It Takes A Village - The Canadian Postpartum Recovery Approach for Vaginal & C-Section Mothers; A Scoping Review

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Abstract

Childbirth is the most frequent reason for hospitalization in Canada, with cesarean sections being the most common surgical procedure among inpatients. Given this, the postpartum recovery period is a critical aspect of health policy that needs attention. This paper uses a political economy of health research paradigm to examine the role of Canada's liberal welfare state in providing postpartum care and programs, focusing on the duration and extent of this care. Following Arksey and O'Malley's methodology, a scoping review was conducted using databases like ProQuest Sociological Abstracts, Medline, CINAHL, PsycINFO, Public Health Database, and Web of Science. The aim was to understand Canada's approach to postpartum care for both vaginal and cesarean births and to identify any differences in care between these methods. Six themes emerged from the data, encompassing the models of care, duration of postpartum care, educational topics, c-section-specific care, available health services and programs, and existing gaps in the Canadian postpartum care approach. The findings reveal that, within the Canadian liberal welfare state, government-funded postpartum care is modest, minimal, and time-limited, with eligibility criteria reviewed to access additional support and referrals. The market offers more personalized care and support, but only for those who can afford it. The study also found that apart from a few additional educational topics and more extended hospital stays, postpartum care for c-section deliveries is mainly similar to that for vaginal births. This paper provides a comprehensive overview of Canada's current postpartum care approach, highlighting its shortcomings and suggesting policy changes to enhance postpartum support.

Keywords: Postpartum Care, Postpartum Recovery, C-Section, Vaginal Birth, Scoping Review, Political Economy of Health, Liberal Welfare State

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Dedication

For my parents, your endless and unconditional sacrifices, love, and support have anchored me through all my years. Thank you for instilling the values of perseverance, resilience, and thirst for knowledge. This achievement is as much yours as it is mine, and I hope it brings you the pride and joy you both deserve.

To my little boy Zaki, the source of inspiration and reason I embarked on this academic journey.

Finally, for all C-Section Mothers who have faced childbirth and postpartum recovery with unwavering strength and courage. This work is dedicated to you and your remarkable endurance and love in the face of unexpected challenges. May this paper serve as a small step towards raising awareness about the unique needs and experiences of C-section mothers, and may it contribute to a more compassionate and inclusive approach to childbirth.

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Finally, to the 50,000 pregnant in Gaza and 5,500 women due to give birth this month without access to any perinatal health or anaesthesia for C-Sections (UNFPA, 2023). The collapse of the healthcare system and its inability to provide the support you and your babies need and deserve, all while the world leaders watch, is unacceptable. My heart, soul, and prayers have been aching with and for you.

Introduction

Canada is a liberal welfare state with a universal healthcare system (Zadoroznyj et al., 2012). Under the Canada Health Act, the healthcare system offers perinatal care to all Canadian citizens and permanent residents through public health insurance (O'Brien et al., 2011; Zadoroznyj et al., 2012). Postpartum care is addressed through federal, provincial, and local policies and guidelines, with each province administering its distinct programs, policies, and insurance arrangements for healthcare coverage (Dol et al., 2022b; Zadoroznyj et al., 2012). In Canada, childbirth is the most common cause of hospitalization, with 344,301 hospital admissions from 2020-2021 and 98% of births occurring within hospital facilities (Salvador et al., 2022).

On a global scale, the prevalence of Cesarean Section (CS) has grown substantially over the past three decades, with a threefold increase from 7% in 1990 to 21% in 2021 and is predicted to rise to 28% in the next ten years (Ahamnonu et al., 2022). The Canadian Institute for Health Information (CIHI) reported a CS rate of 16.4% during the early 1990s, which escalated to 28.2% in the years 2018-2019 and further climbed to 31.7% in the period encompassing 2021-2022 (Canadian Institute for Health Information, 2023). Canadian CS rates went from1 in 20 births to 1 in 3 births within 40 years (Canadian Institute for Health Information, 2023; Wollny et al., 2021).

The recovery from any birthing method and caring for a newborn warrants provisional care that provides support and education. Under a political economy of health framework, the welfare state plays a role in how much care is given, who gives care, and the duration of care provided during this recovery period (Zadoroznyj et al., 2012). The

government is responsible for meeting the healthcare needs of its citizens through social policies, programs, standards, and regulations (Bryant & Raphael, 2020). This framework is crucial to understanding the provisions of publicly provided postpartum care given to women (Zadoroznyj et al., 2012). This scoping review aims to illuminate the postpartum recovery approach in Canada in general while also identifying if there are any significant changes to the postpartum approach for a CS mother.

Statement of Problem

Birth and motherhood are transformative events that wield the potential to empower however, it is also a vulnerable phase of life that confront women with a myriad of physical and psychological changes accompanied by their new responsibilities as caregivers (Razurel et al., 2011; Todd, 2021). The postpartum period begins immediately after birth and lasts six weeks post-birth (Suplee et al., 2014). Due to the intense lifestyle change after having a baby and the rigorous demands of an infant, the postpartum period is a critical time when the mother-baby dyad requires care and attention (Neiterman, 2013). The recent and drastic increase in CS rates within Canada has reconstructed women's birth and recovery experiences, which demands attention and research to see if current Canadian policies and support are up-to-date with the changing landscape of postpartum recovery.

Research Question

Two questions guide my research: "What is the postpartum recovery approach in

Canada for a healthy mother-baby dyad after a standard vaginal birth?” and "How does the standard approach differ for a healthy mother-baby dyad following a cesarean section?". These two questions aim to illuminate the landscape of postpartum care in Canada while also assessing if there are distinctions between standard postpartum care, education, and support for women after vaginal and CS deliveries. It is essential to understand the postpartum recovery approach, in general, to pinpoint the critical differences in CS care for women.

Background

The Postpartum Period

The postpartum period is divided into three distinct and interconnected phases: the subacute phase, and the delayed postpartum period (Romano et al., 2010). Immediately after birth until 12 hours post-birth is known as the initial phase. This phase is characterized by rapid body changes that may require medical attention, warranting the meticulous surveillance of the mother by healthcare professionals (Romano et al., 2010). Subsequently, during the subacute postpartum period, the body faces ongoing transformations through its recovery, metabolism, emotional and mental health from week two to week six (Romano et al., 2010). Lastly, the delayed postpartum period can last up to six months, where the body goes through gradual and subtle changes toward restoring its pre-pregnancy physiology (Romano et al., 2010).

In 1975, Reva Rubin, a pioneering figure in maternal nursing, asserted that the

most significant shortcoming within obstetric care lies within the postpartum period (Todd, 2021). Rubin's perspective emphasizes the continuity of physical, social, and psychological aspects from pregnancy into motherhood (Todd, 2021). Consequently, postpartum care and education emerge as pivotal components essential for the mother's well-being, directly affecting the health and development of her child(ren) (Todd, 2021). Recognizing and addressing the multifaceted needs of mothers during this crucial phase is paramount in ensuring a healthy and fulfilling transition into motherhood.

C-Sections

A CS is a fetal delivery comprising multiple incisions to the abdomen and uterus (Opiyo et al., 2020; Sinai Health, 2023). The history of CS dates to ancient Rome and used to extract a baby from a deceased or dying mother, it remained primarily a post-mortem procedure for the next four centuries (Antoine & Young, 2020; Rosenberg & Trevathan, 2018). Between 1920 and 1970, groundbreaking medical improvements occurred such as surgical techniques, the creation of blood banks, septic methods, and the introduction of antibiotics which reduced both perinatal and maternal mortality rates related to CS (Antoine & Young, 2020; Rosenberg & Trevathan, 2018). Today CS surgical methods have been perfected, requiring less surgery time, blood loss, and recovery compared to the past centuries (Antoine & Young, 2020; Rosenberg & Trevathan, 2018).

The Canadian CS rate is currently at 31.7% despite the safe CS rate of 10%-15%

recommended by The World Health Organization (WHO) (Canadian Institute for Health Information, 2023; Rosenburg & Trevathan, 2018). While having too many unnecessary CS can be an issue of its own, women having minimal access to CS is a bigger health concern. CS are a crucial life-saving surgical intervention that saves both the mother-baby dyad when vaginal births are deemed unsafe (Opiyo et al., 2020; World Health Organization, 2019).

Risks Associated With C-Section

Medical reasonings for a CS include multiple pregnancies (twins/triplets), labor progression failure, breech or transverse position of baby, maternal infections or conditions, problems with the placenta, or concerns related to the baby's health, and macrosomia (Opiyo et al., 2020 ; Sinai Health, 2023; World Health Organization, 2019). Given that a CS is a major abdominal surgery, it is essential to acknowledge that CS also comes with additional risks due to its invasive nature (Healthwise Staff, 2021; World Health Organization, 2019). Complications range from low risk to high risk, which include headaches and nausea to infections, injury to either mother or baby, and heavy blood loss (Healthwise Staff, 2021). Risks after a CS can present itself in subsequent pregnancies, CS scar tissues run a higher risk of developing placenta previa or a uterine rupture during labor (Healthwise Staff, 2021).

Mental Health after a C-Section

Giving birth has the potential to be a source of empowerment for women. However, due to the unpredictable nature of labor and delivery, women may experience feelings of being victimized, betrayed, and a sense of loss of control, leading to emotional

and psychological trauma (Gardner, 2003). Research by Grisbook et al. (2022) demonstrates that emergency CS is associated with an increased risk of postpartum depression (PPD) and post-traumatic stress disorder (PTSD). While the CS itself cannot be blamed for PPD or PTSD, the complications during labor and failure to adhere to a mother's planned and desired birth plan are factors in a negative birth experience.

Theoretical Framework

Research Paradigm: Political Economy of Health, Welfare State, and Neoliberlism

The political economy of health is a research paradigm that explores the interplay between economic and political domains, specifically focusing on how they interact to shape public policies (Harvey, 2021; Raphael, 2015). Healthcare systems, along with their associated insurance systems, depend on subsidiary levels of government to fund and deliver healthcare services, making the role and of the state integral to healthcare (Raphael, 2015; Raphael & Bryant, 2019; Tuohy & Glied, 2012). The state determines the quality, extent, and eligibility criteria for the accessibility of healthcare services to its population (Tuohy & Glied, 2012; Zadoroznyj et al., 2012). The healthcare system is a complex network, reflecting societal norms, cultural values, government regulations, and economic and political systems (Benoit et al., 2005). In the context of Canada, especially concerning postpartum support policies and care services, this system can be analyzed by examining the structures of various elements such as care providers, the structure of care (informal or formal), geographical distribution, duration, extent, and financing of care (Zadoroznyj et al., 2012).

Raphael & Bryant (2019) describe a welfare state as a set of social reforms implemented by governments to address inequalities. Canada is characterized as a liberal welfare state. Scholars such as Raphael & Bryant (2019), Smith (2023), and Zadoroznyj et al. (2012), define a liberal welfare state by several key characteristics. It involves moderate social spending and tends to collect lower revenues through taxes (Raphael & Bryant, 2019). Public programs and benefits under this model are relatively fewer, and those that exist are primarily targeted at individuals most in need (Raphael & Bryant, 2019; Smith, 2023; Zadoroznyj et al.,2012). Canadian politics value a neoliberal and laissez-faire economic approach, encouraging a free market, privatization, deregulation, and modest public expenditure on social services, coupled with minimal state intervention (Smith, 2023). Therefore, in Canada, the values of neoliberalism and its liberal welfare state affect how postpartum healthcare services and support are delivered, financed, and accessed.

Utilizing data from The Organization for Economic Co-operation and Development (OECD) at *www.oecd.org, I analyzed Canada's social expenditure as a percentage of its gross domestic product (GDP) from 2000-2022. The OECD* is an intergovernmental organization founded in 1961 and recognized as a highly credible publisher of economic data for its 38 member countries (Government of Canada, 2023). These figures provide a useful lens for understanding Canada's position in terms of social spending compared to other OECD member states (OECD, 2019). In 2000, Canada ranked 24/38 with a percentage of 15.6% , in 2020, Canada ranked 14/38 with its percentage at 24.9% (OECD, 2019). Post-2020 data is unavailable. The breakdown of

this expenditure, particularly in areas such as postpartum recovery services, is not detailed in the OECD data (OECD, 2019). However, some statistics show Canada's total public social expenditure on families as a percentage of GDP. From 2000-2022, the total public social expenditure spent under *PUBLIC POLICIES FOR FAMILY AND CHILDREN* started at 1.1% in 2001 and rose to 1.9% in 2019 (OECD, 2019). From this analysis, it is evident there have been gradual increases in Canada's social spending relative to GDP; however, the country has maintained a position of moderate and, more recently, a lower moderate social spending compared to other OECD countries (OECD, 2019). Within the postpartum recovery policies and programs in Canada, the influence of neoliberal policies emphasizes individual responsibility for health and recovery, fiscal policies of cost containment, retrenchment in public health sectors, and early discharge from hospitals which have transformed the postpartum experience (Smith, 2023; Raphael & Bryant, 2019; Zadoroznyj et al., 2012).

Methodology

A scoping review was conducted using Arksey and O'Malley's (2005) methodology. The primary aim is to assess the breadth of literature in the current discourse to pinpoint fundamental central concepts (Arksey & O'Malley, 2005). This approach provides a concise overview of the subject matter while identifying gaps in the existing body of literature (Arksey & O'Malley, 2005). Furthermore, this paper follows the step-by-step process which follows: "(1) identifying the research question, (2)

identifying relevant studies, (3) selecting studies, (4) charting data, and (5) collating, summarizing, and reporting results" (Arksey & O'Malley, 2005, p. 22).

Research Goals

This scoping review aims to gain a comprehensive understanding of the Canadian postpartum care landscape while also, identifying any notable disparities in care between women who have given birth vaginally and those who have undergone a CS. It is vital to recognize the inherent differences between these two modes of childbirth and their respective degrees of care and support needed to recover adequately. This understanding helps assess the extent, nature of care, support, and education offered to CS mothers compared to their vaginal-birthing counterparts. I aim to identify and understand the contours of Canadian postpartum care, the educational resources provided, and the available support programs and services for women after birth.

Search Strategy

A search strategy was created by amalgamating key concepts associated with my two primary research questions to produce a focused and pertinent search phrase. Five key concepts were narrowed down to create keywords which was advised by York University's Health Studies and Global Health Librarian. Keywords were selected instead of Medical Subject Headings (MeSH) terms based on their ability to enhance search effectiveness. Keywords can identify relevant terms throughout an article instead of only in subject headings, increasing the likelihood of finding more information (Icahn School of Medicine at Mount Sinai, 2024). Concepts included "C-Section, Canada, Postpartum

Care, Postpartum Recovery, and Programs.” The search terms involved using Boolean operators such as AND, OR, and a truncation through the symbol of an asterisk to help find word variations (University of South Australia, 2024).

With these five concepts, the keywords were identified and chosen. The list of keywords used for the scoping review were: ("C-section" OR "cesarean section" OR "cesarean" OR cesarean delivery") ("Postpartum care" OR "postnatal care") ("postpartum recover*" OR "postnatal recover*") ("educat*" OR program* OR service*)("Canada" OR "Alberta" OR "British Columbia" OR "Manitoba" OR "New Brunswick" OR "Newfoundland and Labrador" OR "Northwest Territories" or "Nova Scotia" OR "Nunavut" OR "Ontario" OR "Prince Edward Island" OR "Québec" OR "Saskatchewan" OR "Yukon Territory"). Despite the efforts to conduct an exhaustive literature search, specific search terms may have inadvertently excluded potentially relevant research. (See Appendix A for Concepts and Keywords).

Search Strategy b.

Scoping for literature was conducted on six electronic databases such as ProQuest Sociological Abstracts, Medline, CINAHL, PsycINFO, Public Health Database and Web of Science. These electronic databases were chosen per the recommendation of York University's Health Studies and Global Health Librarian for their broad and comprehensive cover of a range of disciplines. Due to the lack of literature surrounding CS on the databases, a Google search was conducted. A date limitation of January 2000 and August 2023 was implemented without methodological restrictions. A date range was

chosen to ensure articles were not outdated but long enough to analyze trends or changes in Canadian postpartum policies.

The search strategy consists of three steps to address both research questions. The keywords used for the initial search included: (Postpartum care" OR "postnatal care") ("postpartum recover*" OR "postnatal recover*) AND ("educat* or service* or program*). The second step was to modify the search to see how many articles were applicable to the Canadian context and within the date range. The key terms (Canada" OR "Alberta" OR "British Columbia" OR "Manitoba" OR "New Brunswick" OR "Newfoundland and Labrador" OR "Northwest Territories" OR "Nova Scotia" OR "Nunavut" OR "Ontario" OR "Prince Edward Island" OR "Québec" OR "Saskatchewan" OR "Yukon Territory") with the date range of 2000-2023 was added. The third step of the search strategy was to modify the search to address the CS question. The keywords added to the final search were ("C-section," OR "cesarean section" OR "cesarean delivery").

In the scoping of websites on Google, all three steps were done simultaneously using the weblink *site.ca.* to garner results solely focused on CS in the Canadian context. Keeping Canada as a key concept and keyword was essential to identify and analyze the body of research originating in Canada by assessing both its volume and relevance to maternal care within the country. (See Appendix B for the Search Strategy Process).

Inclusion & Exclusion Criteria

The literature included in this study met the following inclusion criteria: 1) were

published in English, 2) published in and after the year 2000, 3) included Canadian women as the primary sample population, 4) were available in full-text, 5) contained information of Canadian postpartum policies, programs, care, and/or services. Likewise, the exclusion criteria included the following: 1) sources with samples of only high-risk women (conditions such as preeclampsia, gestational diabetes, mental illness/disorder, and disabilities) and high-risk infants (conditions such as pre-term, disabilities, congenital abnormalities etc.). These mother-baby dyads were excluded because the postpartum care education provided to high-risk women and/or their high-risk infants would be different from the care provided to a healthy mother-infant dyad (Cleveland Clinic, 2021). 2) any literature on the bereaved mother's experience and postpartum recovery, 3) any articles that solely discussed prenatal care, the birth experience, or the specific education of caring/health promotion of the newborn. The objective of this scoping review is to explicitly study the education, support, experience, and recovery of mothers during their postpartum period.

Data Screening, Analysis, and Charting

Screening of Literature

The initial search for articles across the six databases retrieved 30,631 articles. The date range limitation was applied, and the search results were narrowed to 28,682 relevant articles. The results were further filtered after the application of Canada as a key term to 592 articles. The third step of the search strategy was applied by adding the keyword c-section, which yielded 6 new articles to the existing count. A total of 602

articles were then scanned to ensure eligibility. The eligibility assessment of the articles involved a two-step process. The first step included a preliminary screening of titles and abstracts to identify and eliminate articles that did not meet the minimum inclusion and exclusion criteria. A total of 123 articles remained applicable however, after the removal of 5 duplicate articles, a total of 118 articles remained. In the subsequent screening step, a thorough examination of the full-text articles with the inclusion and exclusion criteria were applied to confirm eligibility. A further 79 articles were removed, and 39 articles from the databases were included in this review. No abstracts were found on Google websites; therefore, the screening of the Google results was also done by analyzing the full text to confirm eligibility and relevance. The Google search wielded 3280 websites, of which only 26 were eligible after applying the inclusion and exclusion criteria and examining the full text available. In total, 65 articles (39 from electronic databases and literature electronic databases and 26 pieces of grey literature) were included in this current review. (See Appendix H for the Flow Chart of Article Selection).

Charting of Data

All the data was compiled onto a spreadsheet on Google Forms. The spreadsheet was a central data archival for recording the information from the selected literature. The spreadsheet was organized using these subject headings: "citation, research design/population, methodology, objective, conclusion, themes, location, and additional information." Charting for the websites from Google was also done within a Google Form spreadsheet, including the subject headings: “website citation, type of literature, location, and summary”. In Appendix I, I have omitted the columns on methodology,

themes, and locations; in Appendix J, I have omitted the column on type of literature. Those details can be viewed in Appendix C and Appendix D.

