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Women's views and experiences of maternity care during COVID-19 in Ireland: A qualitative descriptive study

Sunita Panda^{a,*}, Deirdre O'Malley^a, Paula Barry^b, Nora Vallejo^b, Valerie Smith^a

^a School of Nursing and Midwifery, University of Dublin Trinity College, 24 D'Olier Street, Dublin, Ireland

^b The Coombe Women and Infants University Hospital, Dolphins Barn, Dublin, Ireland

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ABSTRACT

Objective: To gain insight and understanding of women's views and experiences of maternity care during the COVID-19 pandemic in Ireland.

Design: A qualitative descriptive study using semi-structured interviews. Due to social distancing and associated COVID-19 restrictions at the time of the study, the interviews were held remotely via telephone. The interviews were digitally recorded and transcribed verbatim. Thematic analysis was used to analyse the interview data.

Setting & participants: A large urban tertiary referral maternity unit (greater than 8000 births per year) in the Republic of Ireland. Women of low and high obstetric risk, primiparous and multiparous, who gave birth in April or May of 2020 were eligible for inclusion. Women were invited to take part via a hospital-based gatekeeper who had no other involvement in the study.

Findings: Nineteen women consented to take part and were interviewed. Four dominant themes reflective of women's views and experiences emerged during data analysis. These were: 'navigating the system', 'at the end of the day it's just you', 'preparing for and adapting to uncertainty' and 'blessing in disguise'.

Key conclusions and implications for practice: Women experienced added challenges as a result of COVID-19 associated altered care structures and processes. Some changes implemented in response to the pandemic were positively experienced by women. The findings will contribute to and assist in planning future services for women and their partners, and in tailoring care to meet women's expectations and needs as the COVID-19 pandemic continues and beyond.

Introduction

As of 28 March 2021, almost 127.5 million people globally have become infected with coronavirus disease 2019 (COVID-19) and approx. 2.8 million people have died from the disease (<https://www.worldometers.info/coronavirus/>). Although the risk of contracting COVID-19 appears similar across pregnant and non-pregnant populations, evidence suggests that morbidity outcomes in pregnant women testing positive for COVID-19 are increased (Allotey et al., 2020; Brandt et al., 2020). The risk of intensive care admission and invasive ventilation, for example, is reportedly increased in pregnant women with COVID-19 when compared to non-pregnant women of reproductive age (Allotey et al., 2020; Brandt et al., 2020), particularly in those with moderate or severe disease (Brandt et al., 2020). A more than three-fold increased risk of preterm birth and caesarean section was found in pregnant women who were COVID-19 positive compared to those who were COVID-19 neg-

ative (Yang et al., 2020). Reported risk factors for heightened adversity include Black and Hispanic race, low resource compared to high resource setting, obesity, advanced maternal age, medical comorbidities, and antepartum admissions related to COVID-19 (Brandt et al., 2020; Chmielewska et al., 2021).

The rapidity of transmission and the severity of how COVID-19 affects some individuals has resulted in practice and policy changes across health sectors. In maternity care these changes include, although not limited to, suspension of key services such as parent education or antenatal classes, increased antenatal and postnatal telephone or online consultations, reconfiguration of care areas to accommodate suspected or confirmed COVID-19 positive women, and policies of restricted visiting in hospital wards and neonatal intensive care units (e.g. visiting of one designated parent) (Renfrew et al., 2020; Smith et al., 2021a). Women's choice for place of birth during the pandemic has also been altered in some countries. In the UK, for example, approx. one third of NHS Trusts suspended home birthing services (Sherwood, 2020).

* Corresponding author.

E-mail address: spanda@tcd.ie (S. Panda).

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Elsewhere, women have reported not accessing any type of antenatal care during lockdown periods; for example, from 4% pre-lockdown to 59.5% during lockdown in Jordan (Muhaidat et al., 2020).

Although well-intended, changes in maternity care provision during COVID-19 have the potential to impact both positively and negatively on women's experiences of maternity care. Restrictions on partner attendance at antenatal visits, and during the birthing experience, for example, may reduce women's sense of support during pregnancy and childbirth (Meaney et al., 2021). Conversely, restricted visiting postpartum can provide women with quiet space to bond with their babies or to establish breastfeeding. Restrictions on partner attendance, however, can reduce opportunities for partner bonding and the increased use of on-line and remote consultations may pose additional challenges especially for those with limited technological literacy, a factor which may further exacerbate inequities in access to care (Reingold et al., 2020).

