanstone M, Correia RH, Howard M, et al. How do perceptions of Covid-19 risk impact pregnancy-related health decisions? A convergent parallel mixed-methods study protocol. *PLoS One* 2023; 18: e0288952.
18. Statistics Canada. The Canadian census: a rich portrait of the country's religious and ethnocultural diversity, <https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026b-eng.htm> (2022, accessed 18 September 2024).
19. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000; 23: 334–340.
20. Neergaard MA, Olesen F, Andersen RS, et al. Qualitative description – the poor cousin of health research? *BMC Med Res Methodol* 2009; 9: 52.
21. Tong A, Sainsbury P and Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007; 19: 349–357.
22. Government of Canada. COVID-19 epidemiology update: current situation, https://health-infobase.canada.ca/covid-19/current-situation.html?stat=num&measure=cases_total&map=pt#a2 (2023, accessed 18 September 2024).
23. Statistics Canada. Canadian Vital Statistics – birth database, <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&Id=1456141> (2022, accessed 18 September 2024).
24. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant* 2018; 52: 1893–1907.
25. Boeije H. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Qual Quant* 2002; 36: 391–409.
26. Flick U. *Triangulation in qualitative research*. Thousand Oaks, CA: SAGE, 2004.
27. Daehn D, Rudolf S, Pawils S, et al. Perinatal mental health literacy: knowledge, attitudes, and help-seeking among perinatal women and the public – a systematic review. *BMC Pregnancy Childbirth* 2022; 22: 574.
28. Pilav S, Easter A, Silverio SA, et al. Experiences of perinatal mental health care among minority ethnic women during the COVID-19 pandemic in London: a qualitative study. *Int J Environ Res Public Health* 2022; 19: 1975.
29. Webb R, Uddin N, Constantinou G, et al. Meta-review of the barriers and facilitators to women accessing perinatal mental healthcare. *BMJ Open* 2023; 13: e066703.
30. Atmuri K, Sarkar M, Obudu E, et al. Perspectives of pregnant women during the COVID-19 pandemic: a qualitative study. *Women Birth* 2022; 35: 280–288.
31. Green SM, Furtado M, Inness BE, et al. Characterizing worry content and impact in pregnant and postpartum women with anxiety disorders during COVID-19. *Clin Psychol Psychother* 2022; 29: 1144–1157.
32. Kumari A, Ranjan P, Sharma KA, et al. Impact of COVID-19 on psychosocial functioning of peripartum women: a qualitative study comprising focus group discussions and in-depth interviews. *Int J Gynecol Obstet* 2021; 152: 321–327.
33. Sullivan E, Cameron A and Kornelsen J. Rural residents' perinatal experiences during the initial months of the COVID-19 pandemic: a qualitative study in British Columbia. *J Midwifery Womens Health* 2022; 67: 488–495.
34. Preis H, Mahaffey B, Heiselman C, et al. Vulnerability and resilience to pandemic-related stress among U.S. women pregnant at the start of the COVID-19 pandemic. *Soc Sci Med* 2020; 266: 113348.
35. Morden MV, Ferris EJ-E and Furtmann J. The socioemotional impact of the COVID-19 pandemic on pregnant and postpartum people: a qualitative study. *CMAJ Open* 2023; 11: E716–E724.
36. Cameron EE, Joyce KM, Delaquis CP, et al. Maternal psychological distress & mental health service use during the COVID-19 pandemic. *J Affect Disord* 2020; 276: 765–774.
37. Jackson L, De Pascalis L, Harrold JA, et al. Postpartum women's psychological experiences during the COVID-19 pandemic: a modified recurrent cross-sectional thematic analysis. *BMC Pregnancy Childbirth* 2021; 21: 625.
38. Mari F, Capasso M and Caso D. Exploring the psychosocial impact of the Covid-19 pandemic on women's perinatal experiences and wellbeing: a qualitative study. *Sex Reprod Healthc* 2023; 35: 100805.
39. Kolker S, Biringer A, Bytautas J, et al. Pregnant during the COVID-19 pandemic: an exploration of patients' lived experiences. *BMC Pregnancy Childbirth* 2021; 21: 851.
40. Bayrampour H, Tamana SK and Boutin A. Pregnant people's responses to the COVID-19 pandemic: a mixed-methods, descriptive study. *CMAJ Open* 2022; 10: E146–E154.
41. Dennis CL and Chung-Lee L. Postpartum depression help-seeking barriers and maternal treatment preferences: a qualitative systematic review. *Birth* 2006; 33: 323–331.