Data Analysis

To answer the two research questions, I explored two ways of analyzing my data for themes. The first was pre-determined themes largely influenced by the political economy of health lens, which focused on finding articles that discussed: 1) who was giving care to women during the postpartum period, 2) a defined length considered as postpartum, 3) the extent of care given to women during the postpartum period, 4) topics of education taught to women during this period, 5) the c-section recovery experience, 6) any form of care, support, policies, and programs listed (state-funded or private), and 7) if there were postpartum services that could be privately purchased. The second, using thematic analysis, a methodology that helped further "identify, analyze, and report patterns within the data" (Braun & Clarke, 2006, p.79). This aided in developing and formalizing official themes and sub-themes in my findings during the charting process. This process gave me more flexibility to openly understand the data than the pre-determined themes I knew I had to look for. For example, I knew I had to search for topics of postpartum education however, I did not know what exactly those topics would be. Using thematic analysis allowed me to see what education topics and how frequently it was discussed within the literature. After the charting process was complete, I would analyze the collected data to develop codes within the pre-determined themes until they were refined enough to create sub-themes in the findings section and themes and sub-themes in the discussion section.

Scoping Review Findings

Nature of Evidence

Of the 39 journal articles included in the final synthesis, 17 were qualitative. (Ahmed at al., 2008; Braimoh & Davies, 2014; Chang et al., 2018; Cidro et al., 2021; Cusack et al., 2008; Douglas et al., 2008; Kelleher, 2003; Kornelsen & Koepke, 2022; MacKinnon, 2010; Mercerat & Saïas, 2021; Merry et al., 2011; Neiterman, 2013; Price et al., 2018; Quintanilha et al., 2016; Robb, 2011, Spitzer, 2004; Wollny et al., 2021, 11 were quantitative (Crowley, 2014; Dennis et al., 2018; Ganann et al., 2012; Harris et al., 2012; Mumtaz et al., 2014; Olson et al., 2019; Russell et al., 2018; Salvador et al., 2022; Sword & Watt, 2005; Sword et al., 2006; Youash et al., 2012), 5 were mixed methods (Dol et al., 2022a; Dol et al., 2022b; Ke et al., 2021; O'Brien et al., 2011; Sword et al., 2004), 3 were journal articles (Grisbrook & Letourneau, 2021; St Croix, 2021; Zadoroznyj et al., 2012), 2 were systematic reviews (Suplee et al., 2014; Wooten & Dowsett, 2012), and 1 was a comparative study (Thiessen et al., 2018).

Among the 39 articles, the provinces mentioned, studied, and/or focused on were: 13 on Ontario (Ahmed et al., 2008; Braimoh & Davies, 2014; Crowley, 2014; Dennis et al., 2018; Kelleher, 2003; Merry et al., 2011; Nieterman, 2013; Russell et al., 2018; Salvador et al., 2022; Sword et al., 2004; Sword & Watt, 2005; Sword et al., 2006; Wooten & Dowsett, 2012), 6 on British Columbia (Ahmed et al., 2008; Chang et al., 2018; Dennis et al., 2018; Harris et al., 2012; Kornelsen & Koepke, 2022; MacKinnon, 2010), 5 on Nova Scotia (Dol et al., 2022a, 2022b; Douglas et al., 2008; Price et al., 2018; Robb, 2011), 4 on Manitoba (Cidro et al., 2021; Cusack et al., 2008; Mumtaz et al.,

2014; Thiessen et al., 2018), 4 on Quebec (Ahmed et al., 2008; Dennis et al., 2018; Mercerat & Saïas, 2021; Merry et al., 2011), 3 on Alberta (Mumtaz et al., 2014; Quintanilha et al., 2016; Wollny et al., 2021), 2 on Saskatchewan (Mumtaz et al., 2014; Olson et al., 2019),1 on Newfoundland (St-Croix, 2021), 7 on Canada in general (Cidro et al., 2021; Ganann et al., 2012; Grisbrook & Letourneau, 2021; Ke et al., 2021; O'Brien et al., 2011; Spitzer, 2004; Youash et al., 2012), and 3 on Canada with another country comparison (Kelleher, 2003; Suplee et al., 2014; Zadoroznyj et al., 2012).

Of the 26 websites included in the final synthesis, 16 were hospital websites (Bluewater Health, 2023; Cornwall Community Hospital, 2023; Guelph General Hospital, 2023; Halton Healthcare, 2023; High River Maternity Clinic, 2018; Humber River Health, 2022; Mackenzie Richmond Hill Hospital, 2010; MUHC Royal Victoria Hospital Birthing Centre, 2015; North York General, 2023; Sault Area Hospital, 2019; SickKids Staff, 2009; Sinai Health, 2023; Southlake Regional Health Centre, 2015; Sunnybrook Hospital, 2023; The Ottawa Hospital, 2008; William Osler Health System, 2023), 4 were physiotherapist clinics (Bump Physio & Co, 2022; Burns, 2022; Opal Physio, 2023; Synergy, 2023), 3 were government websites (Healthwise Staff, 2021; Healthwise Staff, 2022a; Healthwise Staff, 2022b), 2 were from a blog (Leach, 2023; Wint, 2022), and 1 from an organization (The Society of Obstetricians and Gynaecologists of Canada, 2023).

Among the 26 websites, the provinces mentioned, studied, and/or focused on were 15 from Ontario(Bluewater Health, 2023; (Burns, 2022; Cornwall Community Hospital, 2023; Guelph General Hospital, 2023; Halton Healthcare, 2023; Humber River Health,

2022; Mackenzie Richmond Hill Hospital, 2010; North York General, 2023; Sault Area Hospital, 2019; SickKids Staff, 2009; Sinai Health, 2023; Southlake Regional Health Centre, 2015; Sunnybrook Hospital, 2023; The Ottawa Hospital, 2008; William Osler Health System, 2023), 4 from British Columbia (Bump Physio & Co, 2022; Healthwise Staff, 2021; Opal Physio, 2023; Wint, 2022), 2 from Alberta (Healthwise Staff, 2022; High River Maternity Clinic, 2018), 1 from Saskatchewan (Healthwise Staff, 2022a), 1 from Nova Scotia (Synergy, 2023), 1 from Quebec (MUHC Royal Victoria Hospital Birthing Centre, 2015), and 2 from Canada (Leach, 2023; The Society of Obstetricians and Gynaecologists of Canada, 2023). (See Appendix C for the Locations and Nature of Study for Literature with Citations, Appendix I for Database Literature Charting, and Appendix J for Google Grey Literature Charting).

Themes

This section elaborates on the key findings of my scoping review. Using the predetermined themes and a thematic analysis approach, six major themes with a total of seventeen sub-themes emerged in my findings concerning the outcome of the comprehensive postpartum approach in Canada for vaginal and CS births. The six major themes identified are Models of Care, The Duration and Extent of Postpartum Care, Postpartum Education, C-Sections, Postpartum eHealth Services, and Gaps and Limitations Found Within Postpartum Care. (See Appendix D for Themes and Sub-themes Citations)

Theme 1: Models of Care

Fourteen articles discussed the different maternal care models available for perinatal women in Canada with a total of four types (Cidro et al., 2021; Cusack et al., 2008; Dol et al., 2022b; Douglas et al., 2007; Harris et al., 2012; MacKinnon, 2010; Mumtaz et al., 2014; O'Brien et al., 2011; Robb, 2011; Russell et al., 2018; Salvador et al., 2022; Suplee et al., 2014; Thiessen et al., 2018; Zadoroznyj et al., 2012). The first two primary and predominant models are the physician and midwifery models. The other two models of care include an integrated model of care and doula care.(See Appendix B for a summary of the models of care in Canada).

Physician Model

The physician model involves a collaborative approach of care between a family physician, nurse practitioner, obstetrician (OB/GYN), and/or pediatrician (Dol et al., 2022b; Douglas et al., 2007; O'Brien et al., 2011; Thiessen et al., 2018). The majority of perinatal healthcare is done under the supervision of an OB/GYN. From conception until birth, pregnant women can have up to fifteen appointments to monitor the mother-baby dyad (Toronto Public Health, 2023). The mother-baby dyad is monitored through check-ups, blood/urine tests, ultrasounds, and prenatal screenings (Toronto Public Health, 2023).

Under the physician model, women give birth in the hospital with the assistance of an OB/GYN (Thiessen et al., 2018). The hospital's OB/GYN team and the maternity ward nurses oversee the initial postpartum period. In the hospital, women are also visited by a lactation consultant to help with breastfeeding (Braimoh & Davies, 2014). Upon discharge, follow-up postpartum appointments are made for the baby within two to three

days of going home with a family doctor or nurse practitioner (North York General, 2023a). For the mother, her follow-up appointment is with her OB/GYN at six weeks postpartum, with the availability of community public nurses to conduct telephone appointments, home visits, and lactation consultations in the meantime (North York General, 2023a).

Midwifery Model

Midwives are qualified experts in low-risk pregnancies and births, they offer primary perinatal care and provide education, counselling, advocacy, and emotional support (Association of Ontario Midwives, 2023). Midwives are not trained to perform CS and thus must transfer care to the OB/GYN if a patient needs a planned or emergency CS (Thiessen et al., 2018). However, midwives will continue to support their patients and resume primary care if possible, during the postpartum period (Association of Ontario Midwives, 2023).

There are 1909 practicing midwives in Canada, and midwife-led birth rates range between 0%-25% depending on the concentration of midwives in a province (Canadian Association of Midwives, 2020). Prenatal care is similar to the physician model. Under the midwifery model, women can birth at home, in a birthing center, or in hospital (Association of Ontario Midwives, 2023). During the postpartum period, women are more likely to have five or more appointment visits with their midwife (O'Brien et al., 2011; Dol et al., 2022b). Two check-ups within the first week, two visits between week 2 and week 4, and the final check-up at six weeks postpartum (Midwifery Task Force on Postpartum Visit Schedules, 2019). After six weeks, the dyad will be discharged

and transferred under the care of a family doctor or pediatrician for the baby's care (Association of Ontario Midwives, 2023; O'Brien et al., 2011).

Integrated Model

Traditionally, physicians and midwives practice independently; however, two articles indicated two instances of integrated care between Obs and midwives (Harris et al., 2012; Salvador et al., 2022). *The South Community Birth Plan* (SCBP) (2004) in Vancouver, British Colombia and Hôpital Montfort in Ottawa introduced the *Montfort Postnatal Care-at-Home Program* (MPCH) (2018) are two integrated models of care offered to perinatal mothers (Harris et al., 2012; Salvador et al., 2022).

The SCBP was a collaborative pilot program of family physicians, midwives, community health nurses, and doulas providing obstetric care during pregnancy, birth, and the postpartum period (Harris et al., 2012). This program was financially covered by the government but had limited availability (Harris et al., 2012). Within 24-48 hours after birth, women are discharged and provided an in-home visit the next day (Harris et al., 2012). Additional visits are conducted on a need basis (Harris et al., 2012). Clinical nurse specialists and certified lactation consultants support women breastfeeding within clinics (Harris et al., 2012). Women and their newborns are discharged at six weeks postpartum to the care of a family physician (Harris et al., 2012). A weekly drop-in clinic is available for up to six months postpartum (Harris et al., 2012).

The MPCH program differs in terms of its lack of prenatal care, doula support, and program duration. However, this program offers home-based postnatal support (Salvador et al., 2022). Under this integrated model, mothers receive one home visit

within 24 hours of discharge and 1-2 additional home or virtual visits during the first week by the MPCH midwife (Salvador et al., 2022). Mothers also have access to a 24/7 helpline for advice or information from a midwife or the on-call pediatrician/OB at the hospital (Salvador et al., 2022). After one week, dyads receive routine follow-ups with their original primary caregiver during pregnancy (Salvador et al., 2022).

Doula Support

Doulas work alongside primary healthcare providers to elevate the care experience by offering a range of comfort measures, physical, emotional, and advocacy support during birth and postpartum (Burns, 2022; Cidro et al., 2021; Harris et al., 2018; Zadoroznyj et al., 2012). Women can hire postpartum doulas to aid in their recovery at home, and/or a night doula to look after the newborn or other children at night (Burns, 2022; Cidro et al., 2021; Harris et al., 2018; Zadoroznyj et al., 2012). The government does not cover doula expenses; women must pay out of pocket for services (Burns, 2022; Zadoroznyj et al., 2012). The charge rate ranges between “25 CAD-1000 CAD” for overnight or weeklong package deals (Zadoroznyj et al., 2012, p. 7). Doula services are unregulated in Canada and are widely available, especially within urban areas; however, it is often expensive to finance, making them inaccessible to low-income families or rural families in Canada (Cidro et al., 2021).

Indigenous doulas have emerged in response to the systemic racism embedded within Canadian health and social services (Cidro et al., 2021). In 2018, The Child and Family Services in Manitoba took custody of 10,300 children, with 90% of these children identifying as Indigenous (Cidro et al., 2021). In response to these statistics, the Manitoba

government created the *Restoring the Sacred Bond* program to help combat indigenous children being apprehended through child services (Cidro et al., 2021). Indigenous doulas are matched with at-risk expectant Indigenous mothers to provide support through the prenatal, birth, and postpartum period to limit Indigenous children going into the care of child services (Cidro et al., 2021).

Theme 2: The Defined Postpartum Period and Duration of Care Recommendations

Defined Timeline of Postpartum

The theme of defining the postpartum period was identified within seventeen articles (Braimoh & Davies, 2014; Chang et al., 2018; Dennis et al., 2017; Dol et al., 2022a, 2022b; Gannan et al., 2012; Harris et al., 2012; Healthwise Staff, 2022a; Neiterman, 2013; Price et al., 2018; Robb, 2011; Salvador et al., 2022; Suplee et al., 2014; Sword & Watt, 2005; Wooten & Dowsett, 2012; Youash et al., 2012; Zadoroznyj et al., 2012). The majority of articles defined the postpartum period as six weeks (Dol et al., 2022a; 2022b; Harris et al., 2012; Robb, 2011; Salvador et al., 2022; Sword & Watt, 2005; Wooten & Dowsett, 2012). This six-week timeframe is widely recognized, especially within the medical field, as it aligns with the time it takes the uterus to shrink and contract back to its pre-pregnancy state (Zadoroznyj et al., 2012). However, it is essential to note that perspectives on postpartum care are evolving. A few authors proposed that the postpartum period does not end at the traditional six-week mark (Braimoh & Davies, 2014; Price et al., 2018; Suplee et al., 2014; Healthwise Staff, 2022a; Zadoroznyj et al., 2012). Some suggested it should be at least four to six months

post-birth (Dennis et al., 2017; Healthwise Staff, 2022a, while others considered up to one-year post-birth (Braimoh & Davies, 2014; Neiterman, 2013; Price et al., 2018; Suplee et al., 2014; Youash et al., 2012). Based on these findings, the postpartum period ranges on length depending on the person, and in some cases, should be considered to extend beyond the traditional six weeks (Braimoh & Davies, 2014; Neiterman, 2013; Price et al., 2018; Suplee et al., 2014; Youash et al., 2012).

Duration of Care

During the postpartum period, women are provided care within two settings, with varying care durations and frequency during the six weeks. The first within the hospital, and the second at home. During the initial postpartum phase, women receive care in the hospital and have access to round-the-clock monitoring and support from nurses (Knudsen et al., 2020). However, the length of stay given to women within this setting is brief. Thirteen articles discussed the topic of early discharge from the hospital (Chang et al., 2018; Crowley, 2014; Cusack et al., 2008; Dol et al., 2022b; Harris et al., 2012; Kelleher, 2003; Olson et al., 2019; Salvador et al., 2022; Spitzer, 2004; Suplee et al., 2014; Sword et al., 2004; Wooten & Dowsett, 2012; Zadoroznyj et al., 2012. Early discharge is considered at least 48 hours for an uncomplicated vaginal delivery and 96 hours for an uncomplicated CS (Cusack et al., 2011; Zadoroznyj et al., 2012).

In 1999, Ontario's Ministry of Health and Long-Term Care implemented the *Hospital Stay and Postpartum Home Visiting* program, recommended women be provided the option of a 60-hour (3-day) stay in the hospital following an uncomplicated vaginal birth (Sword et al., 2004). Presently, early discharge policies suggest that mothers

delivering vaginally should be offered a minimum of 48 hours LOS (Chang et al., 2018; Reproductive Care Program of Nova Scotia, 2003). However, this is not the case. Zadoroznyj et al. (2012), analyzed the downward trend in Canada's average LOS for childbirth. Originally, LOS for an uncomplicated vaginal birth ranged between 11-14 days, by the 1980s, the average LOS was 5.3 days which further decreased to 3.0 days in the 1990s (Zadoroznyj et al., 2012). Regarding a CS, the Canadian LOS was 7.6 days in the 1980s, with the average LOS for a CS of 5.0 days by the mid-1990s (Chang et al., 2018). Today, the average LOS for a healthy maternal-baby dyad in Canada is 2.1 days for a vaginal birth and 3.8 days following a CS (Crowley, 2014; Salvador et al., 2022). However, there are cases where women are discharged earlier. Women can stay a few hours to one full day for a vaginal birth and 1-2 days for a CS (Salvador et al., 2022).

The subacute postpartum phase is spent at home. Thus, recommendations for the frequency of postpartum care has been discussed by WHO, CPS, and SOGC. WHO recommends that a healthcare provider contact postpartum women within "48-72 hours of discharge, at 7-14 days, and at six weeks postpartum" (Dol et al., 2022b, p. 497). CPS recommends a newborn check-up "48-72 hours after discharge and another one-week post-discharge" (Dol et al., 2022b, p. 497; Sword et al., 2004, p. 61-62). SOGC recommends that women and their newborns follow up with healthcare professionals "one week after discharge and 4-6 weeks post-discharge" (Dol et al., 2022b, p. 498; Sword et al., 2004). *The Healthy Babies Healthy Children* (HBHC) program (1998) and *Ontario's Hospital Stay and Postpartum Home Visiting Program* (1999) provide a phone

call 48 hours after discharge from a public health nurse and offer an in-person visit at home or in the community (Dol et al., 2022b; Russell et al., 2018; Sword et al., 2004).

Overall, within the medical and political sphere, the postpartum period is characterized by its six-week duration (Zadoroznyj et al., 2012). The Canadian healthcare system provides comprehensive and attentive care during the initial postpartum phase, where women are at risk for immediate medical attention (Romano et al., 2010). Care is still provided within the subacute postpartum phase but ceases after six weeks (Zadoroznyj et al., 2012). However, medical attention in those six weeks is not solely for the mother, but rather guidelines on when the newborn should be checked up on.

Theme 3: Postpartum Education

Postpartum education is a prominent theme. Four main topics are emphasized: infant care, breastfeeding, maternal care, and mental health. Fifteen articles highlighted the nursing profession's role in providing education and knowledge transfer to mothers within the initial and subacute postpartum phases (Crowley, 2014; Cusack et al., 2008; Harris et al., 2012; Humber River Health, 2022; Kelleher, 2003; MacKinnon, 2010; Mumtaz et al., 2014; Olson et al., 2019; Russell et al., 2018; Spitzer, 2004; St Croix, 2021; Suplee et al., 2014; Sword et al., 2004; Sword et al., 2006; Wooten & Dowsett, 2012). Educational topics, knowledge, and support are given to women by nurses in the hospital, public health nurses in the community, and nurse lactation consultants (Crowley, 2014; Cusack et al., 2008; MacKinnon, 2010; Sword et al., 2006).

Infant Care

Infant care is an integral component of postpartum education. Ten articles and websites outlined infant care as a significant aspect of the Canadian postpartum approach. While admitted to the hospital, nurses prioritize infant care education topics such as baby hygiene and infant daily care (Cornwall Community Hospital, 2023; Crowley, 2014; Halton Healthcare, 2023; Price et al., 2018; Spitzer, 2004; Suplee et al., 2014; The Ottawa Hospital, 2008). Mothers are taught to recognize possible health issues such as jaundice and dehydration which warrant immediate medical attention (Cornwall Community Hospital, 2023; Halton Healthcare, 2023; The Ottawa Hospital, 2008). Despite infant care being a significant topic of education, Sword and Watt (2005), concluded that infant care and behaviors remain unmet learning needs at discharge and four weeks postpartum, while Crowley (2014), found 41.5% of participants felt they did not receive enough infant care education before discharge.