Evans and colleagues (2021), in a project designed to identify research priorities in the context of local maternity settings during COVID-19, described the 'Wellbeing of the workforce' and 'Women's mental health and emotional wellbeing' as the top-two priorities. As a means of addressing women's health and wellbeing in the context of a global pandemic, it is important to firstly understand women's experiences and views of maternity care during this time. Capturing women's views and experiences of care during the pandemic will provide insight into and understandings of how the pandemic affected their experiences. It will also help identify good practice innovations that benefited women or identify possible future care approaches for pregnant women as the pandemic continues. To gain insight and understanding of maternity care during COVID-19, we report on women's views and experiences of maternity care during the first national lock-down phase of COVID-19 in one hospital setting in Ireland.

Methods

Design

A qualitative descriptive study designed to illicit women's subjective views and experiences of maternity care during COVID-19 was used. This approach was chosen as it allowed us to gain contextual understandings of the informants' realities through personal experiences, feelings, and individual perspectives. As the study addresses a novel phenomenon, the basis of the study is not underpinned by a theoretical framework, rather we present the facts, drawing on naturalistic enquiry to 'give voice' to women's narratives of maternity care during COVID-19 (Sandelowski, 2000).

Setting and participants

The study setting was an urban, tertiary-referral, maternity care centre in Ireland that has an annual birth rate of approx. 8500 births. Women can book at the hospital for either public, semi-private or private care, and antenatal care is generally shared between the hospital and a woman's General Practitioner (GP).

COVID lockdown and responsive changes at the study setting

The first case of COVID-19 was identified in Ireland in February 2020. Within three weeks, cases had been confirmed in all counties in Ireland. Societal restrictions were implemented soon after; initially all Schools, Colleges and childcare facilities closed on 12-March, followed by a closure of almost all businesses, venues, and amenities on 24-March. Three days later, on 27-March, a full national lockdown was implemented; this involved a Government imposed stay-at-home order, a ban on all non-essential travel, cocooning for the elderly and vulnerable, and no contact with people outside one's home (including family), unless essential. These full lock-down restrictions continued until 18-May and were slowly eased thereafter until Ireland experienced further

surge in infections, in October 2020 and January 2021 which resulted in second and third state-wide lockdowns being respectively imposed.

As in most healthcare settings, a series of infrastructural and care provision changes were implemented in the study setting in response to the pandemic. These included:

- Reconfiguration of physical space to accommodate women who were suspected or confirmed COVID-19 positive cases. This included establishing 'red zones' in antenatal, labour and postnatal wards, implementing a 24-hour COVID screening station at the hospital entrance, and rearrangement or removal of seating areas to comply with social distancing recommendations.
- Suspension of key services and some facilities. These included the suspension of use of the birthing pool and access to birth reflection clinics, antenatal classes (including classes on breastfeeding) and parent education classes as midwives were redeployed to cover areas affected by other midwives having to self-isolate, and suspension of community visiting.
- Redeployment of outreach antenatal clinics back to the hospital setting, and a reduced schedule of antenatal visits for low-risk healthy women.
- A strict no visiting policy throughout areas; this included a prohibition on partners attending at antenatal scans or other appointments or in visiting their partners on antenatal or postnatal wards. Partners could attend only when their partner was in established labour, and in a single room on the labour ward or during a caesarean section and recovery post caesarean section in operating theatre. A designated one-parent policy was also implemented for visiting babies that were in the neonatal intensive care unit.
- Use of technology replacing face-to-face consultations (e.g. breastfeeding support).

Sampling for the study was purposive, based on the following inclusion criteria; women who were greater than or equal to 18 years of age at the time of study participation, were able to read and speak English, and had experienced pregnancy, childbirth (between 37 and 42 weeks of pregnancy) and postnatal care at the study site during the first national lock-down period. Women who experienced high and low risk pregnancy and childbirth were eligible for inclusion, although, at the time of recruitment we purposely invited women who were, and whose babies were well, to take part in the study. This was a requirement of the Research Ethics Committee of the study site in assuring that women, and their babies, were medically well when deciding to take part in the study.

Women were invited to take part via a gatekeeper who worked with the information technology department at the hospital site, and who had no other involvement in the study. The gatekeeper randomly identified women who had given birth at the hospital during the last two weeks of April and the first two weeks of May, stratified equally by parity (to ensure both primiparous and multiparous women were invited to take part) and by public, semi-private and private care. An invitation letter and a participant information leaflet (PIL) were forwarded by post to 50 women. Women were invited to sign and return the study consent form directly to the study researcher if they were interested and willing to take part, or to contact the researcher if they had any questions. Stamped addressed envelopes were provided for returning consent forms, and the researcher's contact details were also available in the PIL. Once a consent form was received the study researcher telephoned the woman, and a date/time was mutually agreed for the interview to take place.

