

“What if I’m on my own?”

Interim report: Experiences of pregnancy and birth during the COVID-19 pandemic

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the Co-Applicants of the UKRI COVID-19 funded study “Understanding the impact of COVID-19 on pregnant women and new parents: The Born in Bradford 2020 Families Study”, and the Bradford Institute for Health Research Covid-19 Scientific Advisory Group.

Interim Report
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This report presents pregnant women and their partners’ experiences of pregnancy during the COVID-19 pandemic within the Born in Bradford cohort. The report is to aid policy and decision makers in their planning and responses to COVID-19.

Further Information:

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Executive Summary

Introduction

With support from the national funding agency, UK Research and Innovation (UKRI), the Born in Bradford (BiB) team designed a rapid-response research programme to rapidly gather data on the health, social, education and economic impacts of the COVID-19 pandemic on families in Bradford. The research programme included surveys, as well as in-depth interviews with families, to understand what it was like to be pregnant, give birth and bring up a baby during the pandemic. This report is based on the interviews about pregnancy experiences, conducted by telephone between May and November 2020, with 12 women and two male partners, all of whom were interviewed in English. The key topics that we explored with women and partners included: physical health, mental wellbeing, key relationships and access to, use of and satisfaction with services. Future reports will cover childbirth in more detail, as well as the postnatal period. The aim of this interim report is to provide timely information to service providers.

Key findings and recommendations

	Key findings	Recommendations
	<p>Overall women had a positive experience of maternity services in Bradford during the coronavirus pandemic</p> <p>Women we interviewed had a very strong preference for face-to-face appointments.</p> <p>Women valued continuity of care with the same midwife, but most had seen several different midwives during pregnancy; this is not solely pandemic-related but was even more important to women at this time.</p> <p>Government information about COVID-19 was said to be insufficient, unclear and constantly changing, which intensified worry and anxiety.</p> <p>Awareness of online ante-natal classes was mixed; those who attended found them informative.</p>	<p>Feedback to midwives and maternity staff that women value the care and services provided to them during the pandemic.</p> <p>As lockdown eases, and services work towards further opening of maternity settings, creative solutions should be found to overcome challenges to face-to-face appointments. These could include using larger rooms to facilitate social distancing, one-way systems or encouraging women and partners to attend on time and wait outside the facility if they arrive early².</p> <p>Where possible, NICE guidance¹ ensuring all pregnant women are cared for by a named midwife throughout their pregnancy should be implemented. This may involve ensuring local systems and guidance are in place.</p> <p>All pregnant women should be offered information based on the most up to date COVID-19 pandemic guidance available, to enable them to make decisions about their care.</p> <p>All pregnant women should be offered the opportunity to attend antenatal classes and be informed of where and how to access classes.</p>



The thought of being alone was a persistent concern for nearly all women; most were anxious about attending scans and experiencing labour and childbirth without their partners

Some women worried about having to deliver “bad news” identified by a scan to their partner, or about him “being pushed out” and not included in important discussions

Some women were “terrified” and “panicky” that they might need to give birth alone.

Women’s ideas for involving their partners included booking private scans, recording the baby’s heartbeat on their phone and taking information about the sex of the baby home in an envelope to open.

Where possible, maternity services should follow NHS England advice² and facilitate any actions needed to ensure all pregnant women always have access to a support person during their maternity journey (including the early pregnancy unit, antenatal scans, antenatal appointments and labour and birth) during the COVID-19 pandemic.

Often creative solutions can be found to overcome challenges to maximise the support to women throughout their maternity journey.

Following NHS England advice², maternity services should offer all women and their support person lateral flow testing ahead of 12 and 20-week scans to facilitate attendance and ensure support for women.

The pregnant woman’s support person should be welcomed as an integral part of the woman and the baby’s care, and not as a visitor.

All pregnant women should be re-assured that they will have access to a support person of their choice at all stages of her maternity journey, and the service should facilitate this².