Breastfeeding

In total, twenty-two articles and websites discussed breastfeeding (BF) (Bluewater Health, 2023; Braimoh & Davies, 2014; Cornwall Community Hospital, 2023; Crowley, 2014; Halton Healthcare, 2023; Harris et al., 2012; Healthwise Staff, 2022a; Healthwise Staff, 2022b; Leach, 2023; Mackenzie Richmond Hill Hospital, 2010; Mercerat & Saïas, 2021; Neiterman, 2013; Olson et al., 2019; Salvador et al., 2022; SickKids Staff, 2009; Southlake Regional Health Centre, 2015; St Croix, 2021; Suplee et al., 2014; Sword et al., 2006; The Ottawa Hospital, 2008; Wooten & Dowsett, 2012; Youash et al., 2012). The Breastfeeding Committee of Canada and all healthcare institutions conform to WHO's ten step *Baby-Friendly Initiative* (BFI) (Braimoh & Davies, 2014; Breastfeeding

Committee for Canada, 2023). There is a great emphasis within the medical and political systems to create public health programs to initiate and sustain exclusive breastfeeding for the first six months due to breast milk's ability to develop an infant's immune system, promote infant growth and development, and encourage bonding between the dyad (Braimoh & Davies, 2014; Public Health Agency of Canada, 2023; Southlake Regional Health Centre, 2015; St Croix, 2021; Suplee et al., 2014). In-home visits with nurses assess BF, and appointments are often scheduled around feeding times (Olson et al., 2019). During these assessments, nurses monitor the breast and nipple conditions of the woman and baby latch (Olson et al., 2019). Health program extensions, partnerships, and coalitions between provincial programmes, local communities, and organizations work together to expand BF support. The *Healthy & Home program* established breastfeeding centers and cafes to create breastfeeding-friendly spaces for mothers within their communities (Olson et al., 2019). *The Healthy & Home* program collaborates with various organizations depending on the availability of local and provincial groups. For example, in Saskatchewan, the *Healthy & Home* program has formed a coalition among local grassroot mother groups, *Breastfeeding Matters, the Child Hunger and Education Program of Saskatoo*n, and regional mental health community stakeholders (Olson et al., 2019).

Within Google, every hospital has a form of breastfeeding support during the initial postpartum phase, with additional support of a referral to support during the subacute postpartum phase (Bluewater Health, 2023; Cornwall Community Hospital, 2023; Halton Healthcare, 2023; Southlake Regional Health Centre, 2015). For example,

within the Halton region of Ontario, Halton Healthcare hospitals provide numerous BF locations and numbers for women to contact if additional support is needed (Halton Healthcare, 2023). (See Appendix D for a comprehensive list of websites and phone numbers provided). Access to support and specialized BF services, such as lactation consultants, are centralized in regional hospitals and within urban communities (St Croix, 2021). Women living in rural areas face numerous barriers, such as accessibility or long commutes with their infants that hinder their ability to get the support and education they require (St Croix, 2021). The inability to exclusively breastfeed means that formula feeding is a significant aspect of infant care and feeding. One article discussed the need to supplement with formula if breastfeeding is unsuccessful (Braimoh & Davies, 2014). However, I could not identify any sources that discussed bottle and formula buying, cleaning, and water preparation. In the study conducted by Youash et al. (2012), most of the 6117 participants felt information regarding formula feeding was limited.

Maternal Care

While taking care of their newborn, mothers also need to prioritize caring for themselves. Maternal care is another topic of education discussed with women after birth. The standard and most common topics involve perineal care, vaginal bleeding, urination and bowel movements, hemorrhoids, changes in breasts if BF, diet, exercise, sexual health, rest, and identifying possible risks and complications that need medical attention (Bluewater Health, 2023; Healthwise Staff, 2022a; Southlake Regional Health Centre, 2015; William Osler Health System, 2023).

During the subacute postpartum period, maternal assessments are conducted by

public nurses, doctors, or midwives during in-home visits or newborn check-ups (Olson et al., 2019). Women are monitored physically, emotionally, and mentally (Bluewater Health, 2023; Healthwise Staff, 2022a; Olson et al., 2019; Public Health Agency of Canada, 2023; Southlake Regional Health Centre, 2015; William Osler Health System, 2023).

It was identified that the area of maternal care education needs revamping. In Crowley (2014) study, 68% of the nurses surveyed felt women had not received enough education on postpartum maternal care. Mercerat & Saïas (2021), conclude their study stating mothers have limited contact and support within the subacute postpartum period unless a check-up involves the direct care of the baby. These studies suggest that mothers are frequently discharged from hospitals without sufficient maternal care knowledge and education. Additionally, during the subacute postpartum period, healthcare professionals prioritize infant care education, resulting in an ongoing gap in maternal care education and knowledge from the healthcare system (Neiterman, 2013).

Mental Health

Maternal mental health is a significant topic discussed and monitored within the postpartum period and was identified in seven articles and websites (Ahmed et al., 2008; Grisbrook & Letourneau, 2021; Halton Healthcare, 2023; Healthwise Staff, 2022a; Olson et al., 2019; Robb, 2011; Southlake Regional Health Centre, 2015). Scanning for PPD is done using the Edinburgh Postnatal Depression Scale (Grisbrook & Letourneau, 2021). However, perinatal mental health screening is not universal across Canada and is limited to screening PPD (Grisbrook & Letourneau, 2021). There are regional differences in the

availability and implementation of maternal mental health screening. For example, as of 2021, only five provinces are on board: “British Columbia Reproductive Mental Health Program, Alberta Health Services Healthy Children and Families Program, New Brunswick Perinatal Mental Health Program, Reproductive Care Program of Nova Scotia, and Saskatchewan Prevention Institute” (Grisbrook & Letourneau, 2021, p. 241). Some government programs form coalitions with local grassroots organizations to address postpartum mental health (Olson et al., 2019). For example, *The Healthy & Home* program and the mental health community in the Saskatchewan region launched a PPD support group (Olson et al., 2019). However, the emphasis on screening only PPD is concerning; Griskbrook and Letourneau (2021), expressed worry that other perinatal mental health issues, such as PTSD and postpartum anxiety (PPA), are largely ignored by the healthcare system (Grisbrook & Letourneau, 2021). With an increase in awareness around the significant prevalence of PPA and its effects on maternal and newborn outcomes, the group in Saskatchewan rebranded itself to address PPA in 2014 (Olson et al., 2019).

Theme 4: C-Sections Care

Of the 39 articles, only 4 solely focused on c-sections (Thiessen et al., 2018; Robb, 2011; Wollny et al., 2021; Ke et al., 2021), and the remaining 35 focused mainly on the postpartum approach in general, with two slightly discussing c-sections (Kornelsen & Koepke, 2022; Salvador et al., 2022).

Programs

The literature identified one CS recovery program, the Enhanced Recovery After Surgery (ERAS) program for CS births (Wollny et al., 2021). ERAS was formed to develop the first international guidelines to improve CS outcomes (Wollny et al., 2021). However, this program solely focuses on guidelines before, during, and immediately after a CS, it does not focus on any guidelines, tips, or support for the subacute or delayed postpartum period (Wollny et al., 2021). Participants voiced that they needed more information about the risks of CS, local anesthesia, and how the baby is handled during a CS (Wollny et al., 2021). It also found that women need constant updating and involvement in the decision-making leading up to a CS and during the CS to avoid confusion and feeling out of control (Wollny et al., 2021).

Nowhere in the literature did it indicate additional support, visits, or postpartum programs available during the subacute and delayed postpartum period for recovering CS mothers. Besides a slightly longer LOS in the hospital, CS-recovering mothers are expected to recover and cope with their transition to motherhood with the standard postpartum support and care given to every birthing mother during the subacute postpartum period.

C-Section Postpartum Education

Regarding postpartum education surrounding CS, the literature found that postpartum topics of education after a CS overlap with the education provided to vaginal birth mothers. CS mothers were also taught about infant care, breastfeeding, lochia, diet, activity, mental health, sexual health, family planning, identifying complications that require medical attention, and the infamous advice of sleeping when the baby sleeps

(Bluewater Health, 2023; Cornwall Community Hospital, 2023; Healthwise Staff, 2022a; Southlake Regional Health Centre, 2015; William Osler Health System, 2023).

A few aspects of CS postpartum education differ from a vaginal delivery versus a CS. For instance, hospital handouts provide information on the process before a CS, immediately after a CS, during the initial, and subacute postpartum period. Information such as the insertion and removal of a catheter, the post-op recovery room process, the first walk, the removal of staples and wound dressings before leaving the hospital, and body limitations are discussed (Guelph General Hospital, 2023; Humber River Health, 2022; Mackenzie Richmond Hill Hospital, 2010; MUHC Royal Victoria Hospital Birthing Centre, 2015; North York General, 2023; Sunnybrook Hospital, 2023; The Society of Obstetricians and Gynaecologists of Canada, 2023).

Further tips and information are provided for CS women during the subacute postpartum period. Common topics include managing pain by supporting the abdomen with a pillow, prescription medications or opioids, incision care, and hygiene (Bluewater Health, 2023; Healthwise Staff, 2021; Healthwise Staff, 2022a; 2022b; High River Maternity Clinic, 2018; Leach, 2023; SickKids Staff, 2009; William Osler Health System, 2023; Wint, 2022). Women are reminded their bodies had a major abdominal surgery and are advised to ask for help from family, friends, or doulas due to the activity limitation and the need to rest and heal (Burns, 2022; Healthwise Staff, 2022a; Leach, 2023; SickKids Staff, 2009; Wint, 2022). Women are also notified that it takes longer than six weeks for their bodies to heal and may take up to six months or longer to feel

energized and themselves (Healthwise Staff, 2022a; Leach, 2023; William Osler Health System, 2023).

Rehabilitation Medicine

The final subtheme of CS recovery in Canada recognizes women's significant limitation of activity and energy after a CS. The websites identified the availability and options of rehabilitation medicine from physiotherapy, chiropractor, and massage therapy clinics to restore women's bodies and mobility after birth, especially after a CS (Opal Physio, 2023; Synergy, 2023). The goal is restoring pelvic health, targeting lower back pain, and cesarean rehabilitation (Bump Physio & Co, 2022; Opal Physio, 2023; Synergy, 2023). Despite this recognition and improvement in body healing, rehabilitation medicine and its services are not covered by government healthcare nor promoted by state policies, programs or the healthcare system (Bump Physio & Co, 2022; Opal Physio, 2023; Synergy, 2023). Depending on duration and frequency, these services can range between $100 to $190 per session, with women either having to pay out of pocket or relying on private insurance to cover the cost (Bump Physio & Co, 2022).

One anomaly in the literature identified the lack of access to CS in rural areas of Canada, especially among Indigenous women (Kornelsen & Kopeke, 2022). Overall, the CS recovery approach in Canada has a slight expansion and variation in terms of its educational topics and LOS in the hospital compared to the standard vaginal recovery approach. However, in terms of programs, support, and policies, there are no significant changes compared to the standard vaginal recovery approach.

Theme 5: Postpartum eHealth Services and Programs

EHealth services have emerged as a convenient enhancement to existing postpartum care services and support to monitor and connect postpartum mothers (Dol et al., 2022a; Ke et al., 2021). Twelve articles and websites discussed the introduction and move towards eHealth within the postpartum approach in Canada. Ehealth services can take three forms: independent phone apps, tools to remotely assess women for healthcare providers, and additional support for postpartum women (Bluewater Health, 2023; Chang et al., 2018; Dol et al., 2022b; Halton Healthcare, 2023; Ke et al., 2021; Price et al., 2018; Southlake Regional Health, 2015; Sword & Watt, 2005; Sword et al., 2004; Sword et al., 2006; The Ottawa Hospital, 2008; Wooten & Dowsett, 2012).

Virtual and telephone consultations are forms of eHealth services available to mothers per the *Healthy Babies Healthy Children* program (1998) recommendations and Ontario's *Hospital Stay and Postpartum Home Visiting Program* (1999). The literature identified two eHealth pilot program apps that provided information and support to mothers: *The Essential Coaching for Every Mother Program (ECEMP)* and the *C-Care App* (Dol et al., 2022a; Ke et al., 2021). The *ECEMP* was one of the first randomized trials of a text message-based program in Canada (Dol et al., 2022a). Participants received daily texts on maternal and infant care during the subacute postpartum period (Dol et al., 2022a). This program received an 89.2% satisfaction rate from its participants (Dol et al., 2022a). The *C-Care App* was a perioperative mobile app with 36 participants undergoing a planned CS (Ke et al., 2021). A median of 3/5 self-monitoring questionnaires was completed, and the average participant visited the C-Care App 15

times within 30 postoperative days (Ke et al., 2021). The women viewed a median of 4/8 education topics, with “Controlling Pain, Analgesia, and The First Few Days” as the most visited topics (Ke et al., 2021, p. 508).

In most hospitals, handouts provided websites and telephone numbers to contact for additional support (Bluewater Health, 2023; Halton Healthcare, 2023; Southlake Regional Health, 2015). Online resources and websites were provided to connect women to more information on early parenting, additional breastfeeding support, and privatized in-home services (Bluewater Health, 2023; Halton Healthcare, 2023; Southlake Regional Health, 2015). Finally, other services that involve support were highlighted but are localized to certain areas, such as the *Neighbourlink Sarnia-Lambton, The Postpartum Adjustment Services at St. Clair Child and Youth, Milton Group Drop-In,* or the *Community Auntie Service* (Bluewater Health, 2023; Southlake Regional Health, 2015). A positive postpartum recovery is deeply rooted in maternal empowerment through knowledge acquisition, a sense of normalization, and maternal self-efficacy, which avenues of eHealth services allow to flourish (Price et al., 2018).

Theme 6: Gaps and Limitations Within Canadian Postpartum Care

Numerous gaps and limitations were identified within the postpartum approach in Canada, with the lack of research in postpartum care, postpartum care for immigrants, rural Canada, unstandardized and unbalanced check-ups during the subacute postpartum period, and the priority of care focused on the infant being the most significant.

Lack of Research

Thirteen articles discuss the growing dearth and paucity of research on postpartum care, recovery, and experience (Chang et al., 2018; Crowley, 2014; Dennis et al., 2017; Dol et al., 2022b; Gannan et al., 2012; Price et al., 2018; Salvador et al., 2022; Suplee et al., 2014; Sword & Watt, 2005; Sword et al., 2004; Sword et al., 2006; Youash et al., 2012)). Some studies are based on studies conducted years ago. For example, three articles within the scoping review were based on the *Maternity Experiences Survey* (MES) or *The Ontario Mother and Infant Study* (TOMIS) and TOMIS (II) (Harris et al., 2012; Sword & Krueger, 2004; Youash et al., 2012). MES was conducted in 2006, which focused on the experiences of pregnancy, labor, birth, and postpartum (Statistics Canada, 2007). TOMIS was conducted from 1998-2000 to identify postpartum care and education gaps after the implementation of early discharge policies (Sword et al., 2009). TOMIS II was conducted between 2001-2003 to understand the postpartum experience of Canadian women after the implementation of the *Hospital Stay and Postpartum Home Visiting Program* in Ontario (Sword et al., 2009). While these studies are standardized and provide a baseline insight into the postpartum experience of Canadian women, these statistics are 20 years old and may not reflect the care, needs, and satisfaction of women today. Additionally, there is a scarcity of research aimed at understanding women's needs beyond the conventional subacute postpartum period of 4-6 weeks (Suplee et al., 2014). This lack of research creates a significant knowledge gap and lack of understanding of needs within the delayed postpartum period.

Immigrants

The *Interim Federal Health Program* (IFHP) covers the health insurance of

emergency and essential health care for immigrants (Merry et al., 2011). Additional health services are covered after pre-approval from Citizenship and Immigration Canada (CIC) (Merry et al., 2011). Eight articles pinpointed notable disparities, barriers, and adverse care needs experienced by immigrant women in Canada compared to their Canadian-born counterparts (Ahmed et al., 2008; Chang et al., 2018; Dennis et al., 2017; Gannan et al., 2012; Merry et al., 2011; Mumtaz et al., 2014; Quintanilha et al., 2016; Spitzer, 2004). Additionally, one piece discussed the specific distinctions in care requirements among immigrant women, refugees, asylum seekers, and Canadian-born women (Dennis et al., 2017).

Immigrant women, especially refugee women, are more likely to be exposed to certain risk factors such as abuse, trauma, food insecurity, and a lack of a support system due to family separation (Dennis et al., 2017). These women also face a higher risk of isolation, language barriers, stigmatization, and low health literacy (Ahmed et al., 2008; Dennis et al., 2017; Merry et al., 2011). Compared to Canadian-born women, immigrant women were found to have additional and adverse postpartum needs not being adequately addressed by the Canadian healthcare system (Ahmed et al., 2008; Chang et al., 2018; Dennis et al., 2017). A quantitative study done by Mumtaz et al. (2014) utilized the MES study data to compare the postpartum experience of 140 new immigrants in Canada to the postpartum experience of 1137 Canadian-born women. The study found immigrant women were less likely to receive information about breastfeeding, birth control, SIDS, and PPD, yet were more likely to be diagnosed with PPD (Gannan et al., 2012; Mumtaz et al., 2014). Immigrant women found it more challenging to obtain the adequate care

needed for their emotional and mental health and experienced poor/fair satisfaction with their postpartum care experience (Gannan et al., 2012). The immigrant women in Ahmed et al. (2008) study stated they felt rushed, and doctors failed to address their health during their postpartum check-ups with their newborns.

Immigrant women express there is a lack of culturally competent postpartum care. For example, Chinese immigrant women stated they had limited support within the Canadian healthcare system that allowed them to practice elements of zuo yue zi (Chang et al., 2018). Immigrant Northeast African communities in Quintanilha et al.(2016) study, stated their dependance on family members or hired help to experience the cultural postpartum healing practices from back home. In both cases, financial constraints to pay for hired help played a significant role in women's ability to receive the culturally competent care they desired (Chang et al., 2018; Quintanilha et al., 2016). Women also reported using support centers for new immigrants rather than support services for new mothers; this could be due to the lack of culturally competent care, isolation, and the lack of awareness and knowledge of services available for these women (Ahmed et al., 2008).

The literature pinpointed the *Multicultural Health Brokers* (MCHB) Cooperative, run by the city of Edmonton (Quintanilha et al., 2016). The MCHB Cooperative is a community-based organization providing perinatal support and services to at-risk migrant women, including refugees and asylum-seekers (Quintanilha et al., 2016). It offers holistic services related to overarching social determinants of health, such as “housing, income, food security, and education, to promote perinatal health and improve birth outcomes” (Quintanilha et al., 2016, p.2). The authors conclude that there is a need to

create regulatory guidelines to protect mothers from the exploitation of unregulated paid care providers and improve social support network programs in the community (Ahmed et al., 2008; Chang et al., 2018; Quintanilha et al., 2016).