Data collection and analysis

Data collection involved semi-structured interviews, conducted by the lead and second listed authors, both of whom are midwives and experienced in qualitative interview techniques. Due to COVID-19 restrictions at the time of data collection, all interviews were held remotely. Women were offered a choice of being interviewed using the

Table 1
Interview guide.

Introduction	Welcome and introduction. Thank participant for taking the time to take part in the study. Reassurance that interview can be stopped at any time/restarted/rescheduled; ensure participant is comfortable to begin. Reminder about recording and explain about transcribing. Collect demographics.
Beginning of interview	Can you talk to me in general about the impact of COVID on you and your family? Can you tell me about your life in general during the initial lockdown in March and April?
Antenatal care	Can you tell me about the COVID restrictions in the [hospital name] and if/how these impacted on your antenatal care? Possible prompts: waiting times, screening at entrance, space/seats in clinics, no partner in clinics, more phone consultations, frequent hand washing/use of mask, no partner at scans, parenthood education classes, staff using PPE, etc.
Labour	Can you tell me about your labour and childbirth experience, focusing particularly on any impact that COVID might have had on this?
Postnatal	How did you find your postnatal experience in the hospital? Prompts – visiting, staff in PPE, communicating with other mothers, length of hospital stay, availability of early discharge. How did you find those first few weeks with your new baby at home? Prompts – social supports, friends, family, online resources, baby feeding support, visit by midwife/PHN following discharge, etc.
Concluding the interview	To conclude, ask the woman how she viewed her whole experience overall; what could have been done to improve the experience antenatally, during labour and birth and in the first few weeks following birth (focusing specifically on COVID-19 related impacts). Last question - ask participant if she could offer 1 or 2 pieces of advice that would have helped or improved her experience of having a baby during a global pandemic, what would this be? Thank participant for her time and contribution to the study.

telephone or via a secure online ‘face-to-face’ platform (e.g. Microsoft Teams). All participants opted to have their interview by telephone. The interviews were recorded using a separate digital recording device to safeguard confidentiality and subsequently transcribed verbatim. An interview schedule (Table 1) was used to guide the interviews to ensure relative consistency across interviewees and interviews. A short demographic questionnaire was also completed by participants at the start of the interview and labelled with the participant’s code number.

Thematic analysis was used to analyse the data (Braun and Clark, 2006). This involved familiarising oneself with the data, generating initial codes, collating codes into initial themes, identifying dominant themes from the initial themes, reviewing the themes, defining and naming the themes, and producing the study report. Data analysis was largely undertaken by the lead author; however, the process was iterative, involving team discussions and ongoing review of the data as the codes, initial themes and dominant themes began to emerge. The computer software package, NVivo© Version 11 was used to assist with the analysis. Data sufficiency occurred at interview 15, with the subsequent interviews serving to further explore emergent themes. The interviews took place between 15-Sept and 23-Oct-2020.

Rigor

To ensure credibility, the lead author engaged at length with the interviewees’ transcripts to attain insight into the data, to ensure credibility. This was followed by extensive discussions with the second and last authors to review the data and refine the emergent themes, to ensure the participant’s own words were comprehensively reflected in presenting

the findings. Stepwise replication was used to enhance dependability, whereby three members of the research team coded three transcripts independently and met to compare interpretations of the data subsequently (Cronin et al., 2015). To ensure rigour through member checking, all women were offered a copy of their transcript to check for accuracy and resonance of data with their experiences, and transcripts were sent to 10 of the 19 women who wanted to have their interview data. An audit trail was maintained to ensure confirmability (Streubert and Carpenter, 2011). This was achieved through a detailed account of the conduct of fieldwork and through providing examples of the coded, categorised, and thematic data (Fig. 1).

Ethical approval

Ethical approval to conduct the study was granted by the lead author’s University (Ref: Chair_1_20.21) and by the participating Hospital (Ref: Study No. 16-July 2020) Research Ethics Committees. Participant anonymity was maintained by assigning interview codes (ID01, ID02, etc.). All data (interview tapes) were securely stored in accordance with the Irish Data Protection Act 2018 (<http://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/html>) and the General Data Protection Regulations 2018 (<https://gdpr-info.eu/>). Transcription services were used to transcribe the interview data, with the service provider having signed a confidentiality agreement with the University in advance of providing the service. Audio and transcription files were shared between the transcriber and the research team using Microsoft Teams, a University secured file sharing platform.

