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Childbirth Narratives in the Canton of Ticino (Switzerland): Perceptions and Experiences of Mothers Who Gave Birth before and during COVID-19

This article analyzes written and oral narratives of pregnancy, childbirth, and postpartum produced by women who gave birth before and during the COVID-19 pandemic in Italian-speaking Switzerland. By using textual analysis and qualitative descriptive research methodologies, I compare birth stories in two autobiographical essays published before the pandemic in 2018 and 2019 and twenty-three oral testimonies from women who birthed between March 2020 and March 2021. The aim of the exploratory study is to highlight the main elements that define positive and negative birth experiences to understand how better outcomes could be achieved in society and medical practice. The present article discusses preliminary results and addresses possible strategies to improve obstetrical and maternal care in the postpandemic period.

Introduction: Methodology, Texts, and Context

Trauma and mistreatment in childbirth are widespread and recurrent. In Switzerland, one in three women remembers the birth of her children as traumatic,[1] whereas one in four experiences some form of coercion during labour and delivery.[2] These data reflect a dramatic occurrence that was further aggravated by COVID-19 and the resulting tightening measures and hospital protocols. This research discusses experiences of pregnancy, childbirth, and postpartum before and during the pandemic in the Canton of Ticino, Switzerland, and highlights some key elements that define birth as positive or negative. It outlines how better birth outcomes could be achieved in our society to bring effective change in medical practice.

The focus of the present study is to analyze how childbirth was experienced in Swiss-based Italian-speaking culture and society before and during the COVID-19 pandemic by investigating a selection of written and oral narratives. By using textual analysis and qualitative descriptive research methodologies,[3] this article compares birth stories in two autobiographical essays published before the pandemic in 2018 and 2019 with a series of oral testimonies from women who gave birth during the pandemic between 2020 and 2021. The autobiographical essays considered here are Isabella Pelizzari Villa's *Volevo andare a partorire in Olanda: Storia di un taglio cesareo annunciato* [*I Wanted to Give Birth in Holland: Story of An Announced Cesarian Section*] (2018) and Angela Notari's *Quello che ci unisce. Dalla levatrice Lucia al nostro e vostro parto* [*What Unites Us: From Midwife Lucia to Our and Your Childbirth*] (2019).[4] The former recounts a traumatic birth in a private clinic, whereas the latter tells an empowering and positive delivery in a birth centre. Comparing pre-COVID-19 accounts and those collected during the pandemic highlights recurring themes and differences in how childbirth is experienced.[5] In the oral interviews, participants were asked to describe their pregnancy, birth, and postpartum in a narrative way by focussing on positive and negative aspects. They were also required to suggest any change that would help to enhance maternal care. In the present article, I discuss some preliminary results and address possible strategies to improve obstetrical and maternal care in the postpandemic period.

Oral Narratives: Sample

Between April and May 2021, I conducted twenty-three semistructured interviews with mothers who gave birth between March 2020 and March 2021 (see Table 1).[6] The women were recruited by word of mouth, were between twenty-six and forty-two years old at the moment of the interview (see Table 2),[7] had between one and four children (see Table 3), and were married or in a stable relationship.[8] Five of them have foreign origins: Ukraine (one), Sweden (one), and Italy (three). One had relocated from a German-speaking canton of Switzerland, and one had been adopted as a child and grew up in the Canton of Ticino. The others were born and raised in Italian-speaking Switzerland (sixteen) (see Table 4). Among the twenty-three interviews, twenty-two were conducted in Italian and one in English. Besides one interviewee who had only recently moved to the Canton of Ticino, the others speak fluently Italian. They all gave birth to their first or subsequent child during the COVID-19 pandemic and lived in the Canton of Ticino at the time of the interview. Seven gave birth in private clinics, eight in public hospitals, four at home, and four in a birth centre (see Table 5).[9] In four cases, the choice of the facility was influenced by the pandemic,[10] whereas five women had to be transferred to a different place before or during labour.[11]

Twelve mothers had a natural vaginal birth without interventions, whereas the others experienced one or more medical procedures: mechanical or pharmacological induction or augmentation of labour (five), nonemergency caesarean section (two), elective caesarean section (one), epidural or other forms of analgesia (four), episiotomy (two), and vacuum extraction (two) (see Table 6).[12]