As lockdown eases, and maternity services continue to open up, consider involving women in discussions about service adaptation, including how to involve partners in ultrasound scans and other antenatal appointments.



The pandemic impacted on women’s mental health, with two thirds reporting low mood and/or anxiety during their pregnancy

This was attributed to fear of “being alone”, the uncertainty about COVID-19 rules and a lack of control over their pregnancy and birth plan.

Provide culturally appropriate information on mental health problems in pregnancy and the postnatal period to all women and re-assure women that these problems are common, and help is available³.

Be alert to signs of mental ill-health during antenatal appointments and consider referring women if more support is required.

¹ <https://www.nice.org.uk/guidance/gs22/chapter/Quality-statement-2-Services-continuity-of-care>

² <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C0961-Supporting-pregnant-women-using-maternity-services-during-the-coronavirus-pandemic-actions-for-NHS-provi.pdf>

³ <https://www.nice.org.uk/guidance/cg192/chapter/1-Recommendations>

Conclusion

The qualitative findings presented in this report represent one time point in an ongoing study of the impact of the COVID-19 pandemic on women's and partners' experiences of pregnancy and childbirth. It is important to note that the findings reported here are based on interviews with women and partners, all conducted in English; the experiences of women and partners who are not confident in speaking English may be different.

The findings indicate some positive experiences, and our full report provides examples of excellent care and support women have received from maternity services during the pandemic. However, women's and partners' candid accounts of their experiences of pregnancy (and childbirth) also highlight aspects that require further exploration and possible attention. The persistent underlying narrative of women feeling alone during their pregnancy journey and at critical points in their routine care, is concerning. The stringent restrictions imposed on services during the pandemic, and the priority placed on infection prevention and control to keep staff and women safe, probably meant some aspects of women-centred care were compromised. That several women reported feeling a deterioration in their mental health during the pandemic is perhaps unsurprising, but the findings indicate more could be done to identify women at risk of mental ill health during pregnancy and provide access to information and relevant services. As services start to open up, and lockdown is eased in England, the opportunity to creatively adapt and restore services including face to face appointments and facilitating women's birth partners to attend critical appointments should be considered.

Introduction

Born in Bradford (BiB) is an applied research programme with three ongoing longitudinal birth cohort studies. In response to the COVID-19 pandemic, BiB is leading a COVID-19 research programme that aims to understand the impact of the COVID-19 response on BiB families (pregnant women and families with pre-school, primary and/or secondary school aged children), many of whom are from ethnic minority backgrounds and live in deprived areas. The COVID-19 programme has worked to identify research priorities with stakeholders, community and researchers, and aims to provide information in the short term to support policy and decision makers to deliver an effective COVID-19 urgent response in the City of Bradford, and in the longer term to better understand the wider societal impacts of the COVID-19 response on health trajectories and inequalities in these.

One key priority research area identified by researchers within the Bradford Institute for Health Research Covid-19 Scientific Advisory Group (BIHR C-SAG) was the experience of pregnancy and the post-partum period during the COVID-19 pandemic. Pregnant women were identified as a group vulnerable to COVID-19 which had increased health anxieties, alongside reduced access to face-to-face healthcare and reduced social support due to social distancing and restricted hospital visiting.

With funding from UKRI the BiB team designed a mixed methods research study with participants from two birth cohorts with ongoing recruitment: Born in Bradford's Better Start (BiBBS) and BiB4All. Longitudinal quantitative surveys are being used to collect data on the health, social, and economic impacts of the pandemic for women, their partners and their babies in the perinatal period in Bradford, and a linked longitudinal in-depth study is exploring the impacts in more detail using qualitative research methods. The qualitative study seeks to understand the lived experience of pregnancy, childbirth and the postnatal period during the pandemic at three timepoints of pregnancy, childbirth and the postnatal period. Key topics explored at each time point are physical health, mental wellbeing, key relationships and access to, use of and satisfaction with services.