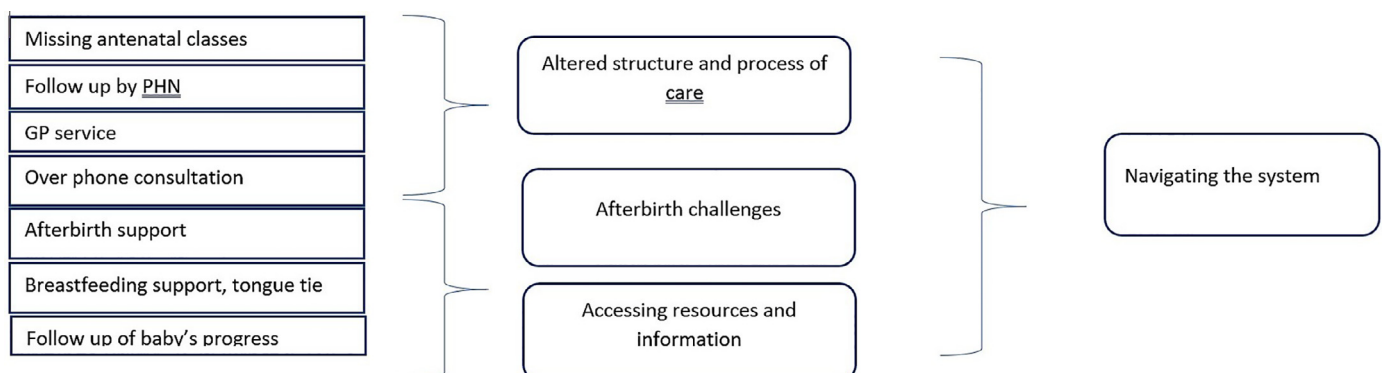


Fig. 1. Audit trail.

Table 2
Summary characteristics of study participants.

Variable		N (%) Mean (range)
Model of care	Public	10 (53%)
	Semi-private	5 (26%)
	Private	4 (21%)
Age	-	35 years (30-39 years)
Nationality	Irish	19 (100%)
Parity (P)	P0	8 (42%)
	P1	8 (42%)
	P2+	3 (16%)
	Gestational age	37 ⁺⁰ to 38 ⁺⁶
	39 ⁺⁰ to 40 ⁺⁶	10 (53%)
Mode of birth	≥41	3 (16%)
	SVB	10 (53%)
	Forceps assisted	1 (1%)
	Emergency CS	3 (15%)
	Planned CS	5 (26%)
Admission to NICU	None	19 (100%)

CS: Caesarean section; NICU: Neonatal Intensive Care Unit; SVB: Spontaneous vaginal birth.

Findings

Participant characteristics

Nineteen women consented and took part in the study. The total recorded interview time was 780 minutes, with a mean interview time of 41 minutes, and a range of 23 to 68 minutes. The participants all gave birth between 20-April and 11-May-2020, approx. four to six weeks into COVID-19 lock-down, all were 30 years of age or older and all were of Irish nationality. A relatively equal proportion of primiparous and multiparous women took part (42% and 58% respectively) and just over half had a spontaneous vaginal birth (53%). Table 2 presents the summary characteristics of the study participants.

Thematic analysis

Four core themes representing women's views and experiences of maternity care during COVID-19 emerged from the data. These were: 'navigating the system', 'at the end of the day, it's just you', 'preparing for and adapting to uncertainty' and 'blessing in disguise'.

Navigating the system

The changes to usual maternity care processes implemented in response to the pandemic resulted in an altered maternity care system that presented women with navigational challenges when accessing services. These challenges, although various, appeared to arise more often for women when accessing postnatal supports. For example, in Ireland, Public Health Nurses (PHN) as part of primary/community care visit postpartum women in their homes usually within 72 hours of returning home from hospital. During lock-down some PHNs continued to visit women, however, advance telephone consultations were carried out to reduce the time spent in the home. For other women, PHN home visiting ceased. In these cases, women were requested to go to their local health centre to see their PHN. The logistics of getting to the health centre, worry that the health centre would be busy with the possibility of having to wait in a busy waiting area, and fear of transmission of COVID-19 caused stress for some women. A few women described how they had to make several phone calls to determine who their PHN was and whether she would visit them in their home.

"There had been no Public Health Nurses assigned to my area. Apparently, they had been redeployed because of COVID...She [student PHN] hadn't been assigned to a particular area, so she was kind of just filling in and covering" (ID 13)

A few women expressed concerns over the possibility of mental health issues being overlooked or unnoticed after birth as a result of reduced social and professional support, as well as being unable to spend time with family members that, in other circumstances, would have been normal during their immediate postnatal period. This potentially increased the risk of mental health issues such as experiences of feeling low, anxiousness, not being able to cope with the transition to motherhood, and other unspoken issues, being missed or going undetected.