Rural Canada

The gaps and lack of perinatal care within some rural regions of Canada were discussed in three articles (Kornelsen & Koepke, 2022; MacKinnon, 2010; St Croix, 2021). The rural-urban divide in postpartum care is a pressing concern. Canada's urban hospitals are well-equipped with specialized medical staff and support services while the quality and accessibility of postpartum care starkly contrast within rural regions (Kornelsen & Koepke, 2022). To combat these shortcomings, policies such as the *Returning Birth to Rural, Remote and Aboriginal Communities* (SOGC 2010) and the *Joint Position Paper on Rural Maternity Car*e explicitly highlight the importance of safe maternity care close to the homes of rural child-bearing women (Kornelsen & Koepke, 2022). Furthermore, Canadian national initiatives such as the *Truth and Reconciliation Commission of Canada* (2015) combined with the Canadian commitment to the United Nations Declaration on the Rights of Indigenous Peoples (2007) politically and formally recognize the cultural significance of local births and its role in reconciliation (Kornelsen & Koepke, 2022). Despite this supportive policy context for local maternity care, a significant gap exists in the accessibility of local care (Kornelsen & Koepke, 2022). For example, due to the centralization of healthcare in BC, many perinatal maternity services within rural areas with low birth numbers, have faced clinic closures (Kornelsen & Koepke, 2022). The Canadian rural maternity care landscape faces an ongoing erosion of

primary maternity care sites without local access to CS, reduced availability of knowledgeable and skilled maternity or prenatal nurses in local hospitals, unstandardized postpartum services, and many specialized services concentrated within urban regions (MacKinnon, 2010; Kornelsen & Koepke, 2022; St Croix, 2021). The geographical dispersion of perinatal care translates to longer travel times for mothers, limited accessibility to necessary medical interventions, and minimal postpartum support (Kornelsen & Koepke, 2022; MacKinnon, 2010; St Croix, 2021).

Unstandardized and Unbalanced Postpartum Check-Ups

Lastly, fifteen articles discussed the absence of standardized follow-up check-ups during the subacute postpartum period (Crowley, 2014; Cusack et al., 2008; Dol et al., 2022a; Dol et al., 2022b; Grisbrook & Letourneau, 2021; Kelleher, 2003; Kornelsen & Koepke, 2022; MacKinnon, 2010; Mercerat & Saïas, 2021; Neiterman, 2013; Salvador et al.,2022; Sword et al., 2004; Sword et al., 2006; Wollney et al., 2021; Youash et al., 2012; Zadoroznyj et al., 2012). With shortened hospital stays, nurses face a time-constricted responsibility of conveying essential information to new mothers about their health, recovery, infant care, breastfeeding, and potential health risks during the initial postpartum period (Kelleher, 2003). In the past, postpartum women had a more prolonged exposure to postpartum education and support in the hospital and better exposure after discharge. Before the rise of early discharge in Canada, public health nurses would visit families “1-2 weeks after birth and continued visitation until urgent problems were resolved” (Cusack et al., 2008, p. 207). During these visitations, care primarily emphasized health promotion and education (Cusack et al., 2008). At-home

visits by public health nurses have transitioned towards screening and management of health concerns such as "infections, breastfeeding difficulties, infant jaundice, and infant weight loss" (Cusack et al., 2008, pg. 207).

The issue of unstandardized care extends into the subacute postpartum period, where there is a notable lack of consistency in the types and scheduling of postpartum check-ups across different clinics and hospitals (Dol et al., 2022b; Salvador et al.,2022; Zadoroznyj et al., 2012). Dol et al. (2022b), explored the postpartum care experience of Canadian women while identifying who provided care and frequency of postpartum visits (Dol et al., 2022b). On average, women saw 1.9 different postnatal healthcare providers during the subacute postpartum period, with a varying number of visits (Dol et al., 2022b). Regarding postpartum visits, 3.2% of women reported no visits, 15.2% had one visit, 21.6% had two or three visits each, and 37.6% had four or more (Dol et al., 2022b). As mentioned previously, within the mental health area of postpartum care, Canada lacks national guidelines on the screening, services, and programs of maternal mental health (Grisbrook & Letourneau, 2021).

Women often found their health and recovery primarily sidelined due to postpartum appointments prioritizing the health and development of the infant (Neiterman, 2013). The OB/GYN appointment with the mother at six weeks postpartum is the only postpartum appointment that revolves solely around the mother and her health (Dol et al., 2022b). Intensifying the postpartum care gap, Salvador et al. (2022) observed a significant reduction of Ontario's routine community-based postnatal services such telephone check-ins and in-home visits occurred in 2012. Once widely available to

healthy mother-infant dyads, these services have become primarily reserved for at-risk dyads (Salvador et al., 2022).

Despite the existence of numerous guidelines and requirements designed to ensure adequate postpartum care after the introduction to early hospital discharge, the reduction in routine community-based postnatal services has further complicated the challenge of providing maternal care during this crucial period. With a limited timeframe of care during the initial postpartum period combined with unstandardized baby-focused postpartum appointments during the subacute postpartum period, the care gap addressing women's health, issues, concerns, and support grows bigger. Twenty-five percent of the participants in Dol et al. (2022b) study responded with unsatisfactory maternal care, due to the challenges of accessing postnatal care primarily, gaps in their postnatal follow ups, and unsatisfactory postpartum checks for themselves on their physical recovery. This suggests a gap in one of the tenets of Canadian health care— the lack of universality and standardized guidelines for postpartum care.

Discussion

In this paper, I reviewed in detail 39 articles from six databases and 26 websites on Google surrounding the postpartum care approach in Canada and the difference in care between a vaginal birth and a CS birth. Under a political economy of health lens, the state provision of postpartum care within the Canadian liberal welfare state is minimal, modest, and time-constricted (Bryant & Raphael, 2020). In-depth care and additional aid have strict eligibility criteria, with women who receive this care categorized as either

stigmatized or high-risk determined through means-tested screening (Bryant & Raphael, 2020).

Due to the higher risk of needing medical attention during the initial postpartum period, the state prioritizes the hospital stay (Romano et al., 2010). Focused and additional support and care are available if women meet eligibility criteria through surveillance tactics and means-tested screening (Bryant & Raphael, 2020). The basic level of care provided by the state encourages the commodification of healthcare and postpartum support through the unregulated availability and costs of doulas and hired help or a dependency of family and friends to fill the postpartum care gap (Bryant & Raphael, 2020). These three options for postpartum care create a stark division between those who rely on the state for aid, those who can afford the private care provisions, and those who have familial support systems (Bryant & Raphael, 2020; Zadoroznyj et al., 2012).

The literature from this scoping review has revealed birth and postpartum is medicalized by the Canadian healthcare and political system (Neiterman, 2013; Spitzer, 2004). With only immediate medical needs being addressed and prioritized, women face unbalanced care appointments during the postpartum stage compared to their prenatal stages (Zadoroznyj et al., 2012). Postpartum care is unstandardized, fragmented, and infant focused, where the onus of healing and recovery is individualistic. Regarding CS, there is a lack of additional and specialized support for mothers to recover.

Medicalizing Postpartum

The Reproductive Care Program of Nova Scotia reports the postpartum period is being defined within the narrow limit of six weeks (Zadoroznyj et al., 2012). In these six weeks, minimal medical interventions are required for the uterus to shrink and recover to its pre-pregnancy physiology (Zadoroznyj et al., 2012). This limited timeframe fails to acknowledge the holistic, multifaceted, and social nature of postpartum experiences, which include the emotional, hormonal, mental, and physical changes mothers must navigate as they adapt to their caregiver roles. The medical and political systems disassociate the postpartum body from its maternal work (Neiterman, 2013). This reductionist view of the postpartum period and the care necessary and appropriate for the recovery of mothers during this period rarely go beyond medical interventions.

A paradigm shift is required to re-conceptualize the postpartum period beyond medical terms. A well-known British childbirth activist, Sheila Kitzinger, stated "there is a fourth trimester to pregnancy, and we neglect it at our peril" (Tully et al., 2017, p. 38). Due to the intensive caregiving warranted by infant biological needs, mother-baby dyads remain mutually dependent, resulting in women's bodies remaining active after birth (Neiterman, 2013). The physical demands put on the mother's body are often overlooked and ignored after giving birth, which results in exhaustion and unpreparedness among women (Matambanadzo, 2014; Neiterman, 2013). By recognizing the postpartum body as an active participant in the ongoing reproductive process, the postpartum period can be viewed as an extended fourth trimester, acknowledging the comprehensive support mothers require during their physical and emotional recovery and adaptation to their new roles.

Infant-Focused Postpartum: Surveillance Not Support

Cost-cutting measures influence the reduction in the LOS in hospitals (Salvador et al., 2022). In response to early discharge policies, postpartum nurses face the challenge of delivering comprehensive knowledge about maternal and newborn health within a brief timeframe to ensure mothers are ready for discharge. A lack of education regarding infant health, handling, and needs could end in infant injury or death. Thus, topics of infant care are prioritized. The gap in maternal-focused care and support persists after discharge. Canadian postpartum programs and policies adopt a model of care and support rooted in the surveillance of mothers to ensure the well-being and safety of the child (Benoit et al., 2014; Kelleher, 2003). The adoption of surveillance methods through assessments, questionnaires, and self-monitoring of individuals aims to identify health risks and illnesses while promoting health (Kelleher, 2003). However, in terms of postpartum recovery and support, this surveillance-oriented approach assesses the mother on her capability to parent rather than her health and needs (Kelleher, 2003). Mothers may feel a sense of judgement, scrutiny, and pressure to display their capability and competency to mother, while also being fearful of speaking out on any negative postpartum experiences in fear of being classified as "unfit" in the eyes of healthcare providers (Ahmed et al., 2008, p. 295; Cidro et al., 2012; Mercerat & Saïas, 2021). The emphasis on evaluating the mother's caregiving abilities can overshadow the provision of holistic care and support for maternal well-being.

Surveillance of the mother takes form even amongst websites and resources

provided by the government and healthcare system. These forms of support focus on development and parenting rather than maternal support. Websites such as *OMAMA* and *The Mothers Program Website* provide information about children's health and needs, parenting, and ensuring healthy children. Other resources such as *Caring For Kids Website, Ask A Public Health Nurse: Drop-In Program, Healthy Babies Healthy Children, Baby-Friendly Initiatives, Halton Parents, Halton Our Kids, and Ontario Early Years Centre* all emphasize the goals of good parenting and providing support and information about children health, needs, and development (Bluewater Health, 2023; Halton Healthcare, 2023; Southlake Regional Health Centre, 2015).

While providing competent newborn care is crucial for the mother's well-being, primary maternal care and support cannot be brushed aside and ignored at the expense of infant care. The emphasis on infants signals that mothers should prioritize their children before their health and their health concerns rank secondary unless they are experiencing high-risk issues that require medical attention.

Individualism

The liberal welfare state of Canada values minimal state interventions unless needed. Canada is described as an “individualistic culture” where every woman is held responsible for their health and well-being (Quintanilha et al., 2016, p.4). As mentioned earlier, early discharge combined with minimal postpartum visits in the postpartum period creates a care deficit for women, thus necessitating extended support from extended family or services on the market. The spatial relocation of postpartum care from

hospital to home has shifted the demand for care from the medical sector to family (Zadoroznyj et al., 2012). "The Canadian healthcare reform focuses on home and community which has increased the burden of all women in their roles of family caregivers" (Spitzer, 2004, p.496).

Familialism

The prevailing assumption and expectation of family members assuming responsibility for provisional care within the domestic realm continue to underlie public health policies, as suggested by the postpartum advice in hospital documents (Bryant & Raphael, 2020; Zadoroznyj et al., 2012). There is an implicit assumption that families are primarily responsible for offering additional postpartum care (Zadoroznyj et al., 2012). The issue stemming from familialism in liberal welfare states is that when a care deficit arises during the postpartum period, women may not have a support system capable of tending to their needs (Zadoroznyj et al., 2012). For instance, as women enter the workforce, their workplaces may not approve of taking time off to facilitate caregiving for postpartum mothers (Zadoroznyj et al., 2012). Raphael (2015), states within a liberal welfare state, individuals who cannot participate in paid employment and the labour force for any reason, receive minimal benefits from the state. This view can also help explain why the support of postpartum mothers during the postpartum period is not deemed necessary. New mothers are granted maternity leave from their participation in the workforce during the postpartum period. It might be plausible to argue that the state sees

this time off from the labour force as a break long enough for a woman to independently heal and recover (Raphael, 2015).

The implicit assumption of familialism poses a challenge in terms of Canadian immigration trends. Most immigrants leave their families, friends, and support systems when they migrate to a new country. Canada is known for its increasing intake of immigrants over the past few decades, in 2019, Canada welcomed 341,000 immigrants, aiming to hit one million new permanent residents in 2022 (Government of Canada, 2019). Female immigrants of childbearing age represent one-third of newcomers to Canada (Hetherington et al., 2022). Immigrant women have higher risks of isolation and navigating their postpartum journey without the help and advice of the support systems they leave behind (Ahmed et al., 2008; Merry et al., 2011). In the study by Benoit et al. (2012), three-quarters of their participants reported a reliance on friends and family members during the postpartum period and recognized that without such support, they would have to consider privatized care (Benoit et al., 2012). Social support networks play a vital role in the care of postpartum women. However, women without such support are left with the option to navigate their postpartum recovery by themselves or through the market.

Commodified Private Postpartum Support

While Canada can be praised for its universal public provision of maternity and postpartum care to its population, it is important to remember that the state provides a bare minimal level of care needed (Benoit et al., 2012; Zadoroznyj et al., 2012). Once

discharged from hospital, women are deemed medically stable and low-risk. Thus, the main pillars of care provided in the subacute postpartum period prioritize infant health, with numerous check-ups being made to monitor infant growth and development, encourage BF rates, and the surveillance of parenting skills rather than providing compressible care that supports the overall health needs of the dyad.

The failure to address the adverse needs of postpartum women has commodified postpartum care and services into "products of purchase" provided by individuals with degrees in nursing, midwifery or trained as doulas through the market (Benoit et al., 2012, p.1; Zadoroznyj et al., 2012). Privatized postpartum care delivers extensive services that are flexibly tailored to fit the mother-infant dyad's distinctive needs, lifestyles, and schedules (Benoit et al., 2012). Unfortunately, these services are unregulated with high costs, making additional care only accessible to those who can afford it (Benoit et al., 2012; Chang et al., 2018). These services include newborn care and support, household chores, meal preparation, running errands, and care for other children in the household to promote rest and healing for the mother (Benoit et al., 2012). A mixed-method study conducted in Victoria, Canada, with 89 participants, concluded that 34% of the women desired additional postpartum care and services not publicly available via the state during their postpartum period (Benoit et al., 2012). These women lacked the familial support and income to purchase these private commodified services (Benoit et al., 2012).. They identified the unavailability of home care support and the out-of-pocket expense of such care as a hindrance to obtaining the needed care (Benoit et al., 2012).

Lack of Additional Support and Care for C-Sections

In-Home

Through numerous of hospital handouts, there is a recognition that CS women will have immense difficulty in completing tasks due to body limitations after surgery (Burns, 2022; Healthwise Staff, 2022a; Leach, 2023; SickKids Staff, 2009). The healthcare system also acknowledges that additional help is needed to maintain a woman's household, such as housekeeping, cooking, and childcare (Burns, 2022; Healthwise Staff, 2022a; Leach, 2023; SickKids Staff, 2009). Despite this recognition, there are no in-home help or support programs provided by the state or its healthcare system for CS mothers once discharged from the hospital in Canada.

The article by Zardoroznyj et al. (2012) compared the Canadian postnatal care provisions to the Netherlands, two countries with universal health care systems that provide maternity care provisions and family-orientated policies promoting healthy children. In contrast to Canada, the Dutch healthcare system incorporates state-provided at-home postpartum care services through a program called the Kraamverzorgende, or Maternity Care Assistants (MCA) (Benoit et al., 2005; Zadoroznyj et al., 2012). Early discharge policies are also present in the Netherlands but, the state still provides proactive, comprehensive postpartum care that focuses on the mother-infant dyad while addressing the social, physical, emotional, and mental needs of postpartum women and their healing (Zagel & Reibling, 2021). These services are provided for all postpartum women regardless of their birthing method (Zadoroznyj et al., 2012).

Postpartum Education for C-Sections

Overall, there were no significant distinctions in the postpartum care and education given to CS mothers than the mothers who birthed vaginally. CS mothers have no other additional support or programs relating to their CS recovery. Unlike other surgeries where rehabilitation medicine is part of recovery, new mothers are left alone to navigate their new bodies (Weerasinghe et al., 2022). Pain management is recognized as being a major challenge for postpartum CS mothers, yet support for healing goes no further than giving a few tips and the prescription of painkillers to manage discomfort (Healthwise Staff, 2022a).

Alternative pain management interventions, such as rehabilitation medicine, can aid recovery by allowing the muscles to regain strength and heal (Arambulo, 2017). The abdominal and pelvic floor muscles undergo significant strain during pregnancy, and a CS incurs further strain by cutting through these muscles to extract the baby (Arambulo, 2017). A study conducted at De Soysa Hospital in Colombo found that women who received physiotherapy before and after a CS presented better recovery outcomes than the control group who received standard postpartum care, which did not include physio as an intervention (Weerasinghe et al., 2022). "These women felt a reduction in pain, required fewer analgesics, had a faster recovery, and resumption of daily activities than the control group" (Weerasinghe et al., 2022, p. 9). These forms of healing should also be fully covered and co-opted as forms of essential care in postpartum recovery after a CS

C-Section Education during the Prenatal Stage

Prenatal care emerges as a pivotal factor that influence birth, postpartum

outcomes, and overall perinatal health (Thiessen et al., 2018). The continuum of perinatal health encompasses pregnancy, labor, delivery, and postpartum, with each stage profoundly impacting the others. Therefore, enhancing prenatal education, with an extensive and expansive focus on CS, can be a strategic approach to preparing expectant parents mentally, physically, and emotionally (Thiessen et al., 2018). The preparation and expectations of birth occur during the prenatal stages; thus, it is of utmost importance that women are informed in-depth about the possibilities of needing an emergency CS (Thiessen et al., 2018). Women with planned CS receive additional information during the prenatal stages that cover the CS procedure, expectations, preparatory steps for postpartum healing (MUHC Royal Victoria Hospital Birthing Centre, 2015). CS in prenatal education is mainly discussed under the pretenses of risks and complications that may warrant a CS (Burns, 2022; Healthwise Staff, 2021; North York General, 2023; Sinai Health, 2023). Robb's (2011), study stated it is essential for expectant mothers to understand the possibility of a CS occurring even in pregnancies that are classified as healthy and uncomplicated. This suggests that unless a woman has a planned CS, most expectant mothers prepare for and anticipate a vaginal birth when going into labor (Robb, 2011; Thiessen et al., 2018). Consequently, when faced with needing an emergency CS, women often find themselves unprepared and blind-sided, with limited time to understand and cope with the necessary steps to birth their baby (Robb, 2011). The unpredictability of labor progression, even for healthy pregnancies, results in unattainable birth plans for some women (Public Health Agency of Canada, 2021). Reforms to prenatal care should include visiting the operating room during hospital tours and

offering a better understanding of the process well before labor (Robb, 2011). This ensures a well-informed, empowered, and emotionally prepared experience for all expectant mothers, while reducing fear, and improves women's autonomy (Robb, 2011).

Research

Finally, there seems to be a significant gap in the literature about the care of CS in Canada. Despite the alarmingly rising rates of CS, there is a significant lack of research on the diverse and different needs of CS postpartum women. Without up-to-date and focused research, postpartum policies and programs do not have evidence-based feedback and understanding to change the current guidelines, policies, and support.

Limitations of Paper

While this scoping review has provided valuable insights into the Canadian postpartum approach, it is essential to recognize and acknowledge its limitations. Critical limitations include geographical, population, research paradigm, and methodological constraints on the findings and analysis of this scoping review. These limitations underscore the need for caution in generalizing the findings and highlight the opportunity for further research and exploration in this area. Acknowledging these limitations also aims to enrich the discussion and analysis of the research found and presented.

Geographical Limitations

One notable limitation of the scoping review is its geographical focus. Almost half of all the literature used in this scoping review, were Ontario-focused (43%). Ontario serves as a significant and informative case study, but healthcare in Canada falls under

provincial jurisdiction. Therefore, postpartum care programs, policies, and practices, can significantly vary from one province to another. Furthermore, it is impossible to comprehensively identify every policy, program, or postpartum initiative on a federal, provincial, and local level within the confines of a major research paper (MRP). Thus, the findings and conclusions drawn from this scoping review may not fully capture the diversity and nuances of postpartum care within specific provinces or local communities. Additionally, it is crucial to understand that this paper only scratched the surface of the postpartum approach in Canada, for there was a complete lack of discussion about postpartum care within the Northwest Territories, Nunavut, and Yukon.