The BiB team are committed to rapidly disseminating key findings from the surveys and qualitative research to District Gold Command and local services to support their response to families most in need. Dissemination of findings to local services can provide decision makers with an enhanced understanding of the wider societal impacts of the COVID-19 pandemic and allow services to 1) prioritise and adapt interventions, and 2) inform the recovery of services to reduce the short and longer-term impact of the COVID-19 pandemic on families in Bradford.

This report presents interim findings from the qualitative study; data were collected using semi-structured interviews with women and their partners from May to November 2020.

Methods

Sampling and recruitment

A sub-sample of women who completed the quantitative survey during the first 6 months of recruitment (May -October 2020) were selected to be invited to interview to give a range of ethnicities, parity and deprivation status. Women who did not speak English were oversampled, as we were particularly interested in their experiences.

The Born in Bradford data team then contacted women, sent them a participant information sheet and asked if they would be interested in taking part in a phone interview, explaining the aims and topics of the research. Women indicating an interest gave verbal permission for their contact details to be passed onto the researchers (JB, ND) who then phoned them and scheduled an interview at their convenience. Forty-

seven women were phoned, of whom 27 were uncontactable, and two declined citing a lack of availability. Eighteen women were recruited, and interviews were completed by telephone. To recruit partners, the Born in Bradford data team re-contacted participating women to ask if their partner would be interested in being interviewed. Those who agreed were asked to forward their phone number to the male researcher (DGR). Three partners made contact and all three were interviewed (by DGR, ND).

Before the start of each interview the researcher reminded the participant of the research aims, ensured they had read and understood the study information and then confirmed consent verbally.

Eighteen women and three partners participated in the first round of interviews conducted between May and November 2020. This report is based on interviews with 12 women and two partners, all conducted in English. Transcripts from interviews with 6 women and one partner were outstanding at the time of writing this report; data from these participants will be incorporated before formal publication. The mean age of women was 32, and just under half were experiencing their first pregnancy (see table 1). Six women were White British and 5 were Pakistani or British Pakistani. Just over half had given birth at the time of the interview; for these women the interviewer touched on childbirth but kept the conversation focused on the pregnancy experience. Two thirds had professional/office jobs.

Table 1. Characteristics of study participants

Characteristic	n (%)
Women	12 (100)
Mean age [range]	32.25 years [27-39 years]
First pregnancy	5 (41.7)
Had given birth at time of interview	7 (58.3)
Ethnicity	
Pakistani or British Pakistani*	5 (41.7)
White British	6 (50)
White Eastern-European	1 (8.3)
Employment	
Professional/office	8 (66.7)
Manual	1 (8.3)
Service	2 (16.6)
Not employed	1 (8.3)
Partners of pregnant women**	2 (100)
Partner's first pregnancy	1 (50)
Partner had given birth at time of interview	1 (50)
Manual employment	1 (50)
Service employment	1 (50)

*All interviews with these women were conducted in English. **Limited demographic data were available for the partners.

During this 6-month period Bradford was subject to various COVID-19 pandemic restrictions. From May to September the city was in a period of ‘summer relaxation’ of pandemic restrictions, from September to November it returned to Tier 2 status, and from November to December 2020 Bradford (like the rest of England) was in a second period of lockdown. We documented the number of interviews conducted in each restriction period (table 2) and where relevant we have highlighted contrasting insights in the data from these different periods.

Table 2. Interviews conducted during different pandemic restriction periods

Participants	May-Sept	Sept-Nov	Nov-Dec
	Summer relaxation	Tier 2	Lockdown 2
Women	5	5	2
Partners	0	1	1

Data collection and analysis

Given the coronavirus pandemic restrictions on face-to-face contact during the study period, interviews were conducted by telephone (by JB, ND, DGR). The interviews explored: experience of pregnancy and birth; physical and mental wellbeing; plans for childbirth; access to, use of, and satisfaction with antenatal and pregnancy services; relationships with partner and family; and general impact of COVID-19 on services. They were audio-recorded and transcribed verbatim. All identifying information was removed from transcripts and participants were given ID numbers so they could not be identified.