"Like I'm lucky I didn't have postnatal depression. But if you had, oh, even ... I found it hard with the night feeds and everything and nobody to talk to. But if you had something like that wrong with you, it must be ... awful in this situation ... Because you have very little connection with the outside world" (ID 09)

Many women talked about their difficulty in accessing support for breastfeeding, which was 'daunting' and 'frustrating' for women. Women described being sent breastfeeding booklets from the hospital and being directed to websites for further information. For some in rural areas this type of information was 'useless' as their internet connections were unstable. Mother and baby groups after birth, many of which are facilitated by PHNs who provide infant feeding support also, were now unavailable to women who would have considered joining these.

"I do remember like we had the breastfeeding groups [after a previous birth]. That I would've went to, like weekly [facilitated by local PHNs]. And that was great because you'd be able to get the baby weighed... just reassurance that you were on track in terms of weight gain... That is definitely something that, you know, I mean COVID has taken away." (ID 05)

A few women described having video consultations with a private lactation consultant, although many described these as being insufficient and inappropriate to meet their needs.

"The lactation consultant...is more important with COVID. Because you don't have your mum or your granny...around you...to...help and correct you, you're on your own. It's hard to...zoom...with private lactation consultants." (ID 03)

The lack of breastfeeding support and directed advice on where to go if experiencing breastfeeding issues was recounted by women as being stressful and frustrating, with women having to work through many of the issues on their own.

"I was a bit concerned about the latch and all that stuff..... so I was really just doing that all, that was just me on my own trying to work all that stuff out. So that was difficult like." (ID 08)

Women spoke to other women as a source of breastfeeding support. They spoke to friends or family who had experience of breastfeeding to determine if what they were experiencing was normal. Several women deferred to a family member who was a healthcare professional for advice on mastitis or with other baby related concerns like weight gain and tongue tie. A few women related challenges they experienced in navigating baby's progress and gaining assurances that their baby was achieving his or her milestones to the restricted follow up appointments by the PHN and GP service.

"It's just the whole after care, it hasn't been there do you know. That you don't get any visits, ... even if you just got, ... he [baby] hasn't been weighed; you don't know how he's getting on ... is he coping okay ... is he hitting his milestones that kind of thing." (ID 01)

Routine GP care was disrupted during COVID-19, both antenatally and postnatally. Some women were happy to avoid their GP surgery as they viewed it as a potential site for COVID-19 transmission. Antenatally, cancelled GP appointments resulted in longer intervals between antenatal assessments. This was worrisome for some women who felt that four weeks between antenatal assessments was too long. Postnatally, telephone consultations were used by some GPs, particularly for

the routine two-week infant assessment. Many women were left non-assured by these telephone consultations, and their preference would have been for their GP to see them and their baby in person.

“And over the phone just doesn't do it like. You don't get the same, to look into somebody's eyes and to trust them and for them to say, you're okay.” (ID 08)

At the end of the day, it's just you

This theme highlights the scenario of being alone which many women experienced during early labour as a direct result of COVID-19 and associated practice changes, and the strong emotions this triggered in women as a result. Many women used the language of 'alone', 'lonely', 'just me' and 'isolated' when recounting their experience of early labour in the hospital when their birth partner was prohibited from being present. Women spoke about feeling teary, emotional, anxious and fearful when entering the maternity hospital on their own.

“So I think with it being COVID and then going into labour by myself I think that's what put the fear into me. A combination of being on my own and then with COVID” (ID 04)

While women described their midwives as being 'lovely' and very supportive during their early labour experience, for most, this was not enough. They were aware that midwives had to care for many women, and they 'needed' their partner. This need was described in terms of having their partner with them for reassurance and constant companionship, and for the simple yet important gestures such as hand holding and back rubbing.

“You know going through something and he wasn't allowed be there. You know, like, to hold your hand, or to tell you that it would be ok. To reassure you that everything was going to be okay. It's just, I found that very hard, yea it was, that was quite difficult now.” (ID 11)

Many women described the unusual situation of their partner waiting in the car park, up to 12 hrs in some cases, while they were in early labour in the hospital. They spoke about going out to the car park to walk with their partner, to pass time and to be with their partner in sharing their experience of early labour.

“...They started the induction medication ... at 9 ... and my husband came in about 2 and I went down and we did laps of an empty car park which was great because there was no visitors the car park was totally empty. It was a lovely sunny day ... he wasn't allowed into the hospital but it was nice to be able to have a bit of contact there and a bit of support there.” (ID 13)

The feeling of loneliness persisted for some women during their postnatal hospitalisation, as visiting on the postnatal wards was prohibited. All 19 women who participated in the study spoke about feeling sad that their partner did not have the opportunity to know and bond with their baby during the first days of life. Women used technology to stay connected with their partner during this time, mainly through frequent video calls and by sending regular video and photograph updates.