Population Limitations

Another major limitation of this scoping review included the population used for analysis. The studies used from the databases relied on generalized populations within Canada to analyze postpartum care experiences and satisfaction. It is crucial to acknowledge that postpartum experiences, healthcare needs, and cultural factors vary significantly among different demographic groups. Different needs are based on age, socioeconomic status, ethnicity, and cultural background. Except for a few articles that solely focused on the immigrant and refugee experience (Ahmed et al.,2008; Gannan et al., 2012; Mumtaz et al., 2014), other studies were conducted in English, with most participants identifying as Caucasian (Dol et al., 2022a; Ke et al., 2021).

The postpartum recovery experience for racialized and immigrant groups can

vary significantly. Firstly, foreign-born women have 16% higher odds of having a CS than Canadian-born women, especially emergency CS's (Gagnon et al., 2013). Conversely, Indigenous women are less likely to receive a CS due to their regions' lack of perinatal health services and care (Riddell et al., 2016). One article addressed the postpartum recovery experience for individuals with disabilities (Mercerat & Saïas, 2021), another study excluded women with major mental illnesses (Dennis et al., 2017). Research also indicates that women with disabilities have an elevated risk for CS (Darney et al., 2019). Limited information is available on how CS and its recovery affect women with disabilities and whether additional support programs exist.

Finally, the paternal perspective during the postpartum period was an intriguing inclusion, as observed in Mercerat and Saïas (2021) study. This was the only study that incorporated the male point of view, voice, and experience. While childbirth and recovery are woman-centric experiences, it would be unwise to neglect the voices and experiences of fathers, especially if they play active roles in supporting childcare and their partners during the postpartum period. Again, addressing every diverse and unique need of specific subpopulations of postpartum women within Canada's entire geographical landscape is unattainable within this MRP's limitations. Thus, multiple in-depth studies of specific geographical locations with the study of diverse populations are needed.

Methodological Limitations of a Scoping Review

Scoping reviews are becoming an increasingly popular methodology for

synthesizing research evidence due to their ability to identify existing literature in a specific field of interest (Pham et al., 2014). However, this research methodology has limitations within the scope of this paper. There's a possibility that relevant studies and websites have been missed during data collection. Given the broad nature of my research question, which aims to identify postpartum recovery in Canada, it is challenging to comprehensively cover all postpartum care programs and support through a scoping review. Scoping reviews are not designed to be exhaustive and may not capture every piece of relevant information (Pham et al., 2014). Every program in Canada will not be covered in a study, journal article, reports, or website, as evidenced by only certain local initiatives and programs identified in the literature, such as SCBP in BC, MCHB in Edmonton, and the *Restoring the Sacred Bond Program* in Manitoba. Using pre-determined themes and criteria in my literature scoping also introduced subjectivity in article selection. Despite efforts to remain objective, the choice of studies was ultimately subjective and guided by my discretion. This approach could have led to the exclusion of some relevant articles.

The Canadian federal government sets and administers national standards for healthcare systems through the Canada Health Act, while provincial governments manage, organize, and deliver healthcare services to their residents (Butler & Tiedemann, 2011). Moving forward, a more effective approach would be to narrow the search for postpartum care programs to individual provinces, allowing for a deeper understanding of the services available across different regions. Incorporating grey literature and conducting primary research could provide more comprehensive answers to this research

question. Data collection from provincial, hospital, midwifery, and local health websites could identify every program rather than relying solely on database literature.

Limitations of the Political Economy Framework

The political economy research paradigm critically examines the intersection of political ideology and power relations, such as the state and market, and their influence on public policies that govern the production, distribution, and consumption of resources within the healthcare system (Raphael & Bryant, 2019). While insightful, its application to women's health has limitations, particularly in understanding the deficit in postpartum care in Canada. This paradigm tends to view and understand issues through an economic lens, overlooking the complex social and cultural factors of childbirth, recovery, and motherhood (Syed, 2021). Although valuable in understanding the forms, extent, and duration of care the government provides, this paradigm fails to offer rich interpretations of data that consider the complexities of postpartum care and women's diverse needs.

The political economy paradigm suggests that the scarcity of postpartum care is economically driven, attributing it to women's perceived reduced contribution to the workforce during the postpartum period (Raphael, 2015). The addition of a feminist analysis can provide an alternative understanding of the underinvestment in postpartum care services. A feminist research paradigm is better suited to understanding a more comprehensive critique of the current postpartum shortcomings, gaps, and inequities surrounding women health. It can provide insight into how gender biases contribute to the neglect and misunderstanding of postpartum care while also delving into the myriad

complexities of how the structure of the healthcare system and its services are influenced by gender roles and societal expectations of women (Beetham & Demetriades, 2007; Schmidt et al., 2023; Syed, 2021). This perspective critically assesses the devaluation of caregiving work such as motherhood, highlighting the invisible and unpaid labour in the home and its significant impact on women (Schmidt et al., 2023; Syed, 2021). Stigmas, societal norms, and expectations pressure women to bounce back as soon as possible, and in the cases where women may be struggling during this period, they may face judgment and inadequate support (Schmidt et al., 2023). Furthermore, the feminist lens argues that patriarchal influences in healthcare systems and policies often overlook or marginalize women's specific health needs (Vernon, 2015). Advocacy from this perspective calls for a more holistic recognition of the postpartum period, going beyond medical terms to acknowledge postpartum women's diverse and complex needs (Beetham & Demetriades, 2007). Lastly, the feminist lens emphasizes the demand for women's experiences and voices to be heard and central to developing comprehensive and effective care policies (Beetham & Demetriades, 2007; Schmidt et al., 2023; Syed, 2021).

Another shortcoming of the political economy research paradigm is its critical approach (Raphael & Bryant, 2019), which often focuses predominantly on the negatives, sometimes overlooking positive outcomes. Firstly, there is a major critique of the biomedical model of birth (Cusack et al., 2008; Neiterman, 203; Spitzer, 2004; Zadoroznyj et al., 2012), however, the medicalization of birth has several positive aspects. These include enhanced maternal and infant safety, reduced mortality rates, and improved mother-baby dyad monitoring, as Espinosa et al. (2022) noted. Although the

over-medicalization of birth has been criticized for not respecting the natural process of childbirth and potentially compromising women's agency and autonomy, its contributions to the health and safety of both mother and child are significant and undeniable. While some CS procedures might be medically unnecessary, the inaccessibility to CS interventions poses greater risks to the mother-baby dyad (Kornelsen & Koepke, 2022). Espinosa et al. (2022) study further reveals that most women prefer a medicalized childbirth, valuing the availability of emergency services and healthcare professionals.

Additionally, critiques of early discharge policies often do not fully consider parental preferences. In certain instances, it has been reported that women view extended hospital stays as unnecessary, particularly when they feel confident in their knowledge and experience of caring for their newborn, and recover better at home (Knudsen et al., 2020; Lindblad et al., 2023).

Policy Recommendations

This scoping review was able to identify numerous gaps and limitations within the current postpartum care and support policies and programs, however, there should be some acknowledgement of what programs currently exist for postpartum women. Firstly, all aspects of birth, hospital stay, and postpartum appointments are covered and paid for by the Canadian government. In comparison to the USA, postpartum women are found to experience higher levels of medical debt due to the lack of universal healthcare coverage (Cahn et al., 2023). Women in the USA need access to privatized health insurance or must pay out of pocket for the same medical services and hospital stays as Canadian

women (Cahn et al., 2023). Second, the government covers care under the midwifery model, allowing women the choice between OBs and midwives. This choice allows women the access to more frequent postpartum appointments than the physician model of care. Lastly, I do not believe that the government and healthcare systems are maliciously and deliberately withholding care for postpartum women as evident in the creation of numerous program initiatives and resources provided within local and hospital communities. I do believe that the commonality of birth and CS put immense resources pressures within the healthcare system and more effective policies need to be put in place to better allocate the resources to achieve the best results of care. I propose four policy recommendations that could be worth exploring in the future to better and reconstruct current care approaches.

First, the reconstruction of current prenatal education for CS. With CS becoming increasingly common, women need to be prepared in advance for the possibility of a CS, even if it is not a part of their desired birth plan. Even women who have healthy and uncomplicated pregnancies are at risk for unexpected complications that can arise during labor and delivery. Prenatal education can provide the mental preparation and understanding for a CS so that in the case of an emergency CS women are not felt completely blindsided and unprepared.

Second, integrated models of care becoming more popular especially during the postpartum period. A coalition between public health nurses, midwives, and doulas could combat the care deficit stemming from early discharge and unstandardized and infant-focused care. The midwife model of postpartum appointments can be shared between

doulas and public health nurses to offer postpartum mothers a blend of social and medical support.

Third, an introduction to post-CS rehabilitation as part of the recovery process for CS mothers. Post-operation pain rehabilitation is often a recovery tool for orthopedics, cardiac, and abdominal surgical procedures (Weerasinghe et al., 2022). Physiotherapy can help provide solutions to managing pain, postural problems, reduced mobility, and the strengthening of the pelvic floor and abdominal muscles after a CS (Weerasinghe et al., 2022). It offers CS mothers a proactive recovery approach where the strengthening of their bodies and muscles are prioritized in addition to the analgesics and tips to manage pain and discomfort.

Lastly, a program initiative that provides subsidized care for women without support systems. Under the liberal welfare state pretenses of providing additional support and assistance through means-tested or on a needs basis, women without support systems can be assessed for eligibility of subsidized postpartum care. The government would still assess factors to determine eligibility such as income and migrant status, however it would take into consideration if women had support systems to help with their recovery. Factors such as the presence of a partner with paid paternity leave, if family is in Canada or abroad, and how many children does the women have, would be considered. Even if the subsidy does not cover the full cost of privatized postpartum care, having that option may help women in those first six weeks after birth.

Conclusion

The Canadian healthcare system and the health policies that govern the duration and extent of care focus on providing reactive care instead of preventative care, where only dyads that are categorized as high-risk receive additional and extensive support (Russell et al., 2018; Zadoroznyj et al., 2012). This reactive approach, coupled with early discharge policies, unstandardized postpartum check-ups, and infant-focused care, minimizes the importance of maternal recovery and well-being during this critical period. As a result, many women navigate the postpartum phase independently, with minimal support and intervention, unless they have family, friends, or money to fill the care deficit.

The shift from CS being a last-resort emergency procedure to a widely applied and elective childbirth method has reconstructed millions of women's birth and recovery experiences worldwide. Even though current policies and care programs pose care deficits for vaginal birth recoveries, recovery policies and protocols are continuously centered around discourses and experiences of women who have uncomplicated vaginal births. As the rate of CS births continues to rise, the prevailing Canadian postpartum care foundation neglects unique needs during the post-CS recovery period. The disproportionate emphasis on vaginal birth recovery in research, policy, and care perpetuates the silencing of the experiences and needs of CS mothers. It hinders the ability to provide tailored, practical support to this growing sector within the postpartum landscape. There is a need for comprehensive reform that addresses the diverse needs of mothers in the postpartum period, irrespective of their mode of childbirth, and ensures that they receive the necessary support and resources to recover after birth. To ensure

both mother and baby are supported, new research is needed to address gaps in the current postpartum approach and to establish better-structured standardized programs and approaches.

Conclusively, "it takes a village to raise a child," however, this scoping review firmly asserts that "it takes a community to raise and support a mother" (Finlayson et al., 2020, p. 17). The glaring disparities between maternal monitoring and care, both during prenatal and postnatal phases, underscore an inequitable ideology—one that implies a mother's health becomes secondary to her child after childbirth. While I do not believe the state or the healthcare system intentionally neglects or withholds care from postpartum women, I do believe the state and healthcare professionals play influential leadership roles in our society. The time, dedication, and care doctors, midwives, and nurses provide women should be applauded however, policymakers must urgently address the expanding postpartum care deficit within the Canadian healthcare system, including the resources and support necessary for a full and healthy recovery.

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Appendix

Appendix A: Concepts and Keywords Used.

Concept	**Search Terms**
C-Section	“C-section” OR “cesarean section” OR cesarean delivery”
Postpartum Care	“Postpartum care” OR “postnatal care”
Postpartum Recovery	“Postpartum recover*” OR “postnatal recover*”
Programs	“Program*” OR “service*” OR “education”
Canada	“Canada” OR “Alberta” OR “British Columbia” OR “Manitoba” OR “New Brunswick” OR "Newfoundland and Labrador" or “Northwest Territories” or “Nova Scotia” or “Nunavut” or “Ontario” or “Prince Edward Island” or “Québec” or “Saskatchewan” or “Yukon Territory”

Appendix B: Search Strategy Process of Keywords.

Search Strategy Part 1	(Postpartum care" or "postnatal care") ("postpartum recover*" or "postnatal recover*) AND ("educat* or service* or program*)
Search Strategy Part 2	(Postpartum care" or "postnatal care") ("postpartum recover*" or "postnatal recover*) AND ("educat* or service* or program*) AND (Canada" OR "Alberta" OR "British Columbia" OR "Manitoba" OR "New Brunswick" OR "Newfoundland and Labrador" or "Northwest Territories" or "Nova Scotia" or "Nunavut" or "Ontario" or "Prince Edward Island" or "Québec" or "Saskatchewan" or "Yukon Territory")
Search Strategy Part 3	(Postpartum care" or "postnatal care") ("postpartum recover*" or "postnatal recover*) AND ("educat* or service* or program*) AND (Canada" OR "Alberta" OR "British Columbia" OR "Manitoba" OR "New Brunswick" OR "Newfoundland and Labrador" or "Northwest Territories" or "Nova Scotia" or "Nunavut" or "Ontario" or "Prince Edward Island" or "Québec" or "Saskatchewan" or "Yukon Territory") AND ("C-section" or "cesarean section" or cesarean delivery")

Appendix C: Locations and Nature of Study for Literature with Citations.

Type of Literature	Location	Citation
Database	1. Ontario: 13 2. Canada: 7 3. British Colombia: 6 4. Nova Scotia: 5 5. Manitoba: 4 6. Quebec: 4 7. Alberta: 3 8. Canada & other countries: 2 9. Saskatchewan: 2 10. Newfoundland: 1	1. Ahmed et al., 2008; Braimoh & Davies, 2014; Crowley, 2014; Dennis et al., 2018; Kelleher, 2003; Merry et al., 2011; Nieterman, 2013; Russell et al., 2018; Salvador et al., 2022; Sword et al., 2004; Sword & Watt, 2005; Sword et al., 2006; Wooten & Dowsett, 2012. 2. Cidro et al., 2021; Ganann et al., 2012; Grisbrook & Letourneau, 2021; Ke et al., 2021; O'Brien et al., 2011; Spitzer, 2004; Youash et al., 2012. 3. Ahmed et al., 2008; Chang et al., 2018; Dennis et al., 2018; Harris et al., 2012; Kornelsen & Koepke, 2022; Mackinnon, 2010. 4. Dol et al., 2022a; Dol et al, 2022b; Douglas et al., 2008; Price et al., 2018; Robb, 2011. 5. Cidro et al., 2021; Cusack et al., 2008; Mumtaz et al., 2014; Thiessen et al., 2018. 6. Ahmed et al., 2008; Dennis et al., 2018; Mercerat & Saïas, 2021; Merry et al., 2011 7. Mumtaz et al., 2014; Quintanilha et al., 2016; Wollny et al., 2021. 8. Kelleher, 2003; Suplee et al., 2014; Zadoroznyj et al., 2012. 9. Mumtaz et al., 2014; Olson et al., 2019 10. St-Croix, 2021

Google Grey Literature	1. Ontario: 15 2. British Colombia: 4 3. Alberta: 2 4. Canada: 2 5. Nova Scotia: 1 6. Quebec:1 7. Saskatchewan: 1	1. Bluewater Health, 2023; (Burns, 2022; Cornwall Community Hospital, 2023; Guelph General Hospital, 2023; Halton Healthcare, 2023; Humber River Health, 2022; Mackenzie Richmond Hill Hospital, 2010; North York Genera, 2023; Sault Area Hospital, 2019; SickKids Staff, 2009; Sinai Health, 2023; Southlake Regional Health Centre, 2015; Sunnybrook Hospital, 2023; The Ottawa Hospital, 2008; William Osler Health System, 2023. 2. Bump Physio & Co, 2022; Healthwise Staff, 2021; Opal Physio, 2023; Wint, 2022. 3. Healthwise Staff, 2022b; High River Maternity Clinic, 2018. 4. Leach, 2023; The Society of Obstetricians and Gynaecologists of Canada, 2023 5. Synergy, 2023 6. MUHC Royal Victoria Hospital Birthing Centre, 2015 7. Healthwise Staff, 2022a
	Nature of Study	Citation
Database	1. Qualitative: 17 2. Quantitative: 11 3. Mixed Methods: 5 4. Journal Article: 3 5. Systemic Review: 2 6. Comparative Study: 1	1. Ahmed at al., 2008; Braimoh & Davies, 2014; Chang et al., 2018; Cidro et al., 2021; Cusack et al., 2008; Douglas et al., 2008; Kelleher, 2003; Kornelsen & Koepke, 2022; MacKinnon, 2010; Mercerat & Saïas, 2021; Merry et al., 2011; Neiterman, 2013; Price et al., 2018; Quintanilha et al., 2016; Robb, 2011, Spitzer, 2004; Wollny et al., 2021. 2. Crowley, 2014; Dennis et al., 2018; Ganann et al., 2012; Harris et al., 2012; Mumtaz et al., 2014; Olson et al., 2019; Russell et al., 2018; Salvador et al., 2022; Sword & Watt, 2005; Sword et al., 2006; Youash et al., 2012. 3. Dol et al., 2022a; Dol et al., 2022b; Ke et al., 2021; O'Brien et al., 2011; Sword et al., 2004. 4. Grisbrook & Letourneau, 2021; St Croix, 2021; Zadoroznyj et al., 2012 5. Suplee et al., 2014; Wooten & Dowsett, 2012 6. Thiessen et al., 2018

Google Grey Literature	1. Hospital Website: 16 2. Physiotherapist Clinic: 4 3. Government Website: 3 4. Blog: 2 5. Organization: 1	1. Bluewater Health, 2023; Cornwall Community Hospital, 2023; Guelph General Hospital, 2023; Halton Healthcare, 2023; High River Maternity Clinic, 2018; Humber River Health, 2022; Mackenzie Richmond Hill Hospital, 2010; MUHC Royal Victoria Hospital Birthing Centre, 2015; North York General, 2023; Sault Area Hospital, 2019; SickKids Staff, 2009; Sinai Health, 2023; Southlake Regional Health Centre, 2015; Sunnybrook Hospital, 2023; The Ottawa Hospital, 2008; William Osler Health System, 2023. 2. Bump Physio & Co, 2022; Burns, 2022; Opal Physio, 2023; Synergy, 2023. 3. Healthwise Staff, 2021; Healthwise Staff, 2022a; Healthwise Staff, 2022b. 4. Leach, 2023; Wint, 2022 5. The Society of Obstetricians and Gynaecologists of Canada, 2023

Appendix D: Themes and Sub-themes of Finding with Citations.