One of the few criteria for selecting the interviewees was the place of delivery. I wanted to make sure that stories of birth in private and public hospitals, at home, and in a birth centre were equally represented. Other criteria considered here were that babies were born alive, at term, and did not have life-threatening conditions.[13] The subjectivity of the narratives and the qualitative nature of the study do not intend to be representative or offer irrefutable data. The sample is not meant to speak for the entire population either, since each mother experiences birth in different ways, and all women interviewed happen to be cisgender, educated, heterosexual, and in a stable relationship. Two of them are BIPOC, whereas all the others are Caucasians. My aim, instead, is to give voice to a selection of women's stories to understand what aspects can likely determine a positive, empowering experience rather than a negative, traumatic one. This preliminary research lays the foundation for future studies that will focus on other experiences and encompass diverse subjectivities.

Giving Birth before COVID-19

Memoirs written before the pandemic by Isabella Pelizzari Villa and Angela Notari shed light on two very different narratives of childbirths in diverse contexts: The first tells a traumatic story of a twin delivery in a private clinic,[14] while the latter addresses an empowering and positive experience in a birth centre.[15] Both writers are feminist, cisgender, educated, heterosexual, married to the father of their children, and originally from the Canton of Ticino. Pelizzari Villa is Caucasian, whereas Notari defines herself as BIPOC. This article first addresses some key aspects that—according to the authors—contributed to defining their positive and negative experiences and later compares them with the testimonies collected in the interviews.

Isabella Pelizzari Villa published her memoir *Volevo andare a partorire in Olanda. Storia di un taglio cesareo annunciato* to reveal the abuse she endured during pregnancy, birth, and postpartum. Writing her story helped her to process trauma and assist her readers in making informed and empowered decisions. Some aspects that contributed to her negative experience are lack of trust in her healthcare providers, the full package of medical interventions that was imposed on her,[16] and a series of procedures performed without asking for her consent or offering alternatives:

> During the visit [the OB] performs a membrane sweep, without

> informing me of the procedure and asking for my consent. During the maneuver, I stiffen and contract the muscles of my face. As he takes off his gloves, he tells me that he gave me 'a little help,' glossing over the discomfort caused and taking the procedure for granted…. According to my doctor, there is no point in prolonging physical pain. In good faith, he believes that I want a quick labor, even though he never asked me about my preferences…. The midwife breaks the first amniotic sac by slipping two fingers and a crochet into my vagina and cervix. The liquid comes out abundantly and clear. I do not agree with this intervention, which I consider an intrusive interference in the physiological process of childbirth, but I no longer object. (Pelizzari Villa pos. 3123-232)

Since Pelizzari Villa and her OB did not manage to communicate effectively, she did not obtain information that was important to her: "With my OB I was not able to build a relationship of trust. Like children, I needed to feel safe to be able to ask questions that mattered to me. I didn't feel understood, but instead of changing doctor I resigned myself" (pos. 149). Her twin daughters were taken away from her after the caesarean section was performed: "My girls are fine at birth. The Apgar score of both is 8/9 out of 10. V. weighs 2500 grams and S. 2600. They are both placed in the incubator for three hours, either because they are twins or to amortize the cost of the machinery. I won't see them again until morning" (pos. 3755-63). Furthermore, Pelizzari Villa did not feel assisted right after birth or in the postpartum period: "Until a few hours earlier I was the obsessive object of care, concern, attention, and medical interventions. Now I feel abandoned like an empty shell. My doctor has done his job. He extracted two 'alive' and 'viable' girls from their mother's belly. Now he can leave for his holidays without any feeling of guilt" (pos. 4730).

Another nuisance that was perceived in negative terms by the writer was the mandatory use of the Venflon IV catheter in all hospital births:

> I inform [the OB] that I do not agree with the use of Venflon IV catheter. He replies that he understands my position but is not willing to negotiate. If I refuse it, I will not give birth with him. He is willing to 'dump me' without referring me to someone else or providing any useful advice.… In the past, protocols limited the application of Venflon to high-risk cases, but in current clinical practice it is generalized. A minority of women question the staff about the usefulness of this procedure. (pos. 2668-706)

In a tentative attempt to be fully in charge of her own experience, Pelizzari Villa considered the opportunity to give birth at home, assisted by an independent midwife. To her regret, she discovered that twin pregnancies in Switzerland must be assisted by an OB. Therefore, the only option left to her

was to deliver her babies in a hospital under medical assistance:

> The more I feel that I did not have the power to dictate the rules, the more the choice of natural childbirth became radical and attractive. In January, I contacted an independent midwife to ask her about home birth. In my thoughts, the house was the suitable, familiar, and protected environment to give birth. I discovered that in Switzerland for twin births medical assistance was mandatory. My ideal birth was opposed by society, doctors, and family. (pos. 2746)

Unlike Pelizzari Villa, the option to have her child in a birth centre was not precluded to Angela Notari. In her memoir *Quello che ci unisce. Dalla levatrice Lucia al nostro e vostro parto*, Notari highlights some key aspects of her positive birth experience. Her book informs and empowers women while celebrating alternative options, which are still little explored in the Canton of Ticino, such as giving birth outside the hospital, assisted by an independent midwife.

The writer and her husband educated themselves, explored different options, and gathered information that helped them to make informed decisions: "During the months of pregnancy, we educated ourselves, by gathering information, participating in meetings with couples who had their babies in the birth centre, and preparing for the event" (Notari 27).

Notari trusted her healthcare providers with whom she managed to build a good relationship and felt always treated with respect and empathy. Of course, the choice to have her baby in a birth centre was made possible by a series of favourable occurrences: Her pregnancy was physiological, she fulfilled all the conditions required for home birth, and no special circumstances that may have required a transfer to a hospital arose. Some of the aspects that greatly contributed to her positive experience were the continued and personalized care she received from her midwife:

> Another important difference is the fact that [in a birth centre] you already know the health care provider who will assist you during birth. In a hospital, it is often not possible to know ahead of time the midwife who will take care of you during birth—which, if labor is long—can involve changing several shifts, and, therefore, being assisted by numerous strangers in a situation of great vulnerability. On the other hand, at home or in a birth center, you are certain to be assisted by the midwife or your choice, the one you already met during pregnancy. Being supported by a person you already know is no small thing. (102)

Finally, Notari recalls her place of birth as exclusive, quiet, and safe:

> Personally, I do remember well how important it was to have our baby in an environment where there were no watches, and we did not feel

> just like one of the many couples who were giving birth that day. We found ourselves in an exclusive environment, prepared just for us, where it seemed that the rest of the world was waiting in silence. I have no evidence, but if it only took five hours for Furio to be born, I think it is because of this muffled atmosphere that made us feel safe. (102-3)

Giving Birth during COVID-19

To better understand how pregnancy, childbirth, and postpartum were experienced during the pandemic, this article addresses some of the most recurrent topics emerging from the interviews by highlighting how they shaped the events in a positive or negative way. Despite concerns about getting sick and the uncertainties related to the possible effects of the illness on mothers and their fetuses, the outburst of COVID-19 and the subsequent lockdowns had a rather positive impact on how pregnancy and postpartum were perceived. Most of the interviewees, in fact, explained that gestation was made easier by COVID-19. Due to the pandemic, expecting women were able to work from home and felt entitled to slow down and focus on themselves. Overall, they enjoyed spending more time with their partner, and the restrictions allowed them to take full advantage of the situation. However, social distancing and the need to protect the elderly put a greater burden on mothers of multiple children. In fact, some of the women who had older kids at home expressed some reservations: Taking care of them, entertaining them, and not being able to rely on the help of teachers and other family members made their life balance more challenging than first-time moms.[17]

Similar reactions were noticed in the postpartum period. In the first days and weeks, most women appreciated being able to focus exclusively on themselves and their families without interference from relatives and friends. Since guests were usually not allowed inside the hospital, and social distancing was recommended everywhere else, COVID-19 restrictions protected moms from receiving unwanted visits. Women expressed feelings of relief because they did not need to make up excuses or reluctantly endure other people's presence. If restrictions were generally appreciated by most of the interviewees, it was also clear from their stories that exceptions need to be made to allow partners to have a more flexible access to the hospital and older siblings to be permitted in the room after birth.