“I knew I wouldn't see him then for three days, and, well, I was more sorry for him actually. Because it was his first. So I felt a bit lousy on his side.” (ID 10)

Isolation and sadness were experienced by some women in the early postnatal weeks at home. Social distancing, COVID-19 restrictions, and concern about elderly or vulnerable family members meant that many women did not have opportunities to introduce their baby to loved ones that they might have otherwise done had the pandemic not existed and which they would have looked forward to.

“...For my husband's parents it was their very first grandchild ...But to me I felt like that was the one thing I wanted my family and especially

close family and grandparents, to be able to hold him. Because I felt like the journey to get to that stage had been a long time coming.” (ID 06)

Furthermore, COVID-19 associated restrictions prevented women from seeking and having face-to-face access to the support of other mothers, female friends and joining mother and baby groups. This postpartum isolation was an extension of antepartum isolation where many women described confining themselves to their home while pregnant to protect themselves from COVID-19 transmission. Although most women were accepting of this as part of the reality of the pandemic, women were impacted both emotionally (sadness) and physically (being extra careful and isolating) as a result.

“Going out and doing the food shopping I stopped entirely I was kind of not really getting out because being pregnant I was very conscious that I had to be that little bit more careful.” (ID 13)

Preparing for and adapting to uncertainty

Preparing for and adapting to the uncertain times caused by the pandemic emerged in many women's narratives and stories. Some women described themselves as being 'adaptive' and 'prepared' in facing the changing circumstances presented by the global pandemic. Although sad and emotional about going to the hospital without their partner, a few women were mentally prepared for it and had accepted the reality that they were going to be on their own for most of their stay in the hospital.

“I knew he [my partner] wouldn't be able to wait around long afterwards. But yea I was prepared for all that. ... I knew exactly what was ahead of me. You know for first time mums ... it must've been much harder.” (ID 16)

In such narratives, women conveyed a sense of resilience and strong coping abilities amidst uncertainty, although multiparous women described how they were glad it was not their first birth while nulliparous women were stoic in saying that they had nothing to compare it to.

Women who were booked for induction of labour or elective caesarean section described this in positive terms, whereby it minimised uncertainty to a degree in offering some control over a situation that was uncontrollable. While arguably women with scheduled induction or planned birth dates outside of a global pandemic may equally experience this sense of control, it appeared heightened for women during COVID-19 as it offered them the opportunity to prepare mentally in advance for being on their own.

“Because it kind of gave me this finite time where I knew I was going to be going in. ...I knew I was having a section. And ... going in for at least three days. So I knew ... I'm going to have to deal with being in there, after a section, on my own.” (ID 17)

Adapting to using virtual media platforms as a means of staying connected with family and friends while being in the hospital or on returning home, for example introducing baby to the extended family via video call or zoom, was described by many women.

“So, it [introducing the baby to the family] was all done through skype and WhatsApp videos.” (ID 04)

“WhatsApp is brilliant. And I don't know what we'd all do without it. Because she [baby] sees both of them [grandparents] at least once a day [via WhatsApp].” (ID 16)

Being reliant on other women was another way in which women adapted to the circumstances following birth. Women drew comfort and support from each other during their postnatal hospitalisation, emotionally and practically, more than they might have had if the visiting restriction had not been in place. Curtains around individual bedside environments were open and women shared their birth stories and their concerns freely. New friendships were forged between women that

continued to the time of interview. A number of women appeared to cope with their own difficult postnatal situation by comparing themselves to others in the room, inasmuch as they were not as badly off as other women who had a sick baby or who had a difficult birth and no support person.

“And you know if you were kind of just worried, but you were able to talk to each other. And just comfort each other.” (ID 16)

“But I actually felt that everybody in the room was worse off than me because there was that woman and then another woman whose baby had potential meningitis or something.” (ID 08)

Blessing in disguise

The theme of blessing in disguise reflects some positive elements that women experienced while giving birth during COVID-19. Although many of these elements oppose the challenges experienced by some women, they also highlight certain advantages brought on by the altered practices, including policies of restricted visiting, that were implemented during the pandemic. Many women, for example, described ‘routine’ antenatal care as being streamlined, with reduced waiting times. The infrastructural and process changes described by women included efficient COVID-19 screening at the hospital entrance, use of personal protective equipment (PPE) by healthcare professionals, quiet waiting areas, exposure to limited numbers of healthcare professionals and short consultations. Many women positively referred to these changes and how they were implemented and were reassured by them.