Themes/Sub-themes	References
Models of Care	Cidro et al., 2021; Cusack et al., 2008; Dol et al., 2022b; Douglas et al., 2007; Harris et al., 2012; MacKinnon, 2010; Mumtaz et al., 2014; O'Brien et al., 2011; Robb, 2011; Russell et al., 2018; Salvador et al., 2022; Suplee et al., 2014; Thiessen et al., 2018; Zadoroznyj et al., 2012)
Defined Postpartum Period	Cidro et al., 2021; Cusack et al., 2008; Dol et al., 2022b; Douglas et al., 2007; Harris et al., 2012; MacKinnon, 2010; Mumtaz et al., 2014; O'Brien et al., 2011; Robb, 2011; Russell et al., 2018; Salvador et al., 2022; Suplee et al., 2014; Thiessen et al., 2018; Zadoroznyj et al., 2012)
Early Discharge & LOS	Chang et al., 2018; Crowley, 2014; Cusack et al., 2008; Dol et al., 2022b; Harris et al., 2012; Kelleher, 2003; Olson et al., 2019; Salvador et al., 2022; Spitzer, 2004; Suplee et al., 2014; Sword et al., 2004; Wooten & Dowsett, 2012; Zadoroznyj et al., 2012
Nurses & postpartum	Crowley, 2014; Cusack et al., 2008; Harris et al., 2012; Humber River Health, 2022; Kelleher, 2003; MacKinnon, 2010; Mumtaz et al., 2014; Olson et al., 2019; Russell et al., 2018; Spitzer, 2004; St Croix, 2021; Suplee et al., 2014; Sword et al., 2004; Sword et al., 2006; Wooten & Dowsett, 2012
Infant Care	Cornwall Community Hospital, 2023; Crowley, 2014; Halton Healthcare, 2023; Neiterman, 2013; Olson et al., 2019; Price et al., 2018; Spitzer, 2004; Suplee et al., 2014; Sword & Watt, 2005; The Ottawa Hospital, 2008
Breastfeeding	Bluewater Health, 2023; Braimoh & Davies, 2014; Cornwall Community Hospital, 2023; Crowley, 2014; Halton Healthcare, 2023; Harris et al., 2012; Healthwise Staff, 2022a; Healthwise Staff, 2022b; Leach, 2023; Mackenzie Richmond Hill Hospital, 2010; Mercerat & Saïas, 2021; Neiterman, 2013; Olson et al., 2019; Salvador et al., 2022; SickKids Staff, 2009; Southlake Regional Health Centre, 2015; St Croix, 2021; Suplee et al., 2014; Sword et al., 2006; The Ottawa Hospital, 2008; Wooten & Dowsett, 2012; Youash et al., 2012
Mental Health	Ahmed et al., 2008; Grisbrook & Letourneau, 2021; Halton Healthcare, 2023; Healthwise Staff, 2022a; Olson et al., 2019; Robb, 2011; Southlake Regional Health Centre, 2015
Postpartum eHealth	Bluewater Health, 2023; Chang et al., 2018; Dol et al., 2022b; Halton Healthcare, 2023; Ke et al., 2021; Price et al., 2018; Southlake Regional Health, 2015; Sword & Watt, 2005; Sword et al., 2004; Sword et al., 2006; The Ottawa Hospital, 2008; Wooten & Dowsett, 2012

Lack of Research	Chang et al., 2018; Crowley, 2014; Dennis et al., 2017; Dol et al., 2022b; Gannan et al., 2012; Price et al., 2018; Salvador et al., 2022; Suplee et al., 2014; Sword & Watt, 2005; Sword et al., 2004; Sword et al., 2006; Youash et al., 2012
Immigrants	Ahmed et al., 2008; Chang et al., 2018; Dennis et al., 2017; Gannan et al., 2012; Merry et al., 2011; Mumtaz et al., 2014; Quintanilha et al. 2016; Spitzer, 2004
Rural Canada	Harris et al., 2012; Kornelsen & Kopeke, 2022; MacKinnon, 2010; St-Croix, 2021
Unstandardized Postpartum Care	Crowley, 2014; Cusack et al., 2008; Dol et al., 2022a; Dol et al., 2022b; Grisbrook & Letourneau, 2021; Kelleher, 2003; Kornelsen & Koepke, 2022; MacKinnon, 2010; Mercerat & Saïas, 2021; Neiterman, 2013; Salvador et al.,2022; Sword et al., 2004; Sword et al., 2006; Wollney et al., 2021; Youash et al., 2012; Zadoroznyj et al., 201

Appendix E: Summary of Models of Care in Theme One.

Model of Care	Healthcare Provider	Prenatal Appointments	Postpartum Appointments
Physician Model:	• Family Doctor/Nurse Practitioner (early pregnancy) - in some cases family doctors can provide complete prenatal, birth, and postpartum services. • OB/GYN (<25 weeks pregnancy until birth) • OB/GYN and nurses (hospital) • Family Doctor and Community Health Nurses (Week 1-6 postpartum) • OB/GYN or Family Doctor (6-week postpartum check-up)	Check-Ups • Week 1 - Week 30: once a month • Week 32-Week 36: biweekly • Week 37-Week 42: once a week	• Week 1: one appointment, within 2-3 days after discharge, mostly focused on the baby. • Week 6: postpartum checkup for the mother • Check-ups are done in the clinic
Midwifery Model	• Midwife from early stage of pregnancy. • Consultation with a physician if needed. • Transferral of care to physician if pregnancy or birth becomes high-risk or complicated. • Midwife resumes care during postpartum period	Check-Ups • Week 1 - Week 30: once a month • Week 32-Week 36: biweekly • Week 37-Week 42: once a week (home visit offered)	• Within 24 hours after birth: one appointment • Day 2-3: one appointment • Week 1-2: one appointment • Week 3-Week 4: one appointment • Week 6: one appointment
Integrated Model: Montfort Postnatal Care-at-Home Program	• OB/GYN • Midwife • Nurses	N/A	• Within 24 hours after birth: one appointment • Week 1: 1-2 appointments (virtual or in-home) • Dyad discharged after one week to receive care original primary

Model of Care	Healthcare Provider	Prenatal Appointments	Postpartum Appointments
			caregiver during pregnancy. ● Week 1-Week 6: 24/7 access to hospital helpline with midwife or OB/GYN
Integrated Model: The South Community Birth Plan	● OB/GYN ● Midwife ● Nurses ● Doulas		● Home visit day after discharge ● Additional Visits scheduled if needed. ● Postpartum support from doula ● Breastfeeding support provided in clinic by nurse lactation consultant. ● Discharged at week 6. ● Weekly drop-in clinic is available to women for up to 6 months postpartum
Doula (Out of Pocket Expenses)	Doula	Available to mothers during labor and delivery for extra support, motivation, and patient advocacy	● Postpartum Doula ● Night Night/Doula
Doula - Government Funded	Postpartum Doulas		● Restoring the Sacred Bond" program - Indigenous Mothers in Manitoba ● The South Community Birth Plan (SCBP) in Vancouver

Appendix F: Organizations and Programs with their Discharge and Follow Up Recommendations.

Programs/Organizations	**Early Discharge Recommendations**	**In-Home Visits/ Follow Up Recommendations**
Early Discharge (General)	• 48 hours for uncomplicated vaginal birth • 96 hours for uncomplicated CS birth	
The World Health Organization	• At least 24 hours for uncomplicated vaginal birth	• One appointment at 48-72 hours after discharge • One appointment at 7-14 days • One appointment at six weeks postpartum
The Society of Obstetricians and Gynecologists of Canada	• Minimum of 48 hours for uncomplicated vaginal birth	• Follow up after one week of discharge. • Appointment between 4-6 weeks postpartum
The Canada Paediatric Society	• Minimum of 48 hours for uncomplicated vaginal birth	• Appointment 48-72 hours after discharge • Appointment one-week post-discharge
The Healthy Babies Healthy Children Program (HBHC)		• Phone call 48 hours after discharge • Offer a home visit to complete assessment of families. • Families who are considered “moderate to high risk” admitted to HBHC blended home visiting program

Ontario's Hospital Stay and Postpartum Home Visiting Program	• 60 hours for uncomplicated vaginal birth	• Phone call 48 hours after discharge • In-person visit at home or in community if needed
Healthy & Home Program	• 48 hours for uncomplicated vaginal birth • 96 hours for uncomplicated CS birth	
The South Community Birth Plan	• 24-48 hours	• Home visit within 24 hours of discharge • Additional visits scheduled if needed. • Postpartum support from doula • Breastfeeding support provided in clinic by nurse lactation consultant. • Discharged at week 6. • Weekly drop-in clinic is available to women for up to 6 months postpartum
Hôpital Montfort in Ottawa introduced the Montfort Postnatal Care-at-Home Program	• 24 hours	• Home visit within 24 hours of discharge • 1-2 additional home visits or virtual visits during Week 1 • Access to 24/7 helpline • Transferred care after one week to OB or Midwife • 6-week appointment

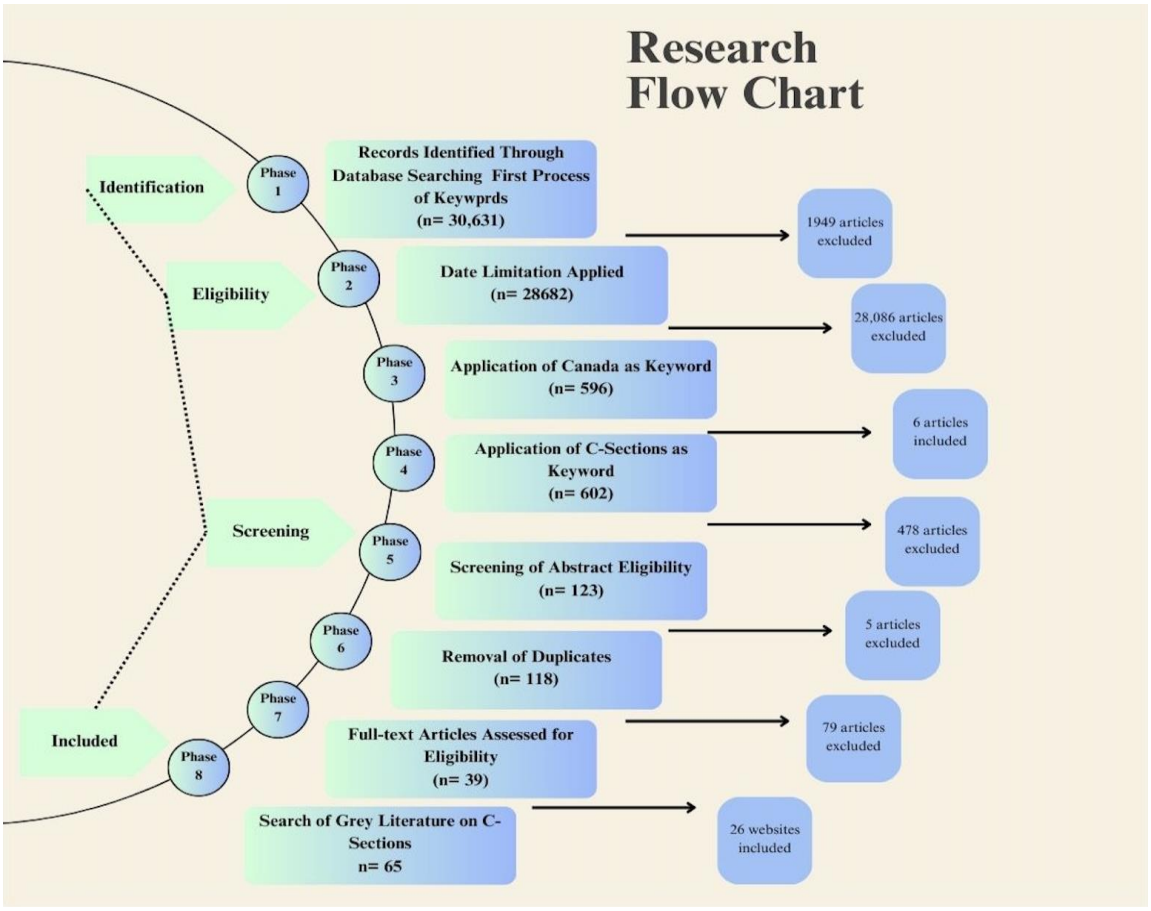
Appendix G: Websites and Phone Numbers Provided for Postpartum Help.

Resource	Description	Contact Information
Telehealth 24hr Breastfeeding Support	Breastfeeding Support Line running 24 hours, 7 days a week	• 1-866-797-0000
After Hours Breastfeeding Support	Breastfeeding Support from 5pm-9pm	• 1-888-847-9614
Motherisk	Questions or Concerns Regarding Medications/Alcohol Use During Breastfeeding	• 1-877-439-2744 • www.motherrisk.org
La Leche League Canada	Breastfeeding Support	• 1-800-665-4324 • www.lllc.ca
Connection Peer Telephone Support	Breastfeeding support supported by Halton region Health Department	• 311 • www.halton.ca
Peel Breastfeeding Support Clinic	Breastfeeding Support	• 905-791-7800
Oaville Trafalgar Memorial Hopsital Breastfeeding Support Clinic	Breastfeeding Support	• 905-338-4131
Milton District Breastfeeding Support Clinic	Breastfeeding Support	• 905-878-2383 ext 7610
Joseph Bryant Hospital Breastfeeding Support Clinic	Breastfeeding Support	• 905-681-4831

Guelph Hospital Breastfeeding Support Clinic	Breastfeeding Support Monday to Friday 8:30am-4:30pm	• 519-822-3330 ext 2238
Credit Valley Hospital Breastfeeding Support Clinic	Breastfeeding Support	• 905-813-2200
Community Care Access Centre	Postpartum Help	• 905-639-5228
Association of Ontario Doula	Postpartum Help	• 1-888-879-3199 • www.ontariodoulas.org
Community Auntie Services	Assisting New Parents with Newborn Care	Within the Mohawk Council of Akwasasne: Kanonhkwat'sheri:io
Postpartum Adjustment Services	Mental Health Help at St. Clair Child & Youth	• 519-337-3701 • www.stclairchild.ca
NeighbourLink Sarnia-Lambton	Church members and Volunteer help with finances and transport	• 519-336-5465 • www.neighborlinksarnia.org
OMAMA Website	Ontario website connecting women/families to trusted information about healthy pregnancy, birth and early parenting	• www.omama.com
Mothers Program Website	Information on latest medical information to ensure health pregnancy, healthy children =healthy adult	• www.themotherspro gram.ca/about.
Ontario Maternal Newborn and Early Child Development Resource Centre		• www.beststart.org

Ontario Early Years Centre	A place for parents and their children	• http://www.oeyc.edu.gov.on.ca/
Ask a Public Health Nurse: Drop-In Program	Breastfeeding support, infant child nutrition, newborn care, growth, and development, and parenting	• 519–383-3817
Caring for Kids Website	Developed by the CPS to provide information about children's health and needs	• www.caringforkids.cps.ca
Healthy Babies Healthy Children Program	Support from both until school age	
Halton Baby Friendly Initiative		• www.babyfriendlyhalton.ca
Halton Our Kids	Support healthy development of children and youth	• ww.ourkidsnetwork.ca

Appendix H: Flow Chart of Article Selection.



Appendix I: Charting Information for Database Literature.

Database	Citation	Research Design/Population	Objective	Conclusion
psychINFO	Price, L. S., Aston, M., Monaghan, J., Sim, M., Tomblin Murphy, G., Etowa, J., Pickles, M., Hunter, A., & Little, V. (2018). Maternal Knowing and Social Networks: Understanding First- Time Mothers' Search for Information and Support Through Online and Offline Social Networks. *Qualitative Health Research, 28(10)*, 1552–1563. https://doi.org/10.1177/1049732317748314.	focus groups, electronic interviews (e-interviews), and online forums. n=19	explore how first-time mothers accessed support and information during the initial 6 months postpartum, utilizing a feminist poststructuralism methodology. Data were collected from focus groups and e-interviews, then analyzed through discourse analysis.	first-time mothers desire more opportunities to share experiences with peers for empathy, reassurance, and validation, as existing programs often focus on imparting "skills and knowledge" by healthcare professionals.
psychINFO	Chang, H. S., Hall, W. A., Campbell, S., & Lee, L. (2018). Experiences of Chinese immigrant women following “Zuo Yue Zi” in British Columbia. *Journal of Clinical Nursing, 27(7-8),* e1385–e1394. https://doi.org/10.1111/jocn.14236	Semi Structured Interviews conducted in Mandarin, translated into English, transcribed, and analyzed using inductive content analysis. N=19	growing immigration from China and Taiwan to Canada, thus study explores the experiences of Chinese women practicing “zuo yue zi” in British Columbia, Canada	Chinese immigrant women in Canada face challenges adapting traditional postpartum practices due to financial constraints, unregulated helpers, and varying healthcare support. The study emphasizes the need for appropriate postpartum care and healthcare provider support for those following “zuo yue zi,” and highlights the necessity of regulatory guidelines to protect mothers and newborns from unregulated paid care providers in their new country.

psychINFO	Dennis, C. L., Merry, L., & Gagnon, A. J. (2017). Postpartum depression risk factors among recent refugee, asylum-seeking, non-refugee immigrant, and Canadian-born women: results from a prospective cohort study. *Social Psychiatry and Psychiatric Epidemiology*, *52(4)*, 411–422. https://doi.org/10.1007/s00127-017-1353-5.	Two questionnaires at 1–2 and 16 weeks postpartum. Bivariate analyses and multivariate logistic regression were performed to examine and compare risk factors for postpartum depressive symptoms at 16 weeks postpartum. n= 1536 women (1024 migrant and 512 Canadian-born) were recruited from 12 hospitals	The study aimed to compare postpartum depression risk factors between recent (≤5 years) migrant and Canadian-born women, as well as among refugee, asylum-seeking, and non-refugee immigrant women.	Certain risk factors make migrant women more susceptible to post-birth depressive symptoms, particularly those related to vulnerability, such as abuse, food insecurity, family separation, lack of social support, and a diminished sense of belonging. Early assessment during pregnancy and postpartum can guide interventions to reduce or prevent these symptoms.
psychINFO	Braimoh, J., & Davies, L. (2014). When “breast” is no longer “best”: Post-partum constructions of infant feeding in the hospital. *Social Science & Medicine*, *123*, 82–89. https://doi.org/10.1016/j.socscimed.2014.10.052	in-depth interviews and follow-up interviews. n=32	explores the social construction of infant feeding in hospitals by examining mothers' initial breastfeeding experiences.	This study identifies moments in breastfeeding categorized as Successful, Ultimately Successful, or Unsuccessful. Successful moments portray breastfeeding as natural but learned. Unsuccessful instances indicate a shift to formula when healthcare providers view breastfeeding as not working. Although formula becomes necessary, it is not considered a "good or best" practice. Mothers transitioning from breast to formula often perceive it as a failure or inadequacy in mothering.

psychINFO	Suplee, D. P., Bloch, J. R., McKeever, A., Borucki, L. C., Dawley, K., & Kaufman, M. (2014). Focusing on Maternal Health Beyond Breastfeeding and Depression during the First Year Postpartum. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 43(6)*, 782–791. https://doi.org/10.1111/1552-6909.12513.	Literature search on CINAHL, 2003-2013	The practices for the care of women during the recovery year after childbirth focus on maternal transition, role and function, and psychosocial support.	emphasize need for clarification on the psychosocial aspects of childbirth and motherhood, as well as family support systems. The review calls for further evidence to guide health professionals in understanding maternal needs beyond the traditional 6-week postpartum period, suggesting research on interventions, conceptual discourse, cultural considerations, and long-range studies
psychINFO	Ganann, R., Sword, W., Black, M., & Carpio, B. (2012). Influence of Maternal Birthplace on Postpartum Health and Health Services Use. *Journal of Immigrant and Minority Health, 14(2)*, 223–229. https://doi.org/10.1007/s10903-011-9477-2	Self-reported questionnaires were completed by women before hospital discharge and structured telephone interviews were conducted 6 weeks post-delivery. The materials were accessible in English, French, Spanish, and Chinese. N=1045	Compared health status, postpartum depression rates, perceptions of health services, unmet service needs, and barriers to service use among women born inside and outside of Canada six weeks after postpartum hospital discharge.	Immigrant women were significantly more likely to experience fair/poor postpartum health status and risk for postpartum depression. Immigrant women were also more likely to rate community health services as fair/poor and were less likely to be able to get care for emotional health problems. Postpartum health services need to be responsive and accessible to meet the needs of immigrant women
psychINFO	Sword, W., & Watt, S. (2005). Learning Needs of Postpartum Women: Does Socioeconomic Status Matter. *Birth (Berkeley, Calif.), 32(2)*, 86–92. https://doi.org/10.1111/j.0730-7659.2005.00350.x	cross-sectional survey of Participants completed a self-report questionnaire in hospital; 890 (71.2%) took part in a structured telephone interview 4 weeks after hospital discharge. n=1250	This study aimed to examine women's concerns at the time of hospital discharge and unmet learning needs as self-identified at 4 weeks after discharge	About 17% of participants had low socioeconomic status, with common concerns being breastfeeding and signs of infant illness. Unmet learning needs were mainly related to signs of infant illness and infant care/behavior, particularly among women with low socioeconomic status. It is essential to address these needs during the hospital stay and provide accessible community-based information resources for new mothers, especially those with low socioeconomic status.