We conducted a thematic analysis. Three researchers (CJ, JB, DGR) read a subset of transcripts (n=9) to develop the coding framework, which was subsequently applied to all the interview transcripts. The researchers then independently identified key themes and patterns within these themes, including differences in responses by the pandemic restriction period (on the date of the interview) and ethnicity. Preliminary findings were discussed with the wider research team, themes were refined (LS, HS) and discussed again before being finalised.

Findings

Women’s views and experiences of pregnancy and birth are captured in three overarching themes, described below with illustrative quotes. The experiences of the partners are included alongside those of women; where there were differences by pandemic restriction period or by ethnicity these are described.

Theme 1: Women’s experiences of maternity services in Bradford during the coronavirus pandemic

Overall women reflected positively on their contact with healthcare providers and antenatal services. The consensus was that services had adapted well to the pandemic, continuing to provide a professional service with staff simply “*getting on with their job*”, “*doing their best*”, and often going the extra mile:

I think they’ve been brilliant, you wouldn’t know they’ve been affected, even though you know they have, even though I know like the midwives last week said they’ve got like loads of staff off, and she went, yeah, I’ve just pulled a 24-hour shift. And just still being professional through it all, and yeah, they’re just brilliant. (W04, White British, Tier 2)

Just two women were less positive about the overall service they had received, although both recognised the challenges the pandemic generated:

I wouldn't say it's anything to start complaining about, it's just obviously it's the time of Coronavirus, it can't be helped, but at the same time the question obviously, there's no positives to it. I think all the changes that have happened aren't good, but obviously that's because it's for safety for everybody, but I don't think they should stay like that, I think we should be changing back to normal as soon as possible. (W03, White British, Tier 2)

Approximately half of the women (predominantly interviewed during the summer relaxation period) reported most or all their appointments with the midwife to be face-to-face, either at their GP practice or at the birth centre at Bradford Royal Infirmary (BRI). The other half (all interviewed when Bradford was in tier 2 and during lockdown 2) had their appointments over the phone until later in the pregnancy (around 25-6 weeks) from then on, they saw the midwife face-to-face.

Face-to-face appointments. A very clear finding was that women reported preferring face-to-face appointments. They spoke about feeling reassured, and confident that they had had a “proper check-up” leading to “peace of mind” that everything was OK. The extent to which women were unhappy with phone appointments varied. Some spoke of feeling “pushed out” and “unsupported”, often mentioning that blood and urine tests were not done. For others, whilst they would have preferred face-to-face, they reported that phone appointments were acceptable, typically adding this was because they were having an easy pregnancy. Irrespective of whether this was a woman’s first or subsequent pregnancy, all of the women reported that only having phone appointments would likely be hardest for those in their first pregnancy. Video calls were not considered to be a good compromise because this still meant not having any physical examination or blood/urine tests:

Erm, well, a lot of the appointments had to be done over the phone. I wasn't allowed to go and see anybody. To be honest with you, I felt pushed out because obviously with it being my first baby I didn't know what to expect and it were just a case of, you know, you get on the phone to somebody, they'd ask you a few questions, and that would be it and you just think, well, surely, you know, surely, you know, a pregnant lady, especially with her first child, they need that support from the midwives. (W08, White British, Tier 2)

I've had a very, very easy pregnancy, I've not had no problems so to me I feel, I've felt OK but I just feel like I don't see how a midwife can see if you're okay over the phone. They can't. They can't check your urine, they can't check your blood pressure, they can't check anything, all they can do is say, 'are you okay'? (W03, White British, Tier 2)