42. Schwartz H, McCusker J, Law S, et al. Perinatal mental healthcare needs among women at a community hospital. *J Obstet Gynaecol Can* 2021; 43: 322–328.e321.
43. Sambrook Smith M, Lawrence V, Sadler E, et al. Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. *BMJ Open* 2019; 9: e024803.
44. Deroche C, Hooykaas A, Ou C, et al. Examining the gaps in perinatal mental health care: a qualitative study of the perceptions of perinatal service providers in Canada. *Front Glob Womens Health* 2023; 4: 1027409.
45. Bridle L, Walton L, Van Der Vord T, et al. Supporting perinatal mental health and wellbeing during COVID-19. *Int J Environ Res Public Health* 2022; 19: 1777.
46. Hippman CL, Adham M, Zlobin C, et al. An environmental scan of perinatal mental health infrastructure across Canada. *J Obstet Gynaecol Can* 2022; 44: 745–746.
47. Hippman CL. Maternal mental health: is Canada doing enough? A review of maternal mental health support across the country, https://www.lifewithababy.com/resources/Documents/Maternal%20Mental%20Health%20Support%20in%20Canada_%20A%20Review.pdf (2021, accessed 18 September 2024).
48. Grisbrook M-A and Letourneau N. Improving maternal postpartum mental health screening guidelines requires assessment of post-traumatic stress disorder. *Can J Public Health* 2021; 112: 240–243.

49. BC Reproductive and Mental Health Program & Perinatal Services BC. Best Practice Guidelines for Mental Health Disorders in the Perinatal Period. <http://www.bcwomens.ca/Professional-Resources-site/Documents/Best%20Practice%20Guidelines%20for%20Mental%20Health%20Disorders%20in%20the%20Perinatal%20Period%20%282014%29.pdf> (2014, accessed 18 September 2024).
50. Groulx T, Bagshawe M, Giesbrecht G, et al. Prenatal care disruptions and associations with maternal mental health during the COVID-19 pandemic. *Front Glob Womens Health* 2021; 2: 648428.
51. Lang E, Colquhoun H, LeBlanc JC, et al. Recommendation on instrument-based screening for depression during pregnancy and the postpartum period. *CMAJ* 2022; 194: E981–E989.
52. Kingston DE, Biringer A, McDonald SW, et al. Preferences for mental health screening among pregnant women. *Am J Prev Med* 2015; 49: e35–e43.
53. Kingston D, McDonald S, Tough S, et al. Public views of acceptability of perinatal mental health screening and treatment preference: a population based survey. *BMC Pregnancy Childbirth* 2014; 14: 67.
54. Waqas A, Koukab A, Meraj H, et al. Screening programs for common maternal mental health disorders among perinatal women: report of the systematic review of evidence. *BMC Psychiatry* 2022; 22: 54.
55. El-Den S, Pham L, Anderson I, et al. Perinatal depression screening: a systematic review of recommendations from member countries of the Organisation for Economic Co-operation and Development (OECD). *Arch Womens Ment Health* 2022; 24: 54.
56. Koschorke M, Oexle N, Ouali U, et al. Perspectives of healthcare providers, service users, and family members about mental illness stigma in primary care settings: a multi-site qualitative study of seven countries in Africa, Asia, and Europe. *PLoS One* 2021; 16: e0258729.
57. Johnson A, Stevenson E, Moeller L, et al. Systematic screening for perinatal mood and anxiety disorders to promote onsite mental health consultations: a quality improvement report. *J Midwifery Womens Health* 2021; 66: 534–539.
58. Saad A, Magwood O, Aubry T, et al. Mobile interventions targeting common mental disorders among pregnant and postpartum women: an equity-focused systematic review. *PLoS One* 2021; 16: e0259474.
59. Tabb KM, Bentley B, Pineros Leano M, et al. Home visiting as an equitable intervention for perinatal depression: a scoping review. *Front Psychiatry* 2022; 13: 826673.
60. Statistics Canada. Educational attainment of the population aged 25 to 64, by age group and sex, Organisation for Economic Co-operation and Development (OECD), Canada, provinces and territories, <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3710013001> (2023, accessed 18 September 2024).
61. Ahmed R, Jamal O, Ishak W, et al. Racial equity in the fight against COVID-19: a qualitative study examining the importance of collecting race-based data in the Canadian context. *Trop Dis Travel Med Vaccines* 2021; 7: 15.