“We were well distanced in the waiting area. ... A lot of things went a lot quicker, the wait times and stuff... you were in and out a lot quicker whereas in a normal day it would be quite packed and you'd be, you could be waiting there a while.” (ID 04)

Although many women described feeling alone and isolated postnatally and were sad that their partners were unable to be with them, or be with their baby, many drew comfort from the peace and quietness offered by less crowded postnatal wards. The visiting restrictions while in the hospital were valued by many women and were described as ‘pleasant’ because they provided women with the time and space to ‘bond’ with their baby, without any distraction or disruption from visitors.

“...the whole experience with not having ... gangs of ... visitors coming in and out ... it was just so pleasant.” (ID 01)

In particular, women who were breastfeeding narrated feeling more relaxed, comfortable and less exposed as a result of the visiting restrictions in the hospital.

“I was able to breastfeed without feeling really exposed and thinking about it now I think if there had been people around, strangers marching in and out of the ward I would have had the curtains pulled all the time and I wouldn't have put my foot outside you know.” (ID 13)

Following discharge home from the hospital a few women described their feelings of ‘bonding’ with the baby in their ‘perfect little bubble’ with other siblings and their partner. Many of these narratives centred on guests not arriving unexpectedly as might have occurred had COVID restrictions not been in place.

“It was lovely, we had our own little bubble, me and my husband and my baby; because my husband was off from work as well. So ... it was quite calm and relaxed. Because that was kind of the atmosphere we wanted.” (ID 14)

Although this didn't detract from the sadness women felt in not being able to share and introduce their baby to extended family members and friends it was a ‘blessing in disguise’ for women whereby the task of entertaining visitors, as one woman described it, was removed.

“... it was an absolute blessing in disguise really with COVID. Because you couldn't have people in your house. People weren't rocking up, arriving and you'd like feed them, or make tea and coffees and all that.” (ID 03)

Discussion

This study provides insight and understanding from the perspectives of women who experienced pregnancy, labour and childbirth during the early stages of COVID-19. Positive aspects and associated challenges were described by women, many of which were directly associated with the structural and process changes to maternity care that were implemented in response to the pandemic. These changes, while explicitly described in the context of this study, are not isolated to this study's environment, rather they appear reflective of changes that have occurred internationally (Menendez et al., 2020; Renfrew et al., 2020; Robertson et al., 2020; Jardine et al., 2021).

Postnatal adaptations can be challenging for women, especially for first-time mothers as they transition to the role of being a mother, in caring for and bonding with their baby, in establishing feeding, and in accessing support and advice as needed. Changes implemented in response to the pandemic have heightened these challenges, especially as women returned home from hospital after the birth of their baby. Effective social and practical supports, or lack thereof, can positively or negatively influence women's ability to successfully initiate and continue breastfeeding (Brown and Shenker, 2021; Snyder and Worlton, 2021). Emotional support and professional advice postpartum can help optimise women's childbirth experiences (Downe et al., 2018), or conversely, inadequate supports may negatively affect maternal wellbeing and interfere with effective maternal-fetal bonding (Oskovi-Kaplan et al., 2020). The findings of our study revealed that postnatal care during COVID-19, outside of the hospital setting, has largely been inadequate for women. Limited or unsatisfactory breastfeeding supports reduced or unclear PHN care, follow-up care that involved women attending health centres when they would otherwise have been visited in their homes, and insufficient or unsatisfactory telehealth consultations were identified. This type of unsatisfactory or insufficient maternity care has a potential cumulative effect of negatively impacting maternal mental wellbeing in the short and longer-term, a concerning issue which some women in our study alluded to.

Previous systematic reviews have reported indices of maternal mental health, such as anxiety (15.2%), postpartum depression (12%), and poor sleep quality (46%), in pregnant and postpartum women pre-COVID-19 (Dennis et al., 2017; Woody et al., 2017; Sedov et al., 2018; Shorey et al., 2018). Comparatively and concerningly, a recent systematic review involving 23 studies and 20,569 participants, exploring the impact of the pandemic on maternal psychological wellbeing has demonstrated considerable increases in these indices (Yan et al., 2020). Anxiety, antenatal depression, and psychological distress during the pandemic were respectively reported at 37%, 31% and 70%, while the prevalence of depression postpartum was 22% (Yan et al., 2020). Being cognisant of and addressing the needs of women in accessing perinatal supports, in particular, postnatal supports and professional advice, must be a priority as the pandemic continues. This priority should extend beyond the pandemic as the effects of the difficulties and challenges experienced by women as a result of COVID-19 have the potential to persist long-term.