psychINFO	Ahmed A, Stewart, D., Teng, L., Wahoush, O., & Gagnon, A. (2008). Experiences of immigrant new mothers with symptoms of depression. *Archives of Women's Mental Health, 11(4).* https://doi.org/10.1007/s00737-008-0025-6.	the multi-provincial study aimed to examine the postpartum needs of immigrant women (including refugees, asylum seekers, and family class immigrants) living in Toronto, Montreal and Vancouver, Canada, for less than five years prior to giving birth. n=25 immigrant women	The goal is to comprehend women's experiences and perspectives on contributing factors to postpartum depression, while identifying factors that either facilitated or hindered help-seeking.	Women, lacking family support, hesitated to discuss postpartum depression during rushed doctor visits, often turning to immigrant support centers due to language barriers and stigma. Recovery was attributed to informal social support, including family, friends, and community groups, yet many were unaware of available services.
CINAHL	Douglas, S., Cervin, C., & Bower, K. N. (2007). What women expect of family physicians as maternity care providers. *Canadian Family Physician Médecins de Famille Canadien, 53(5),* 875–874	In-depth semi structured one-on-one interviews were conducted at 36 weeks' gestation and at 6 weeks postpartum. n=11	To explore women's expectations and experiences of family physicians as maternity care providers.	Four broad themes emerged regarding women's expectations and experiences of their family physicians as maternity care providers: informational support, emotional support, advocacy, and professional medical care
CINAHL	Thiessen, K., Nickel, N., Prior, H. J., Morris, M., & Robinson, K. (2018). Understanding the Allocation of Caesarean Outcome to Provider Type: A Chart Review. *Healthcare Policy, 14(2),* 22–30. https://doi.org/10.12927/hcpol.2018.25689.	conducted a retrospective chart review to understand how provider type had been assigned the outcome of Caesarean section. Facility 1 (n=3,563) and Facility 2 (n=4,158)	aimed to determine if the primary outcome of Caesarean section in their pilot study was misallocated to the MRP. The research questions focused on comparing the assignment of MRP between chart data and administrative data reports and identifying the percentage of incorrectly allocated Caesarean sections.	In Manitoba, obstetricians, except in rural areas, mainly handle maternity care, including most Caesarean sections. Midwives focus on low-risk pregnancies. Understanding care models should consider prenatal care's impact on perinatal health, as it has been shown to significantly influence outcomes.

CINAHL	Neiterman, E. (2013). Sharing Bodies: The Impact of the Biomedical Model of Pregnancy on Women's Embodied Experiences of the Transition to Motherhood. *Healthcare Policy*, *9(SP)*, 112–125. https://doi.org/10.12927/hcpol.2013.23595	n=42, interviews in 2007–2008 with women residing in Ontario, Canada.	This paper investigates how women's transition to motherhood is influenced by biomedical culture, examining pregnant and postpartum body experiences. Reveal how a medicalized perspective shapes the process of pregnant embodiment and postpartum experiences.	Postpartum challenges include social isolation, pressure for quick body recovery, and the disconnect between breastfeeding and maternal work. Existing literature often overlooks the physical demands of mothering, leaving women feeling inadequately supported compared to pregnancy. The persistent view of bodies as active in reproduction intensifies feelings of exhaustion and unpreparedness. In contrast to biomedical discourse, women view the transition to motherhood as a process rather than a reproductive assessment.
CINAHL	Merry, L. A., Gagnon, A. J., Kalim, N., & Bouris, S. S. (2011). Refugee Claimant Women and Barriers to Health and Social Services Post-birth. *Canadian Journal of Public Health, 102(4)*, 286–290. https://doi.org/10.1007/BF03404050	Qualitative text data on services that claimant women received post-birth and notes (recorded by research nurses) about their experiences in accessing and receiving services were examined. Thematic analysis was conducted to identify common themes related to access barriers. n=112	This project seeks to understand the barriers faced by these vulnerable migrant women in accessing postpartum health and social services	In Canada, refugee claimants receive essential health care under the Interim Federal Health Program (IFHP), covering postpartum services. Research indicates that refugee claimant women face unaddressed postpartum concerns, including isolation, challenges in reaching mothers postpartum, language barriers, low health literacy, inadequate psychosocial assessments, and limitations and confusion regarding IFHP coverage.
CINAHL	Cusack, C. L., Hall, W. A., Scruby, L. S., & Wong, S. T. (2008). Public Health Nurses' (PHNs) Perceptions of their Role in Early Postpartum Discharge. *Canadian Journal of Public Health, 99(3)*, 206–21. https://doi.org/10.1007/BF03405475.	Focus groups with PHNs from four community health areas (CHAs) in Winnipeg Regional Health Authority (WRHA) were conducted using the semi structured interview guide. n=24)	explore the PHN perceptions of early postpartum discharge (EPD) and its effects on their practice	To cut healthcare costs, early postpartum discharge (EPD) was implemented in the 1990s, reducing hospital stays. Public health nurses' activities shifted to acute problem management, impacting infant outcomes and increasing healthcare resource utilization.

CINAHL	Russell, K., Gilbert, L., Hébert, D., Ali, A., Taylo, R. S. L., & Hendriks, A. (2018). Ontario's Healthy Babies Healthy Children Screen tool: identifying postpartum families in need of home visiting services in Ottawa, Canada. Canadian Journal of Public Health, *109(3)*, 386–394. https://doi.org/10.17269/s41997-018-0052-7	HBHC screen in Ottawa (2013-2016), survey of 36 questions use of regression analysis. n=29,162	two objectives: describe the HBHC Screen profile of postpartum families in Ottawa and identify screening questions associated with a high-risk assessment using the IDA. Additionally, the study will assess the sensitivity and specificity of prioritizing contact based on these questions.	The Healthy Babies Healthy Children (HBHC) program, funded by the Ontario Ministry of Children and Youth Services, provides a healthy start from prenatal to early childhood. Following public health standards, HBHC contacts postpartum clients within 48 hours for an in-depth assessment (IDA) using the Family Assessment Instrument (FAI). Identified moderate or high-risk families are referred to the HBHC home visiting program and other services, with high-risk families using more HBHC services than moderate-risk ones.
CINAHL	O'Brien, B., Chalmers, B., Fell, D., Heaman, M., Darling, E. K., & Herbert, P. (2011). The Experience of Pregnancy and Birth with Midwives: Results from the Canadian Maternity Experiences Survey. *Birth (Berkeley, Calif.)*, *38(3)*, 207–215. https://doi.org/10.1111/ j.1523-536X.2011. 00482.x.	Based on the MES 2006 Canadian census, a random sample of women (n = 6,421) completed a computer-assisted telephone interview for the Maternity Experiences Survey.	The purpose of this study was to compare perceptions of maternity outcomes and experiences of those who received care from midwives with those who received care from other providers	Maternity care in Canada, publicly funded under the Canada Health Act, exhibits limited and uneven provider choices. Statistics indicate 58% receiving care from OBs, 34% from family physicians, and 6.1% from midwives. Midwives offer more appointments and timely care, with fewer ultrasound scans. Canadian midwifery emphasizes continuity of care, with surveyed women twice as likely to have the same provider for both prenatal and delivery care if their provider was a midwife.

CINAHL	Grisbrook, M., & Letourneau, N. (2021). Improving maternal postpartum mental health screening guidelines requires an assessment of post-traumatic stress disorder. *Canadian Journal of Public Health*, *112(2)*, 240–243. https://doi.org/10.17269/s41997-020-00373-8.			Regional disparities in maternal mental health screening across Canada underscore a gap in the universality of healthcare. There is a need for national guidelines incorporating PTSD screening to address mental health issues in new mothers. Despite recommendations from the World Health Organization for universal postpartum mental health screening, only five Canadian provinces have adopted it, with Health Canada yet to provide leadership. Canada requires comprehensive national guidelines for maternal mental health screening, covering both PPD and PTSD, as part of routine postpartum care.
CINAHL	Harris, S., Janssen, P. A., Saxell, L., Carty, E. A., MacRae, G. S., & Petersen, K. L. (2012). Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes. *Canadian Medical Association Journal* (CMAJ), *184(17)*, 1885–1892. https://doi.org/ 10.1503/cmaj.111753.	conducted retrospective cohort study of women who attended the South Community Birth Program in Vancouver. n=1238 in the birth program and n=1238 of women in standard care	Assessed the impact of an interdisciplinary program aimed at promoting physiologic birth and encouraging active engagement of women and their families in maternity care on perinatal outcomes.	The South Community Birth Program, initiated in 2004 with funding from federal and provincial health authorities, offers team-based shared-care by midwives, family physicians, nurses, and doulas. Women self-refer or are referred by physicians, receiving free-of-charge maternity care with a focus on postpartum support, including home visits and breastfeeding assistance. The program has shown significant benefits, including a reduced risk of C-section, shorter hospital stays, and higher rates of exclusive breastfeeding compared to standard care.

CINAHL	Kornelsen, J., & Koepke, K. (2022). Building Blocks to Sustainable Rural Maternity Care: Toward a Systems Approach to Service Planning. *Healthcare Policy, 18(1)*, 60–74. https://doi.org/10.12927/hcpol.2022.26904.	In-depth interviews and focus groups between sept 2017 - dec 2018. n=58	Explore barriers faced by local care providers and administrators in delivering sustainable maternity services in North Vancouver Island. Identify necessary system supports for providing enduring maternity services to the community.	Over the past two decades, healthcare centralization in British Columbia has led to the closure of numerous maternity services, particularly in low-birth-number rural settings. The maternity care needs of rural communities, endorsed by national organizations like the SOGC and aligned with cultural mandates, require system supports for sustaining local care providers. Despite supportive policies, there is a gap in understanding the necessary supports amid the shifting landscape of Canadian rural maternity care.
CINAHL	Robb, K. (2011). A qualitative study exploring womens' experiences of unplanned Cesarean surgery and their suggestions for improving care. *Canadian Journal Midwifery, 10(3),* 17-28.	data collected using semi-structured interviews, n=8	This study addresses gaps in research on intrapartum cesarean surgery by exploring the impact of different primary providers and care models on the experience, considering long-term effects, and incorporating participant-generated recommendations.	focuses on the emotional and nerve-wracking aspects of childbirth, emphasizing the need for better mental preparation and expressing anxiety. While midwifery care is supportive, relationships with OBs are lacking. Patients desire extended contact beyond six weeks and a comprehensive review of birth events. After hospital discharge, there is a lack of follow-up care from OBs. Improved prenatal education on the possibility of a CS in healthy pregnancies, including detailed explanations, is suggested to enhance autonomy and reduce fear.

CINAHL	Wooten, B., & Dowsett, K. (2012). A new model of care for low-risk postpartum families. *Canadian Nurse (1924), 108(2)*, 20–22.	In 2009, a committee of 25 public health nurses and three managers reviewed the HBHC program, finding issues with high referrals and workload management for low-risk cases. They recommended exploring a new care model with community visits as an alternative for low-risk families.	Our goals were to offer effective and efficient HBHC services, ensure cost-effectiveness, streamline staff workloads, maintain client-centered care, and uphold the principle of a telephone contact and visit for every family after childbirth.	The program, administered through local health units, includes screening, assessments, and home visiting services primarily in the postpartum period. A new model, featuring community visits for low-risk families as an alternative to home visits, was influenced by various factors, including research evidence, available resources, community integration efforts, and program monitoring and evaluation data. The second evaluation in fall 2011 confirmed the effectiveness of the new model and the benefits of adding a breastfeeding protocol to enhance PHNs' service provision.
CINAHL	Dol, J., Hughes, B., Tomblin Murphy, G., Aston, M., McMillan, D., & Campbell-Yeo, M. (2022b). Canadian Women's Experience of Postnatal Care: A Mixed Method Study. *Canadian Journal of Nursing Research, 54(4)*, 497–507. https://doi.org/10.1177/08445621211052141	Using a cross-sectional design, online survey. Frequencies were computed for quantitative outcomes and thematic analysis was used for qualitative responses. n=561	explore with whom and how often women receive postnatal follow-up visits and the postnatal care experiences of Canadian mothers	Women had an average of 1.9 postnatal healthcare providers, mainly family doctors (72.4%). About 3.2% had no postnatal visits, while 37.6% had 4 or more within 6 weeks. Overall, 76.1% of women were satisfied with postnatal care. Satisfaction was linked to in-person and at-home follow-ups, support, and timely, appropriate care. Conversely, challenges accessing care, gaps in follow-up visits, and unsatisfactory recovery assessments were associated with dissatisfaction.

CINAHL	Salvador, A., Peterson, W., Nault, J., Gravelle, A., McCoubrey, D., Tsorba, L., Leduc, D., Bandrowska, T., Crowley, C., Messier, J., & Moreau, D. (2022). Hôpital Montfort's Postnatal Care-at-Home Program: An Innovative Model for Early Postnatal Care. *Healthcare Quarterly (Toronto, Ont), 25(3),* 42-48. https://doi.org/10.12927/hcq.2022.26942.	n=28, satisfactory surveys.	The Montfort Postnatal Care-at-Home (MPCH) Program, an integrated care model involving physicians, nurses, and midwives, offers early hospital discharge to families. This innovative program aims to enhance family experiences, maternal-newborn health outcomes, and provide 24/7 support during the initial seven days postpartum at home.	Hôpital Montfort's interdisciplinary team collaborated with researchers to create the MPCH Program, aiming to enhance early postnatal care by transitioning it from hospital to home. The program provides accessible care for healthy dyads in their first postnatal week, integrating physician and midwifery models. This innovative approach has the potential to improve health outcomes, optimize hospital capacity, and reduce acute care costs.
CINAHL	Sword, W., Watt, S., & Krueger, P. (2004). Implementation, Uptake, and Impact of a Provincial Postpartum Program. *Canadian Journal of Nursing Research, 36(2),* 60–82.	data were collected via a self-administered in-hospital questionnaire and a structured telephone interview at 4 weeks post-discharge. n=1250	This paper analyzes the implementation and adoption of the Hospital Stay and Postpartum Home Visiting Program across five Ontario sites through a cross-sectional survey. It also investigates concurrent shifts in service satisfaction and maternal/infant health indicators by comparing the current survey with a prior one conducted before policy implementation.	Significant site-based variations were found in the implementation of the 60-hour hospital-stay option (11.7-81.2%), while the offer of a home visit by a public health nurse remained consistent (91.5-96.6%). However, uptake showed differences (21.1-39.4%). Client satisfaction and health indicators minimally changed post-implementation, warranting further research on the program's efficacy.

CINAHL	Crowley, C. (2014). Addressing a gap in postpartum care. Canadian Nurse (1924), 110(8), 12–13	survey consisted of eight Likert-type quantitative questions and an open-ended qualitative question. n=20 for first survey and n=20 for second survey (nurses)	The survey aimed to identify gaps in nurses' postpartum education and assess whether an implementation program would impact patient satisfaction surveys.	Sixty-eight percent found insufficient teaching on postpartum maternal care and 41.5% on newborn care in hospitals, aligning with patient satisfaction survey data. Most respondents felt knowledgeable about postpartum maternal care (86.2%) and newborn care (82.6%). Suggestions for improvement included enhanced written patient information (87.5%) and standardized nurse reference materials (31.25%). A month post-implementation, 31.5% felt patients lacked enough maternal postpartum teaching, and 26.3% lacked adequate newborn care teaching.
CINAHL	Sword, W., Krueger, P. D., & Watt, M. S. (2006). Predictors of Acceptance of a Postpartum Public Health Nurse Home Visit: Findings from an Ontario Survey. *Canadian Journal of Public Health, 97(3),* 191–196. https://doi.org/10.1007/bf03405582 .	A self-report questionnaire, n=1,250 women recruited from five hospitals across the province; 890 (71.2%) women completed a structured telephone interview 4 weeks following discharge.	Study aims were to assess rates of offer and uptake of home visits under Ontario's Hospital Stay and Postpartum Home Visiting Program, and factors influencing acceptance of a home visit.	The universal program primarily uses telephone follow-up, with varying acceptance rates across sites. Women with specific needs are more likely to accept visits. Further research is required for evidence-based postpartum nurse home visit programs. Key predictors of visit acceptance include first live birth, lower social support, lower maternal satisfaction with services, poorer maternal health, and breastfeeding initiation.

Sociological Abstracts	Dol, J., Aston, M., McMillan, D., Tomblin Murphy, G., & Campbell-Yeo, M. (2022a). Participants' Perceptions of Essential Coaching for Every Mother - A Canadian Text Message-Based Postpartum Program: Process Evaluation of a Randomized Controlled Trial. *JMIR Formative Research, 6(5)*, e36821–e36821. https://doi.org/10.2196/36821.	6-week survey and open-ended questions, mothers in the intervention group were asked about user experience, perspectives on the frequency and timing of messages, and what did they like and not like about the Essential Coaching for Every Mother program. n=150	This study examines the process evaluation of the "Essential Coaching for Every Mother" program, focusing on research implementation extent and quality. It aims to assess the number of participants recruited, timing of recruitment, and gather participants' perspectives on program likes, dislikes, and suggestions for improvement.	Intervention participants reported an 89% satisfaction rate with the program, and 100% of participants would recommend the program to other new mothers. Participants liked how the program made them feel, the format, appropriate timing of messages, and content while disliking the frequency of messages and gaps in content. Participants also provided suggestions for future improvement
Sociological Abstracts	MacKinnon, K. (2010). Learning Maternity: The Experiences of Rural Nurses. *Canadian Journal of Nursing Research, 42(1)*, 38–55.	two research studies guided by institutional ethnography (IE) were conducted to explore rural nurses' experiences with the provision of maternity care in the Canadian province of British Columbia. n=88 nurses n=10 other healthcare provider	understand the experience of maternal nurses and their education in postpartum	Rural nurses struggle to ensure skilled maternity care due to declining birth rates, increased workloads, and limited mentoring opportunities. Institutional processes for continuing professional education (CPE) place a burden on them, affecting both their CPE opportunities and the quality of maternity care, potentially impacting patient safety and nurse retention.

Sociological Abstracts	Zadoroznyj, M., Benoit, C., & Berry, S. (2012). Motherhood, Medicine & Markets: The Changing Cultural Politics of Postnatal Care Provision. *Sociological Research Online, 17(3)*, 1–11. https://doi.org/10.5153/sro.2701		This paper argues that post-birth care is influenced by both welfare state policies and cultural norms, proposing an analytic framework. Using examples from the Netherlands, Australia, and Canada, it illustrates how welfare state policies and cultural norms impact home and community-based postnatal services.	Welfare states in high-income countries shape publicly provided care, emphasizing family responsibility due to cost containment and neoliberal policies. This has led to reduced state-provided care services and limited alternatives to familial care. Shorter hospital stays during the postpartum period reflect a professional logic assuming minimal medical intervention. In Canada, post-birth care services are limited to low-intensity interventions, lacking intensive, home-based support for new mothers.
Sociological Abstracts	Spitzer, D. L. (2004). In Visible Bodies: Minority Women, Nurses, Time, and the New Economy of Care. *Medical Anthropology Quarterly, 18(4)*, 490–508. http://www.jstor.org/stable/3655400.	interviews. n=19	aimed to investigate hospital childbirth experiences, focusing on interactions with nursing staff, among visible minority women due to rising dissatisfaction noted in patient exit surveys, influenced significantly by health care reform and its consequences.	Canadian health care reform, driven by fiscal constraints, led to restructuring in obstetrics, emphasizing dyadic care for mother-infant bonding. Shortened hospital stays raised concerns among nurses about identifying issues like postpartum depression and educating mothers on infant care. The reform's focus on home and community care added to women's caregiving responsibilities.