If the pandemic had some positive repercussions on pregnancy and postpartum, labour and delivery in a hospital setting were more challenging. Stricter protocols, restrictions, and uncertainties were perceived as burdensome and increased women's confusion and concerns about childbirth.[18] All but one considered the presence of the partner as nonnegotiable and could not have

imagined giving birth without him. Therefore, women who were delivering a baby in a hospital worried that their partner may not be allowed to assist, whereas those who were planning to give birth at home or in a birth centre feared that the presence of their companions may be jeopardized in the event of a transfer to a hospital.

Three women who gave birth in public hospitals reported that their partners were not allowed to assist them during induction. Birth companions were admitted to the hospital only hours later when active labour had eventually begun. Enduring emotional and physical distress without being supported by the person of their choice was upsetting. Women believed that a different solution should be provided even in the event of a pandemic.[19] In some cases, women in labour shared the room with another patient, which aggravated the situation, adding stress and nuisance to an already trying experience. One of the interviewees gave birth alone through a caesarian in a private clinic. Since there was no time to perform a COVID-19 test, her husband was not allowed in the OR. In her personal account, however, this aspect, albeit disappointing, was not perceived as particularly distressing.

Continuity of care appears to be another criterium for positive experiences. The level of satisfaction of the seven women who gave birth out of hospital is consistently high. The reasons may be related to the fact that their labour was physiological, they had no complications, they were not transferred to another facility, and their partner could assist them with no limitations. But above all, they managed to develop a strong bond with midwives earlier in their pregnancy and eventually gave birth in a place they considered safe, calm, and cozy, where they were neither disturbed by the coming and going of different people nor had to share the room with unfamiliar faces. Overall, being able to rely on a trusted and competent professional figure with whom they had built a deep personal connection and who would take care of them before, during, and after birth had a large impact on their positive experience.

In a hospital setting, the level of satisfaction varies: Some experiences are positive, others quite negative, and again others are remembered with mixed feelings. In this context, continuity of care provided by a person the mother already knows and with whom had previously built a relationship is hardly possible. Unlike what happens at home or in a birth centre, in the Canton of Ticino's private and public hospitals women are not assisted by the midwife of their choice but by the employees on duty. Moreover, when labour is protracted, shifts can change, and women end up meeting several midwives. Whereas some interviewees were satisfied with the care they received, others felt they were not treated with empathy and respect. Outcomes are influenced by many factors, such as patients' and healthcare providers' personality, age, previous experiences, expectations, complications, medical interventions, and transfers from another facility, just to mention a few. Although their level of satisfaction

varied greatly, shift change had a stressful impact on all women's experiences. Even when they managed to build good relationships, starting all over with another person was described as nerve racking. Two mothers met a healthcare provider they already knew, and according to them, this fortuitous event initially improved the care they received. Nonetheless, the subsequent transition to a different healthcare provider was referred to as destabilizing. Women would have appreciated if midwives had facilitated smoother transitions and guaranteed more continuity in the way care was provided.

Another negative aspect frequently reported in hospital experiences was the lack of adequate information and communication. To the mothers' knowledge, medical interventions—when they occurred—were not clearly explained to them. In addition to this, healthcare providers did not offer alternatives, nor did they ask for the mothers' informed consent. Women who had devoted time to prepare for a natural birth and had previously educated themselves to avoid unnecessary medicalization were more prone to challenge their healthcare providers' opinions and ask detailed questions. This attitude, in the event of uncomplicated births, allowed them to avoid procedures that were perceived as unnecessary, such as artificial rupture of membranes (AROM) or postpartum injection of oxytocin, to mention a few. Statements such as "We are inducing," "I'm going to break your water," and "We'll do the postpartum injection" were commonly reported. In one case, procedures were performed without the mother's acknowledgment (AROM and episiotomy). A woman who arrived at the hospital when she was already in active labour complained that healthcare providers insisted on applying an IV catheter on her arm simply because "it was the procedure." She said that she was "tortured," that inserting the IV line "was more painful than her contractions," and that "they would not leave her alone." She concluded that women should be allowed to sign a waiver in such situations.

Another person mentioned that she and her husband needed to be constantly "on their toes" to avoid unnecessary interventions, since healthcare providers described all procedures as "routinely performed." In an interview, a woman repeated several times that she was "on a war footing" while interacting with midwives, OBs, and paediatricians to make sure she and her baby could stay clear of procedures that were not needed. Based on her previous childbirth experiences, she had learned that "you must dig your heels; otherwise, they [the doctors] won't listen to you." Even though she eventually managed to give birth without interventions as she had wished, her experience is recalled in stressful terms because of the interaction she had with her healthcare providers.