Continuity of care. In addition to a predilection for face-to-face contact, women preferred to have continuity of care. Most of the women reported having seen several different midwives from primary care and secondary care during their pregnancy. Women who attended appointments via GP practices were more likely to say they had seen the same midwife consistently. The lack of continuity of care meant that women felt they had not developed a relationship with “their” midwife. A minority were upset about this:

Yeah, I didn't have anyone familiar and that was a bit upsetting. I thought I'd have someone, and I'll be happy but to be honest with you one went on a holiday, one's pregnant, she's working from home. I don't know whether, maybe some of them were not working on that day if you know what I'm saying. (W09, Pakistani, Summer Relaxation)

They've all been nice enough to deal with, you know, they've all been nice enough to go see but it is nice to know that you're going to see one person, so if it had stayed the same throughout it would have been nice but do you know, that's not happened. (W10, White British, Tier 2)

However, a lack of continuity of care did not impact on women's overall perception of their midwives and the care they provided. The majority of women made positive remarks, describing them as lovely, friendly, helpful, supporting, reassuring and accessible. For the few who did see the same midwife, the "added" benefit was clear:

I was lucky with her too because she's been my midwife all the way through my pregnancy and then on the day that I go into labour, well yeah, she's there and she was the one that delivered my baby. I couldn't believe it because, you know, I know her and she kind of knows me. Because obviously you get, over the nine months you get to kind of know each other and it was like, and it just, as soon as I saw her face it was like all my anxieties disappeared.

(W06, Pakistani, Tier 2)

Just three examples of frustrations with a midwife were mentioned but none were related to COVID-19 or the impact of the pandemic on services. One woman felt rushed in an appointment when the midwife was late after attending an emergency. Another expressed frustration at receiving different advice from different midwives. A third had not liked how one of the midwives present during her labour behaved, who she described as smelling of smoke, "bossy, shouty and clearly aggravated, not very empathetic to the pain I was going through". These were all exceptions to otherwise positive feedback from these same women.

Information needs. Women commonly described having insufficient, unclear, and constantly changing information about how COVID-19 affects pregnant women, their unborn and new-born babies; and how the pandemic impacted on maternity and other healthcare services. It is important to state that most women reported that this information was not withheld by healthcare providers, rather that everyone was "in the dark" with this new situation, certainly at the beginning of the pandemic.

I think the information should have just generally been clearer as to what measures were in place because everything changed on an almost three weekly basis." (W02, Pakistani, Summer Relaxation)

Yeah, it's one of them isn't it, it's all a bit unknown [partner attendance at birth] and they don't give you enough information to tell you. (W10, White British, Tier 2)

The lack of clear and consistent information seemed to intensify worry and anxiety in women. In terms of information about the impact of the pandemic on services, women and partners were unclear about constantly changing hospital protocols for ante-natal appointments, birth partners and the availability of antenatal classes as well as other non-maternity services.

Ante-natal classes: Awareness of the free online BRI ante-natal classes was very mixed. Half the women said they knew about the classes whilst the other half did not. Those who knew had seen this information on a BRI Facebook page, in a flyer or booklet provided by the midwife or on posters around the hospital. One woman who had not known about the classes instead paid £200 to attend a condensed 2-week online course provided by the NCT.

The minority who did attend the online classes or said they would have attended had they been aware of the classes were mainly, but not exclusively, women in their first pregnancy. Conversely, the majority who declined to attend or said they would decline were mainly, but not exclusively, women who had given birth before; most had attended ante-natal classes with previous pregnancies or had always chosen to not attend. The first timers in this declining group spoke of feeling sufficiently informed by other sources such as books, the internet (Google, YouTube), friends and family. They perceived this to be as good as attending virtual classes.

Women's remarks about the BRI online classes were generally positive and they were described as informative and enjoyable and had reassured participants about giving birth during the pandemic. Limitations related to a lack of practical hands-on experience, difficulty in discussing issues with the midwife as they came up and lack of opportunity to share experiences with other people going through the same thing. Not being able to have shared experiences was linked to women also saying that they were not making "new Mum friends", which would usually happen in these types of classes.