Sociological Abstracts	Mercerat, C., & Saïas, T. (2021). Parents with physical disabilities and perinatal services: defining parents' needs and their access to services. *Disability & Society, 36(8)*, 1261– 1284. https://doi.org/10.1080/09687599.2020.1788513	in-depth individual interviews between July 2017 and March 2018. n=13	two objectives. Explore and describe the experiences and needs of parents with physical disabilities regarding perinatal and early childhood services and assess the ability of perinatal and early childhood services in Quebec's public healthcare system to address the needs of parents with physical disabilities.	Parents highlighted postnatal challenges, expressing needs in home care, leisure, household tasks, and baby care. Existing literature focuses on pre- and perinatal stages, overlooking postnatal needs. Limited contact with medical staff during the postnatal period, apart from direct baby care, was observed. Services, including home support and paratransit, struggled to meet the needs of parents with disabilities. Participants felt service providers were unable to accommodate both their disabilities and parenting role simultaneously.
Sociological Abstracts	Kelleher, C. M. (2003). Postpartum matters: Women's experiences of medical surveillance, time and support after birth (Order No. 3096330). Available from *ProQuest Dissertations & Theses Global*. (305344634). https://ezproxy.library.yorku.ca/login?url=https://www.proquest.com/dissertation-theses/postpartum-matters-womens-experiences-medical/docview/305344634/se-2.	conducted observations and interviews in two hospital postpartum units. n=60	This study explores the historical development of postpartum medical surveillance and women's contemporary experiences of postpartum care during the first month after vaginal childbirth in Canada and in the United States	Chapter one delves into early postpartum medicalization, while chapter two explores the evolving medical management. Factors like maternal preparation concerns, shifts in hospital stays, and heightened newborn safety anxieties influence medicalization. Chapter three highlights the hospital's role in childbirth and early motherhood training. Chapter four/five observes women negotiating support based on instant and independent mothering ideals. Chapter six examines how structural and ideological forces affect women's bodies and minds. Chapter seven explores women's sense of time in the first postpartum month, and chapter eight delves into the broader cultural framework shaping early mothering experiences.

Web of Science	Wollny, K., Metcalfe, A., Corrigan, C., Drobot, A., Gilmour, L., Wood, S., Wilson, R. D.,Gramlich, L., & Nelson, G. (2021). Maternal perceptions of cesarean birth care: A qualitative study to inform ERAS guideline development. *Birth, 48(4),* 550–557. https://doi.org/10.1111/birt.12561	Open-ended, semi-structured interviews were conducted in-person and over the phone at six weeks postpartum. May-October 2023. n=12	the purpose of the study was to explore patient experiences with the evidence-based suggestions included in the Enhanced Recovery After Surgery (ERAS) program for c-section births	ERAS program, an international guideline for c-section births, aims to enhance patient focus and outcomes. Women reported feeling informed but lacking choices during c-section processes, including presurgery maternal care, preoperative procedures causing confusion, and postpartum infant care after a c-section.
Web of Science	Ke, J. X. C., George, R. B., Wozney, L., & Munro, A. (2021). Perioperative mobile application for mothers undergoing Cesarean delivery: a prospective cohort study on patient engagement. *Canadian Journal of Anesthesia, 68(4),* 505–513. https://doi.org/10.1007/s12630-020-01907-x.	self-monitoring questionnaire and open-ended questions. n=36	aimed to gather feedback on patient engagement with C-Care, a perioperative education and self-monitoring program focused on potential anesthetic complications during cesarean sections.	Participants engaged with C-Care by completing 3 daily self-monitoring questionnaires over a 7-day period, with peak activity in the first week. Most responses were submitted between 18:00 and 20:00 in the first five postoperative days. Each participant viewed 4 education topics, with 'Controlling Pain' and 'The First Few Days' being the most popular.
Web of Science	Mumtaz, Z., O'Brien, B., & Higginbottom, G. (2014). Navigating maternity health care: a survey of the Canadian prairie newcomer experience. *BMC pregnancy and childbirth, 14(1),* 1-9. https://doi.org/10.1186/1471-2393-14-4.	Data were obtained from the Canadian Maternity Experiences survey. n= 40 newcomers arriving to Canada after 1996 and n=1137 Canadian born women met inclusion criteria	The study aims to explore and understand the maternity experiences of newcomer women in the Canadian Prairies, focusing on their care-seeking experiences, navigation of the health system, and satisfaction with received care. The research seeks to identify potential differences in access and utilization compared to Canadian-born women, contributing valuable insights for improving	Newcomer women received less information on key maternal topics compared to Canadian-born women, relying less on family doctors and nurses. They were also less likely to seek information from friends and family. Notably, newcomer women had a higher C-section rate, consistent with existing evidence.

			maternity services and addressing care inequities.	
Public Health Database	Cidro, J., Doenmez, C., Sinclair, S., Nychuk, A., Wodtke, L., & Hayward, A. (2021). Putting them on a strong spiritual path: Indigenous doulas responding to the needs of Indigenous mothers and communities. *International Journal for Equity in Health, 20(1),* 1–11. https://doi.org/10.1186/s12939-021-01521-3.	n=5. five interviews with five Indigenous doula collectives in Canada, including one in Winnipeg.	Indigenous doulas offer crucial culturally sensitive support to Indigenous women, addressing systemic medical racism and socio-economic barriers. This analysis of interviews with five Indigenous doula collectives highlights their common challenges, strategies, and missions.	Doulas offer essential support during pregnancy, labor, and postpartum, focusing on physical, emotional, and advocacy assistance. Indigenous doulas have emerged, addressing systemic racism in health and social services, especially in the context of the overrepresentation of Indigenous children in child welfare systems. In Manitoba, the "Restoring the Sacred Bond" project, part of a Social Impact Bond program, connects doulas with expectant Indigenous women at risk of CFS involvement.

Public Health Database	Olson, T., Bowen, A., Smith-Fehr, J., & Ghosh, S. (2019). Going home with baby: Innovative and comprehensive support for new mothers. Primary Health Care Research & Development, *20*, E18. doi: 10.1017/S1463423618000932.	online survey to evaluate maternal satisfaction with Healthy & Home services. 2016-2017. n=429, but only 403 useable survey responses	Outlines the 25-year evolution of the Healthy & Home program, providing insights for organizations seeking to develop postpartum programs to support the physical and mental health needs of postpartum families, thereby promoting maternal and infant wellbeing.	The Healthy & Home program, initiated in 1992, offers comprehensive postpartum services, including home visits, breastfeeding support, clinics, and mental health groups. Home visits assess physical and mental health factors, determining follow-up needs. The program prioritizes breastfeeding, collaborating with local organizations for Baby-Friendly™ initiatives. A postpartum depression/anxiety support group was launched, and an onsite clinic was established in 2014 to address growing demand. The program strives to meet diverse needs, promoting maternal and infant wellbeing.
Public Health Database	Youash, S., Campbell, M. K., Avison, W., Peneva, D., & Xie, B. (2012). Examining the pathways of pre- and postnatal health information. *Canadian journal of public health = Revue Canadienne de Sante Publique*, *103*(4), e314–e319. https://doi.org/10.1007/BF03404242	Data from the 2006 Maternity Experiences. n= 6117	The objectives of study were to assess Canadian women's health information levels regarding pre- and postnatal topics in both primiparous and multiparous sample	women lacked information on key prenatal topics like pain medication side effects and warning signs/complications. Addressing these gaps can improve maternal-fetal health and satisfaction with labor and delivery.
Public Health Database	Quintanilha, M., Mayan, M. J., Thompson, J., & Bell, R. C. (2016). Contrasting “back home” and “here”: how Northeast African migrant women perceive and experience health during pregnancy and postpartum in Canada. *International Journal for Equity in Health, 15(81)*, 1-8. https://doi.org/10.1186/s12939-016-0369-x.	A focused ethnography was conducted with four Northeast African communities, 10 focus groups with women from four Northeast African communities in Edmonton. n=80	Explored migrant women's perceptions and experiences of health during pregnancy and postpartum in a perinatal program. Examined sociocultural factors influencing women's health upon migration to Edmonton, Alberta.	migrant women receive perinatal support from the Multicultural Health Brokers (MCHB) Cooperative. offers holistic services to at-risk migrant women, addressing social determinants of health. Participants noted a shift from a collective support system "back home" to a more individualistic culture in Canada, impacting their resources for healthy living during pregnancy and postpartum.

Public Health Database	St Croix, K. (2021). Supporting breastfeeding in rural Newfoundland and Labrador communities during COVID-19. *Canadian Journal of Public Health, 112(4)*, 595–598. https://doi.org/ 10.17269/s41997-021-00513-8			This commentary explores the impact of geographic location, societal norms, and healthcare accessibility on breastfeeding in rural NL communities. Barriers in rural settings, such as limited access to specialized services like lactation consultants and a lack of peer support, contribute to challenges in achieving breastfeeding goals.

Appendix J: Charting for Google Grey Literature.

Website	Website Citation	Type of Literature	Location	Summary
Google	Sinai Health. (2023). Caesarean section. Caesarean Section. https://www.mountsinai.on.ca/care/cs	Hospital Website	Toronto, Ontario	Covers what a C-section delivery is, why it happens, how it might affect future pregnancies, possible complications, and includes extra resources for more info on C-sections.
Google	Mackenzie Richmond Hill Hospital. (2010). 1024-Postpartum Care After a Caesarean Section. Mackenzie Health Patient Information. https://www.mackenziehealth.ca/programs-services/mother-and-baby-care/h-postpartum-care-after-a-caesarean-section.pdf	Hospital Website	Richmond Hill, Ontario	provides postpartum care tips for mothers, addressing hospital stay, breastfeeding, self-care at home, including rest, hygiene, and recognizing signs of postpartum depression.
Google	Sunnybrook Hospital. (2023). Caesarean Recovery. Sunnybrook Health Sciences Centre. https://sunnybrook.ca/content/?page=crib-newborn-csection.	Hospital Website	Toronto, Ontario	Cesarean section recovery in the hospital, addressing aspects like mobility, stitches, gas, pain management, constipation, and vaginal bleeding, a focus on the initial 2-3 days.
Google	Healthwise Staff. (2022b). Caesarean section: What to expect at home. MyHealth.Alberta.ca Government of Alberta Personal Health Portal. https://myhealth.alberta.ca/Health/aftercareinformation/pages/conditions.aspx?hwid=ud1242	My Health Alberta	Alberta	Cesarean recovery tips, including managing bleeding, activity levels, rest, restrictions, incision care, diet, constipation, medication, breastfeeding with incisions, and when to contact a doctor.
Google	Healthwise Staff. (2021). Caesarean Section. Caesarean Section | HealthLink BC. https://www.healthlinkbc.ca/pregnancy-parenting/labour-and-birth/during-labour/caesarean-section	Health Link BC	British Colombia	covers the procedure, risks, why needed, recovery duration, restrictions, vaginal bleeding, driving, sexual health, incision care, diet, and when to contact a doctor.

Google	Burns, R. (2022). Belly birth parents, i “c” you. Bruce Village Chiropractic. https://www.brucevillage.ca/blog/cesarean-birth-1	Chiropractor	Goderich, Ontario	Discusses commonality of CS, what is a CS, who should prepare for a CS, How to prepare for a CS, resting, meal prepping, postpartum doulas
Google	The Society of Obstetricians and Gynaecologists of Canada. (2023). Caesarean section (C-section) – Pregnancy Info. https://www.pregnancyinfo.ca/birth/delivery/caesarean-section/	Organization	Canada	Cesarean Sections, including reasons for the procedure, associated risks, the process, immediate post-op steps, and the choice of a C-section without medical necessity.
Google	William Osler Health System. (2023). Caring for yourself as a new mother. https://www.williamoslerhs.ca/en/areas-of-care/caring-for-yourself-as-a-new-mother.aspx#C-section-incision	Hospital Website	GTA, Ontario	C-section incision care, covering the 7-day skin healing period and the overall 6–8-week recovery. It provides guidance on clothing, showering, keeping the incision dry, and the removal of dressings or stitches.
Google	North York General. (2023). Special procedures. North York General Hospital. https://www.nygh.on.ca/areas-care/maternal-newborn-and-paediatric-care/pregnancy-and-birth/guide-pregnancy-and-birth/giving-birth/special-procedures	Hospital Website	North York, Ontario	c-section birth, reasons for CS, preparation for an elective CS, what to expect right after birth, VBAC
Google	Guelph General Hospital. (2023). Family Birthing Unit. Welcome to the Rotary Club of Guelph Family Birthing Unit. https://www.gghorg.ca/family-birthing-unit/	Hospital Website	Guelph, Ontario	Discusses C-section facility such as operating rooms and recovery rooms, discusses team of doctors
Google	SickKids Staff. (2009). Recovery After Caesarean Section. SickKids - AboutKidsHealth. https://www.aboutkidshealth.ca/article?contentid=407&language=english	Hospital Website	Toronto, Ontario	Pain expectation, cramping, gas, hospital LOS, seek help with infections, support needed, expect breastfeeding challenges and consider lactation consultant

Google	Southlake Regional Health Centre. (2015). A Baby's Coming: Information to Help You Prepare for the Birth of Your Baby. https://southlake.ca/wp-content/uploads/2019/08/SL0760_10_A_Babys_Coming_Booklet-lo.pdf	Hospital Website	Newmarket Ontario	info on pre-op and post-op procedures, pain management, your first walk, and incision care. Consider help for housekeeping and support from friends to minimize stress and visitor pressure during the recovery period.
Google	Humber River Health. (2022). Instructions for your caesarean section (C-section) delivery. Humber River Health Maternal and Child program. http://hrccatalog.hrrh.on.ca/InmagicGenie/DocumentFolder/005169_instructions%20for%20c-section%20surgery.pdf	Hospital Website	North York, Ontario	nurse preparation for discharge and education on medicines how to take care of yourself and what follow ups are needed, management of pain, mostly focusing on prep before the CS
Google	Healthwise Staff. (2022a). Postpartum: First 6 weeks after childbirth. SaskHealthAuthority. https://www.saskhealthauthority.ca/your-health/conditions-diseases-services/healthline-online/abl1277	Saskatchewan Health Authority	Saskatchewan	Accept help from support systems, sleep when baby sleeps, mental health, use of health tools, support incision with a pillow, and take gentle shower
Google	Sault Area Hopsital. (2019). Cesarean Delivery. Sault Area Hospital Patient Information. https://sah.on.ca/wp-content/uploads/2021/06/14256-Cesarean-Section-Patient-Information.pdf	Hospital Website	Sault St Marie, Ontario	focuses on activity, diet, wound care, medications and signs of medical attention needed, showering, lifting, someone to come help, fluids, rest
Google	Bluewater Health. (2023). Preparing For the Birth of Your Baby: Care for Mom and baby After Birth. Preparing For the Birth of Your Baby. https://www.bluewaterhealth.ca/sites/default/files/BWH_Birth%20Prep_Booklet_1UP_FNL.pdf.	Hospital Website	Sarnia, Ontario	reasons for a CS, pre-surgery preparations, post-surgery care including gas pain and wound care, recognizing emergencies, and practical tips for showering, diet, activity, and getting out of bed. The booklet also includes guidance on deep breathing exercises, circulation, and targeted postnatal exercises.
Google	Leach, J. (2023). Recovery after a caesarean birth. BabyCenter Canada. https://www.babycenter.ca/a539020/recovery-after-a-caesarean-birth	Blog	Canada	Emotional and physical recovery, managing pain and wound care, what to expect directly after CS, and hospital stay, limitations

Google	Halton Healthcare. (2023). Having Your Baby At Halton Healthcare. https://www.haltonhealthcare.on.ca/site_files/content/services/pdf/maternity/having_your_baby_at_hhs_-_2015-11_nov_for_website.pdf	Hospital Website	Halton, Ontario	CS preparation during labor, elective CS, support for breastfeeding. highlights resources like parent-child centers, Ontario Early Years Centers, infant care information, guidance on when to call the doctor for baby-related concerns, and crisis helplines for mental health.
Google	Wint, J. (2022). C-section Recovery Tips for Caesarean Awareness Month. Vancouver Mom. https://www.vancouvermom.ca/for-mom/c-section-recovery-tips-for-caesarean-awareness-month/	Blog	Vancouver, BC	encourages rest, supporting your belly, seeking physiotherapy, getting comfortable with your scar, and finding support at home. suggests assistance like meal services, nutrition bundles, meal trains, grocery delivery, cleaning services, and emphasizes the importance of processing your emotions
Google	Cornwall Community Hospital. (2023). A Baby is Coming: Information About Your Stay Here at Cornwall Community Hospital. Cornwall Community Hospital - Hópital communautaire de Cornwall. https://www.cornwallhospital.ca/uploads/Public%20reporting%20BPSAA/Financial%20statements%202020.pdf	Hospital Website	Ontario	what to expect for a CS in the hopsital, gas pains, exercises, incision support and care, gas, stitches, vaginal bleeding, rest
Google	Synergy. (2023). Prenatal + Birth + Postpartum. Prenatal + Postpartum. https://www.synergyphysiopilates.ca/pre-post-natal-health	physio clinic	Halifax, Nova Scotia	goal is to empower people with the knowledge and guidance needed to meet the challenges of pregnancy, childbirth, and postpartum recovery. physiotherapists are trained to assist with post and birth pains
Google	Bump Physio & Co. (2022). Prenatal & PostpartumPhysio. Bump Physiotherapy. https://www.bumpphysioco.ca/services-rates/prenatal-postpartum-physiotherapy/	physio clinic	Langley, BC	pelvic health, focus on low back pain, scar tissue management, cesarean rehab, pelvic floor, initial assessments start at $190, short session 25 mins $100, extended session 55 mins $190, follow up sesions $132
Google	Opal Physio. (2023). Pregnancy and Postpartum Physiotherapy Treatment. Physiotherapy And Health Clinic. https://www.opalphysio.ca/pregnancy-and-postpartum-physiotherapy/	physio clinic	Langley, BC	physiotherapy services address a range of postpartum conditions, such as pelvic floor dysfunction, organ prolapse, incontinence, diastasis recti, C-section and perineal scar management, as well as postural issues, low back, and neck pain, helping new mothers recover and regain pre-pregnancy fitness

Google	The Ottawa Hospital. (2008). Information For the New Mother & Her Family. The Ottawa Hospital - L'Hópital D'Ottawa. https://www.ottawahospital.on.ca/en/documents/2017/01/cp18benglishdec2008.pdf/	Hospital Website	Ottawa, Ontario	highlights rest, avoiding lifting and driving, sleep, gentle exercise, a healthy diet, and personal care. covers managing incisions, addressing hemorrhoids, preventing constipation, handling vaginal bleeding, breastfeeding, and emotional well-being.
Google	MUHC Royal Victoria Hospital Birthing Centre. (2015). Preparing for Your Cesarean Birth: Information for Women and Their Partners. McGill University Health Centre. https://muhcpatienteducation.ca/DATA/GUIDE/514_en~v~preparing-for-cesarean-birth.pdf	Hospital Website	Montreal, Quebec	Guide for planned CS process, details on what to expect and how to prepare
Google	High River Maternity Clinic. (2018). Caesarean Section: What to Expect at Home. High River Maternity: Delivering a Better Experience. http://highrivermaternity.ca/wp-content/uploads/2019/11/HRMC"-C-section-Recovery.pdf	Hospital Website	Alberta	Discusses activity, resting, walking, vaginal bleeding, diet, constipation, medications, in care, showering, when to call a doctor or 911