According to the mothers interviewed, another aspect that needs to be improved is breastfeeding support after birth. Women were disappointed by the lack of information and claimed that assistance from a professional consultant was not usually available. During their stay in hospital, mothers

were not routinely referred to a certified lactation consultant and at dismissal no useful contact information was provided. According to the women's narratives, breastfeeding assistance in hospital was "nonexistent," and patients received "conflicting" and "confusing" information from different healthcare providers. In some cases, this lack of appropriate care had short-term repercussions on women's nursing experiences. While patients did not receive the help they needed in hospital, useful resources and practical tools were usually found elsewhere. An important role was played by the midwives who assisted them at home during the postpartum period[20] while insightful advice was provided by family members, friends, and the local La Leche League consultants.[21] The four public hospitals in the Canton of Ticino are accredited by the Baby-Friendly Initiative,[22] which promotes breastfeeding success; private clinics do not formally adhere to it. However, women expressed similar disappointment and frustration about how breastfeeding support was handled both in hospitals and private clinics. Despite the differences—and besides the exceptions that will be discussed later—the oral narratives follow a similar pattern: When possible, breastfeeding was promoted by offering immediate skin-to-skin contact with the newborn for an uninterrupted period, usually longer than an hour, both in public hospitals and private clinics. The downside reported by the majority of interviewees was that even though nursing was generally encouraged, competent and personalized support was not available in case of need.

In a few cases, the newborn was taken away from the mother abruptly or without explanation right after birth (three) or after skin-to-skin had been facilitated (two). The lack of information and the separation from their babies were particularly excruciating for mothers, triggering anxiety and concern.[23] At the request of leaving the child longer with the mom, a midwife replied: "I have already left her more than it was required." After a couple complained with their paediatrician that they could hardly spend time with their daughter, they were advised "to assert themselves" and go with their baby anytime she was taken away. Being constantly on their guard is recalled in stressful terms. Women would have appreciated if complete and detailed information had been automatically provided and if they had been openly invited to stay with their kids all the time, without having to ask for permission.

Common and semiprivate accommodations posed several problems. If having a roommate during labour was described as particularly bothersome and challenging, sharing the room with another mom and her baby in the postpartum period was excruciating for a woman whose child was in the NICU and annoying for others. Usually, women who were upgraded to a single room in the hospital appreciated the calm and comfort provided, whereas mothers who gave birth at home and in the birth centre enjoyed the familiarity and discretion that was offered.

One downside commonly referred to in out-of-hospital experiences was that women did not have the option to stay longer in the birth centre, nor were they provided with extra help at home: They usually resumed their routine right away and were not allowed more time to recover and adjust. Even though their births were usually unproblematic, and their recovery was fast, they believed that more assistance in the postpartum period should be granted to all women.

Conclusions

From a selection of women's written and oral narratives from pre-COVID-19 and COVID-19 times, it appears that—even though the pandemic made childbirth more challenging—key aspects of a positive and negative experience are not directly linked to the measures taken to prevent the illness from spreading. In addition to this, according to most women, lockdowns, social distancing, and tightening measures also had positive effects on how pregnancy and postpartum were perceived.

This article addressed strategies that may enhance the level of satisfaction for all women who give birth, regardless of whether they face high or low-risk pregnancies, plan for hospital or home birth, or wish for an unmedicated or medicalized experience. According to the stories gathered in this study, the assistance of the partner is of paramount importance and should always be allowed without restrictions. Since in some circumstances, the presence of other people during labour and postpartum can be particularly upsetting, family rooms should be routinely provided as in other Swiss cantons and countries.

OBs and midwives are advised not to take anything for granted. Mothers expressed the need to receive detailed information and that each decision regarding their bodies or their babies should be discussed and made in agreement with them. Healthcare providers should always remember to ask their patients' permission before touching or checking them.

Even though one-to-one midwifery care[24] proved to be effective in enhancing maternal satisfaction, this service is not offered in Canton of Ticino's hospitals and private clinics. This model should be pursued, since women perceived continued and personalized care in a positive way, whereas fragmented assistance provided by multiple caregivers was cause of stress. Assistance should be also improved in the postpartum period and appropriate and individualized breastfeeding support should be offered to every woman regardless of whether it is her first birth or a subsequent one.