We did like an antenatal course but it was all just via Zoom so it wasn't, it didn't feel as maybe hands-on and practical as it could have been but obviously that's just the way it had to be. But obviously if you were there meeting the other couples and the lady running the course it could have been different. The face-to-face contact [was missing].

(W02, Pakistani, Summer Relaxation)

The clear consensus amongst the few who had attended the online classes and those who did not but had previously completed face-to-face classes, was that attending classes *in person* was the ideal. This resonates with the overall preference for in-person contact described above.

Theme 2: Being alone

All the women participants expressed that "*being alone*" was an underlying concern throughout pregnancy, during labour and birth. Partner involvement in antenatal care – and the potential for this to be restricted because of COVID-19 - was an emotional topic of conversation. Numerous examples illustrated women's inherent fear of not being together with their partner at critical points, especially when attending ultrasound scans and during labour and childbirth.

Attending ultrasound scans: Since the end of March women had been attending antenatal appointments, including ultrasound scans, alone. Two women who had been pregnant before mentioned they would have liked their partner to attend the scans, but "*it wasn't too much of a big deal*". For other women, not having a partner there for support during the 12 and 20-week scans had a substantial impact; the words women used to describe how they felt about this were striking - "*terrifying*", "*scary*", "*daunting*" "*freaked out*" and "*horrendous*".

Women described how they worried about hearing bad news alone, as well as having to break this bad news to their partner. Indeed, the partners who were interviewed regarded this as the hardest part of not being allowed to attend scans with women. The worry was exaggerated for a few women who had learnt of problems with previous pregnancies during a scan appointment:

That was horrible, we had a lot of mixed feelings about the pregnancy and we were really worried. We'd not allowed ourselves to be positive about it because it felt like it wasn't a very healthy pregnancy up to that point. So, I felt like the first scan was a really important one that I really needed my husband to be there because either way was a difficult conversation, a difficult time for us both whatever was to be the outcome and so having to do that on my own was really tough. (W11, White British, Lockdown 2)

Women were also mindful of their partner "*being pushed out*" – which they explained as not being able to hear the baby's heartbeat, not being there to be told the baby's sex and unable to ask their own questions. Most believed their partner was disappointed, upset or had missed out as a result of not attending ultrasound scans. One partner confirmed that he had found this hard.

You really, really look forward to the 12 week scan to sort of seeing your baby on the screen, and then again the 20 week scan to find out what sex it is, that for me as a Dad is sort of part of early bonding I suppose, just to get to see your baby and not being able to do that

and just looking at sort of the printed photos that you get has been a bit heart-breaking I suppose is the word, you know, missing out sitting there with my wife and, you know, taking that moment in together, and missing out on that moment together has been hard.

(PW10, White British, Tier 2)

Women's suggested ways to involve their partners included booking private scans, recording the baby's heartbeat on their phone and taking the sex of the baby home in an envelope to open together. Some accepted why the rule of attending antenatal appointments alone was in place, others described it as "crazy" and "unfair", struggling to understand why a member of their own household could not attend whilst at the same time people from different households could mix in pubs.

You know, they want to reduce the risk. They want to reduce the risk of COVID-19 so that's why it was done. To be honest with you, it's not a good thing but like it was for the sake of us, wasn't it, and it was for the sake of the staff. It's not like they'd be doing it for the fun of it, if you know what I'm trying to say. (W09, Pakistani, Summer Relaxation)

Rapid COVID-19 testing, wearing personal protective equipment (PPE) and strict adherence to protective rules were suggested ways to enable partners to attend the appointments. Alternatively, recording the scan or finding a way for the partner to watch it remotely.