Privacy, especially following childbirth and when trying to establish breastfeeding is valued by women (Gaboury et al., 2017). COVID-19 and national lock-down activities have resulted in policies of restrictive visiting in hospitals and in homes internationally (Coxon et al., 2020; Hermann et al., 2020; Viaux et al., 2020). Although the absence of support postnatally (e.g. from family, friends, support groups and professionals) and the decreased ability of sharing pregnancy and childbirth experiences in person, which are known to matter to women (Downe et al., 2018), were identified as particular challenges that

caused stress for many women, certain visiting restrictions were contrastingly described positively by many women in our study. This was related mainly to the absence of a large amount of visitors in hospital wards and the opportunity to spend time with their new baby and partner, without distraction from external visitors, on returning home. This finding emerged in our study as a *'blessing in disguise'*, albeit as a possible oxymoron, whereby the peace and quiet enjoyed by women as a result of restricted visiting contrasted to the sadness and loneliness that women felt from their partners' absence; an absence which was acutely felt by women who laboured early in the hospital *'on their own'* and for women in the immediate days postpartum. Other studies have also identified these contrasting positive and negative impacts that policies of restrictive visiting have had for women (Cullen et al., 2021).

At the time of writing (early April 2021), Ireland was in its third COVID-19 national lock-down. Although some maternity units have reevaluated policies on partner attendance, with easing of restrictions for labour and postnatal attendance (Cullen et al., 2021), this has not been uniformly applied across all maternity units. Admittedly, new strains of COVID-19 and ongoing community transmission are presenting ongoing and new challenges for dealing with virus transmissibility, the roll out of COVID-19 vaccines will, we hope, result in more widespread and further easing of restrictions. Arising from the findings of our study, this appears critically important for pregnant and postpartum women, so that they can be fully supported by their partners while in hospital and look forward to introducing their new baby, in person, to parents, family members and friends in the near future. In the interim, however, novel and practical ways to enhance the support that women need and rely on, must be ensured to optimise women's childbirth experiences during this challenging time. Furthermore, policies of restrictive widespread visiting in postnatal wards (not including partner visiting) should be considered as a potential standard beyond the pandemic and into the future. The peace and quiet and having the space to bond with their baby afforded by limited visiting was clearly valued by women, as evidenced in our findings.

Strengths and limitations

This study adds to the global body of evidence on women's experiences of maternity care during COVID-19 and will help expand on this evidence by contributing to a planned systematic review (Smith et al., 2021b). The study in applying mechanisms and activities to ensure rigor and establish trustworthiness, reflects women's voices directly based on their personal experiences of pregnancy, childbirth and postpartum care during COVID-19. The voluntary participation of a self-selecting sample of 19 women provides depth and richness to the data, with equal representation from multiparous and primiparous women, from women who experienced private, semi-private and public maternity care, and from women who had diverse modes of birth. Limitations of our study are also acknowledged, however. These include a study population who were all ≥ 30 years of age and who were all of Irish nationality. The inclusion of underrepresented or marginalised populations, such as women from ethnic minorities or women whose babies were admitted to neonatal intensive care, may have altered the overall findings of our study. Moreover, it highlights the need for research specifically with these discrete and often hard to reach maternity populations; thus, future research should also aim to investigate migrant women's views and experiences of maternity care during the COVID-19 pandemic.

Context in qualitative enquiry also plays a pivotal role, and one which can affect the transferability of study findings. Although our study was carried out in one maternity unit in Ireland, where maternity care is largely obstetric-led and hospital based, many of our findings are reflected in studies internationally. This provides reassurance to the transferability of our findings beyond our study's specific context, with informative relevance globally.

Conclusion

Structural and process changes in maternity care provision, in response to the COVID-19 pandemic, are likely to continue for some time. The longer-term effects of the challenges and difficulties presented by these changes, and the pandemic in general, for pregnant and postpartum women may not be fully revealed or understood for some time yet. The findings of our study have provided insight and understanding of women's experiences of maternity care during the early stages of the COVID-19 pandemic, highlighting both positives as well as the difficulties and challenges experienced by women. In addressing these aspects as the pandemic continues, our study has identified that enhanced care and support postnatally is urgently required, being cognisant of the potential effects that COVID-19 is having (and may have into the future) for pregnant and postpartum women is paramount, and re-evaluating the policy of restrictive visiting for partners, while simultaneously continuing restrictions on widespread visiting is urgently needed.

Ethical approval

Granted by the lead author's University (Ref: Chair_1_20.21) and by the participating Hospital's (Ref: Study No. 16-July 2020) Research Ethics Committees.

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Contributors

VS conceived the idea. VS, SP, D'OM, PB and NV recruited women to the study. SP and D'OM conducted the one-to-one interviews with women. SP carried out the thematic analysis with independent coding by and close discussions with VS and D'OM. SP, VS and D'OM drafted the manuscript with review and feedback from PB and NV.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2021.103092.

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