Since this study has concluded, some steps ahead have been made. In October 2022, Associazione Nascere Bene Ticino, an association that promotes positive birth experiences and assists parents in making informed decisions, launched an appeal for hospitals to provide family accommodations and for the right to give birth with the midwife of one's choice.[25] If implemented,

this proposal will introduce one-to-one midwifery care in all maternity wards and allow partners to assist mothers before, during, and after birth without restrictions.

Even though the narratives discussed in this article do not claim to represent all birthing people or address the challenges faced by everyone, they do highlight some recurring elements that affect birth in positive and negative ways and suggest adjustments to improve everyone's experience. By comparing childbirth before and during COVID-19, the survey highlights the impact of COVID-19 measures and hospital protocols on mothers' lives. It also lays the foundations for further studies, focussing on the postpandemic era, aimed at including other individuals who birth under different circumstances—such as single moms, teenagers, LGBTQ+, and women who gave birth to stillborn, premature, or disabled children, to mention just a few—to voice their specific concerns, challenges, and needs.

Tables

Table 1: Number of Women Who Gave Birth Each Month

Mar. 2020	Apr. 2020	May 2020	June 2020	July 2020	Aug. 2020	Sep. 2020
4	1	3	1	5	1	1
Oct. 2020	**Nov. 2020**	**Dec. 2020**	**Jan. 2021**	**Feb. 2021**	**Mar. 2021**	
0	4	0	0	2	1	

Table 2: Age of Women

26	29	30	33	34	35	37	38	40	42
1	3	1	5	1	1	2	4	2	3

Table 3: Number of Children per Woman

1 child	2 children	3 children	4 children
12	7	2	2

Table 4: Origins

Ukraine	Sweden	Italy	German-speaking canton (CH)	Adopted as a child	Canton of Ticino (CH)
1	1	3	1	1	16

Table 5: Place of Birth

Private clinics	Public hospitals	Home	Birth centre
7	8	4	4
Sant'Anna: 5	Civico: 6		
Santa Chiara: 2	San Giovanni: 2		

Table 6: Medical Interventions

Induction (mechanical / pharmacological)	Nonemergency caesarean section	Elective caesarean section
5	2	1
Epidural / analgesia	**Episiotomy**	**Vacuum extraction**
4	2	2

Endnotes

1. Switzerland is not an exception, and similar outcomes can be found in several other countries (Deforges et al.).
2. For more information, see Oelhafen et al. and Mayer et al.
3. For more information, see Lambert and Lambert and David et al.
4. All translations from Italian are mine.
5. Switzerland is a federal country divided in twenty-six cantons (states) and four linguistic regions (German, French, Italian, and Romansh). The Canton of Ticino is an Italian-speaking region and the southernmost canton of Switzerland, located between the Alps and the Italian border. The approximately 350,000 inhabitants share their language and culture with their Italian neighbours but are politically part of the Swiss Confederation. In Switzerland, health insurance is mandatory and private (paid by citizens). Basic insurance includes hospitalization in common rooms. By subscribing to extra coverage, it is possible to upgrade to semiprivate or private rooms. Giving birth at home or in a birth centre is a choice made only by a minority of families in Italian-speaking Switzerland where most women—even in the event of a low-risk and physiological pregnancy, a condition required to birth at home—choose to deliver their babies in public or private hospitals. In the Canton of Ticino in 2020, only 2.26 per cent of the births took place outside a hospital (Grylka and Borner).
6. In Italian-speaking Switzerland (Canton of Ticino), the first lockdown started in March 2020. Here are the numbers of women interviewed who

gave birth each month during the one-year timeframe: March 2020 (4), April 2020 (1), May 2020 (3), June 2020 (1), July 2020 (5), August 2020 (1), September 2020 (1), October 2020 (0), November 2020 (4); December 2020 (0), January 2021 (0), February 2021 (2), and March 2021 (1). See Table 1.