Labour and childbirth: There was a common and significant worry among women that they would have to give birth alone (or experience labour alone). Women recounted how they felt "terrified" and "panicky" at the thought of being alone at these critical times. Indeed, one reason some women cited for choosing a home birth was that their partner could be there throughout. Any anxiety was heightened by a lack of clear indication from midwives of what the restrictions would be at the time of the birth and a perception that the rules were constantly changing (mentioned above).

The situation was understood by women to be that a birthing partner could be present once she was in established labour, with several women citing the exact dilation that they believed to equate to this stage.

Um, that's probably what I don't understand at the minute because I've been told different. Since the new lockdown rules there hasn't been anything on the news about the new rules for people being able to go to the hospital, there's been things online about certain hospitals allowing one or two birthing partners with you. I asked my cousin the other week, what's the scores on the doors with the BRI and she just said, your partners allowed in established labour which is from 5cm onwards, oh, it might be further on, it might have been 8cm, I'm not sure. Yeah, it's one of them isn't it, it's all a bit unknown and they don't give you enough information to tell you. (W10, White British, Tier 2)

One woman was concerned about potentially being induced without a birthing partner present. One partner we interviewed had been reassured he could be present at the birth and commented he found it difficult to imagine someone having to give birth alone. Several women would have liked to have had two birthing partners, typically their partner and their mother or a good friend. However, they knew this would not be possible, even for a home birth. One woman said she would have to choose her mother to be with her at the birth as her husband would want to leave the room at that point.

Because of the COVID-19 it's really affected pregnant women because, you know, things are not the same. So, because my husband said he doesn't want to see it, you know, see me having the baby and stuff. They said you need to sit and discuss it with your partner if he wanted to come because you're not, you know, you can't be swapping partners. You can't

have him and then say oh, he's not doing anything and then say oh, please can you call my mum. (W9, Pakistani, Summer Relaxation)

Another was worried that her husband would not be back from working away in time, so her mother would have to attend but this would also mean she would not be allowed to switch birthing partners if her husband arrived.

Women who had given birth prior to the interview described how being alone during labour and childbirth was a significant feature of their experience. They spoke of their, and other, husbands sitting in cars waiting to be called in to the maternity unit. Whilst this had gone to plan for most women, there were implications for others. One woman's husband had missed the birth because labour was so rapid. Another woman had returned home after her first contractions because she did not want her husband to wait for hours in the car or go home and then not be back in time. She rushed back to hospital later, but it was too late for the pool birth she had planned. Another was induced and on her own for a day during this time, which prompted her to choose to leave hospital early once her baby was born because she did not want to be there alone anymore.

I wasn't happy. I felt quite, sort of, you know, anxious and I just felt as though I didn't have any support with me, which I would have had otherwise. Now, because it was my first baby, ideally, I would have liked to have stayed in hospital to get a bit more support, a bit more advice. But because of the fact that my partner wasn't able to stay, nobody was able to come visit, I opted to go home, as long as everything was OK. So, I gave birth and literally a few hours later, I went home because I wasn't willing to just stay on my own.

(W05, Pakistani, Summer Relaxation)

Despite these strong emotions, only one woman suggested the rules regarding birthing partners were "unfair" suggesting that partners should also be tested for COVID -19 so they could be present with the women for longer.

Theme 3: Impact of the pandemic on pregnant women's mental health

Two thirds of women, and one partner, reported low mood and/or anxiety during pregnancy. For most, this was described as relatively small mood change or mild anxiety. Women's explanations included the above-described fear of "being alone", feeling out of shape, and having social plans and holidays changed or stalled. The partner described feeling "on edge" about not being able to live a normal family life and worrying about the safety of going out, both of which dampened the excitement of having a baby.

I felt okay, but I have put on more weight this pregnancy than I have in my other pregnancies and I do wonder if that's just being in the house all the time. You do just kind of, you just eat more I think and the boredom kind of thing. So, working at home and I mean I had to set up a desk in my bedroom and that wasn't very healthy because I was just waking up, jumping in the shower, going back into the bedroom to work all day and then dealing with children and then going back into the bedroom to sleep. (W11, White British, Lockdown 2)

Things you look forward to like people's weddings got cancelled, so everything just kind of went on hold, the summer holidays as a teacher you just didn't get to do.

(W04, White British, Tier 2)

Of particular concern were four women who shared experiences indicative of moderate or severe low mood and high anxiety. They identified several different reasons. First, was the uncertainty of ever-changing COVID 19 rules and their fears of "being alone". As one explained:

It has been awful. I think I've felt the worst since this pandemic, I think it's made my anxiety go higher than what it was. I do have my emotional breakdowns quite often now. Before where if I felt my anxiety was going a bit higher, I would go out for a drive, I'd take the kids out, we'd go to a park, we'd just let loose, breathe in some fresh air, you know, clean oxygen and stuff like that, it was a different environment. But now when you're 24/7 stuck in the house it has a massive effect. I feel heavy loaded, like I've got so much going on even though there isn't much going on, I just feel really stressed out. (W12, Pakistani, Lockdown 2)

The general lack of accurate and up-to-date information had intensified these worries. One woman described how a lack of information and ever shifting rules had resulted in a sense of having no control over her pregnancy and birthing plan. She wished her midwife had picked up on her mental health needs at the time; but with only phone appointments available, she had had to discuss this in the presence of her youngest child and so continually downplayed the severity of her low mood.

I was very teary, very, very teary. I had panic attacks. I'd never had a panic attack before. I think it was the restrictions placed on us. I felt out of control and I felt panicked about what was going to happen. I felt like we're going into the complete unknown with this baby compared to the other babies and I didn't know how my maternity leave was going to go, I didn't know how life was going to be, but just the waiting to hear on the news what I was allowed and not allowed to do, I think that had a bigger impact than I imagined it would do. (W11, White British, Lockdown 2)

One woman who had unconfirmed COVID-19 during her pregnancy felt so ill she feared she might die. She was then anxious about becoming dangerously ill again with her new-born and not knowing how it would affect the baby:

What if I get ill again? What if I'm positive? What if they take my baby away? Then I was thinking because I'm like the mother and the baby's attached with me, with me, if I have the symptoms will it affect the baby? Because I do know it has affected kids, but I mean young babies? (W09, Pakistani, Summer Relaxation)

Mental health struggles were compounded by a lack of support sources for new parents. One woman declared that she was not aware of any support groups that women could have access to. Her experience was aligned with that of other participants:

I think if people are quite down within the pregnancy and having low moods and things like that, because I haven't actually experienced that, I don't know what support there is out there. There's like going to the doctor's and going and speaking to people so I can't really comment on if there's anything else that can be done. (W08, White British, Tier 2)

Conclusion

The qualitative findings presented in this report represent interim findings from an ongoing longitudinal study of the impact of the coronavirus pandemic on women's and partner's experiences of pregnancy and childbirth. The findings reported here are based on interviews with women and partners, all conducted in English; the experiences of women and partners who are not confident in speaking English may be different.

The findings indicate some positive experiences and examples of excellent care and support women have received from maternity services during the pandemic. However, women's and partner's candid accounts of their experiences of pregnancy (and childbirth) also highlight aspects that require further exploration and possible attention. The persistent underlying narrative of women

feeling alone during their pregnancy journey, and at critical points in their routine care, is concerning. The stringent restrictions imposed on services during the pandemic, and the priority placed on infection prevention and control to keep staff and women safe, probably meant some aspects of women-centred care were compromised. That several women reported feeling a deterioration in their mental health during the pandemic is perhaps unsurprising, but the findings indicate much more could be done to identify women at risk of mental ill health during pregnancy and provide access to information and relevant services. As services start to open up, and lockdown is eased in England, the opportunity to creatively adapt and restore services including face to face appointments and facilitating women's birth partners to attend critical appointments should be considered.