7. Age of women interviewed: 26 (1), 29 (3), 30 (1), 33 (5), 34 (1), 35 (1) 37 (2), 38 (4), 40 (2), and 42 (3). See Table 2.
8. Number of children per woman interviewed (born alive): 1 child (12), 2 children (7), 3 children (2), and 4 children (2). See Table 3.
9. In the Canton of Ticino during the pandemic, women had the following options to deliver their babies: two public hospitals, two private clinics, a birth centre, and at home. Among the mothers interviewed for this study, six gave birth at Ospedale Civico (Lugano), two at Ospedale San Giovanni (Bellinzona), five at Clinica Sant'Anna (Sorengo), two at Clinica Santa Chiara (Locarno), four at home, and four at the birth centre lediecilune (Lugano-Besso). The maternity wards at Ospedale Beata Vergine (Mendrisio) and Ospedale La Carità (Locarno) were closed during most of the COVID-19 pandemic. See Table 5.
10. The choice was either made by parents who decided to give birth in a different facility because of the pandemic (some of the reasons mentioned were: The place of choice made them feel safer, they did not have to wear a mask, the presence of the partner during labour and delivery was not restricted) or was forced by external factors (the maternity ward in their first-choice hospital was closed during the pandemic).
11. None of the transfers were due to medical emergencies.
12. In our sample, medical interventions and caesarean rates are considerably below the average and comply with the WHO recommendations (10 to 15 per cent). It is important to bear in mind that this is not representative of what happens to most women in the Canton of Ticino, since in 2020, one in three babies were born via caesarean section. Official data are based on statistics released by hospitals only and do not consider home births and birth centres, where women deliver their babies vaginally and without any medical intervention. In our study 30 per cent of women (seven out of twenty-three) gave birth out of hospital, a higher ratio than the actual one (2.26 per cent). This explains why in the sample, medical interventions and caesarean section rates are lower than those displayed by official statistics (see Grylka and Borner).
13. In our sample, one baby was born a few days ahead of term, and two newborns spent time in the NICU.
14. Clinica Sant'Anna (Sorengo).
15. Birth centre lediecilune (Lugano-Besso).
16. "Medical interventions, on the other hand, were taken for granted. It was

as if by choosing to give birth in a clinic, I had tacitly accepted the whole package of tests, protocols, and procedures" (Pelizzari Villa pos. 339).

17. It should be mentioned that despite the lockdowns, schools and daycares in the Canton of Ticino were closed for a shorter period than in other countries, such as Italy and the United States.
18. Public hospitals, private clinics, and birth centres had different protocols and requirements that changed all the time during the pandemic. It was challenging for pregnant women to keep track of all the rules and plan for their birth ahead of time. Since the twenty-three women interviewed gave birth in various settings and over a period of a year, protocols at the time of birth were different for each of them. In one case, the partner was not allowed in the hospital during birth; in others, he could assist only after the mom was in active labour. Other factors varied as well, such as mask mandates, if a doula could attend the labour, length of the postpartum visits from the partner, and if siblings or other close family members were allowed to visit after birth. In addition to this, depending on the circumstances, some healthcare providers would be more prone to make exceptions than others. In my study these variables were not specifically considered. Instead, I focussed on women's testimonies to highlight the impact of mandates on their level of satisfaction and highlighted when protocols were perceived as particularly upsetting.
19. This is likely not related to COVID-19 protocols, since some women had to wait until active labour before being assisted by their partners also before the pandemic.
20. In Switzerland, maternal care is covered by mandatory health insurance and includes assistance from a midwife in the postpartum period.
21. La Leche League Switzerland, a branch of La Leche League International, offers breastfeeding support, provides resources, and organizes support groups to inform and help nursing women and their families.
22. The *Baby-Friendly Initiative* was launched by UNICEF and WHO to encourage hospital and healthcare facilities to provide a better support in breastfeeding (Baby-Friendly Hospital Initiative).
23. A mother was separated from her child for ninety minutes. Another interviewee mentioned that her baby was taken away from her for forty-five minutes right after birth, with no explanation. A newborn was placed on her mother's chest for a few seconds before being taken to the NICU. She would see him again only in the morning. In another case, a child was taken away by a midwife to be dressed and later by the paediatricians for their visits without asking for the mother's consent. A woman complained that nurses would take her child away for hours without providing information.
24. For more information, see McCourt et al.

25. "We ask for the right to give birth in hospital with one's trusted midwife (independent midwife)…. We ask that expectant mothers are offered family rooms in all the maternity wards of the Canton of Ticino, with the possibility for the father to stay overnight" (Redazione Nascere Bene).

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