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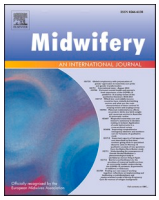

The social and healthcare professional support drawn upon by women antenatally during the COVID-19 pandemic: A recurrent, cross-sectional, thematic analysis

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ABSTRACT

Objective: To explore antenatal experiences of social and healthcare professional support during different phases of social distancing restriction implementation in the UK.
Design: Semi-structured interviews were conducted via telephone or video-conferencing software between 13 July 2020 – 2 September 2020. Interviews were transcribed and a recurrent, cross-sectional, thematic analysis was conducted.
Participants: Twelve antenatal women were interviewed during UK social distancing restrictions (Timepoint 1; T1) and a separate sample of twelve women were interviewed in the initial easing of these restrictions (Timepoint 2; T2).
Findings: T1 themes were: 'Maternity care as non-essential' and 'Pregnancy is cancelled'. T2 themes were: 'Technology is a polarised tool' and 'Clinically vulnerable, or not clinically vulnerable? That is the question'.
Key conclusions: At T1, anxieties were ascribed to the exclusion of partners from routine care, and to perceived insensitivity and aggression from the public. For T2, insufficient Governmental transparency led to disillusionment, confusion, and anger. Covert workplace discrimination also caused distress at T2. Across timepoints: deteriorated mental wellbeing was attributed to depleted opportunities to interact socially and scaled back maternity care.
Implications for practice: Recommendations are made to: protect maternal autonomy; improve quality of mental health and routine care signposting; prioritise parental community support in the re-opening of *'non-essential'* services; prioritise the option for face-to-face appointments when safe and legal; and protecting the rights of working mothers.

Introduction

Pregnancy is a transitional period of significant change, whereby a number of social factors can contribute to women and birthing people's feelings of emotional distress, poor psychological well-being, or even mental ill health; with higher levels of antenatal anxiety significantly associated with adverse outcomes in the postnatal period for both mother and infant (Grigoriadis et al., 2019). Socially, pregnant women are more likely to experience workplace discrimination (Salihu et al., 2012), and deterioration of relationship quality (Mitnick et al., 2009). Perception of low quality familial and/or partner support are risk factors for postpartum depression and anxiety (Hetherington et al., 2018), while feeling well supported is protective against distress (Giesbrecht et al., 2013). Quality of maternity care, too, determines levels of anxiety late in pregnancy (Nicoloro-SantaBarbara et al., 2017). Perceived satisfaction with one's birth experience has been shown to significantly

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predict physical and emotional recovery post-birth and development of post-traumatic stress disorder (PTSD; Webb et al., 2021).

In the first wave of the COVID-19 pandemic, social distancing restrictions were mandated in attempt to control spread and mortality of the virus (UK Government and Public Health England, 2021). During initial social distancing restrictions in the UK (March 2020 – May 2020; UK Government and Public Health England, 2021), antenatal women were advised to *'shield'* so to protect themselves and their unborn babies from infection (RCOG & RCM, 2020; Anderson et al., 2021). Although it is now known pregnant women are not at a heightened risk of contracting COVID-19, pregnant women who contract COVID-19 – especially in the third trimester – are at increased risk of worse symptomatology, pre-term birth, difficult and assisted labour and birth, and maternal death (Di Mascio et al., 2020).

Social distancing restrictions included the substantial restructuring and scaling back of UK maternity care services (De Backer et al., 2022; Horsch et al., 2020; Kotlar et al., 2021). Maternity reconfiguration was characterised by a shift towards virtually held perinatal appointments; redeployment of midwives across the sector (for COVID-19 screening and vaccination); reduced/altered levels of postnatal support; and prohibited birth partner attendance bar from active labour (Panda et al., 2021; Silverio, De Backer, et al., 2021). Post-birth, many hospitals implemented a 'no partner' visiting rule (Montgomery et al., 2023), with overall restrictions making many women consider birthing outside of the system (Greenfield et al., 2021). Satisfaction with maternity care was often deemed a 'postcode lottery' during mandated social distancing restrictions (Iacobucci, 2020). An abundance of qualitative, pandemic-informed literature (Dasgupta et al., 2024) now understands that exacerbated maternal distress (e.g., Kolker et al., 2021), perceived abandonment and isolation (e.g., Riley et al., 2021), and dissatisfaction with maternity care (e.g., Keating et al., 2022) was attributed to: partner exclusion from routine appointments and from labour suites (Atmuri et al., 2022; Crowther et al., 2022), frequently changing and conflicting maternity guidance in regard to COVID-19 (Vasilevski et al., 2022); and depleted accessibility to face-to-face formal and informal perinatal support (Sweet et al., 2021; Wilson et al., 2021). Healthcare professionals mirrored maternal accounts with regards to changing social distancing restrictions, with needs highlighted for a central, frequently updated and time-stamped resource for acquiring COVID-19 related guidance (Szabo et al., 2020).

Indeed, a growing body of global literature now reiterates maternal need for: reinstating choice around birth plans, transparent communication regarding social distancing policy change, and improved access to routine healthcare (Combellick et al., 2022). Social distancing restrictions also resulted in the loss of informal support from one's family and friends, which had dire consequences for mental health during the transition to new parenthood (Bradfield et al., 2021; Jackson et al., 2021, 2022). Stripped-back access to formal and informal support may explain increased prevalence of clinically relevant anxiety and depression observed during the pandemic when compared with pre-pandemic estimates (Fallon et al., 2021), causing an invisible mental health epidemic (Bridle et al., 2022; Fallon et al., 2021; Jackson et al., 2024; Pilav et al., 2022; Racine et al., 2021). Qualitative literature mirrors quantitative outputs, with disruption to formal and informal support resulting in reports of ambivalence towards one's pregnancy (Bolgeo et al., 2022; Zheng et al., 2022) and perinatal elevation in anxiety, depression, and stress (Huynh et al., 2023; Saleh et al., 2023). The current study therefore sought to build on quantitative trends which had highlighted elevated distress among antenatal women. We aimed to conduct an in-depth exploration of women's antenatal experiences of social and healthcare professional support during two different phases of national lockdown restrictions in the UK, using a recurrent, cross-sectional thematic analysis.

Statement of Significance

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Problem or Issue	The transition to motherhood is a significant lifecourse event for women and one which can be marked by increased psychological distress. The impact of COVID-19 restrictions on both formal and informal social support as well as access to healthcare services and professionals have had an adverse impact on perinatal mental health. This may be attributed to longer-term negative outcomes for both mothers and babies.
What is Already Known	As a result of the COVID-19 pandemic, national lockdown restrictions were implemented which restricted access to in-person healthcare professional support as well as reducing access to social support networks. The transition to motherhood during the pandemic therefore posed a unique circumstance with unique stressors negatively impacting preparation for birth and the arrival of a new baby, however, qualitative work has been sparce on the distinct impact of restrictions linked to the pandemic in relation to healthcare professional and social support.
What this Paper Adds	This research has provided an in-depth understanding of specific psychological, social, and community level factors which may have contributed to more negative prenatal outcomes during the pandemic. We provide further evidence for the damage caused by specific restrictions such as the removal of partners from antenatal spaces and also provide new evidence of workplace discrimination for women who were pregnant. Overall pregnant women attributed anxieties about their maternity care to the fact it had been reduced in frequency and form, as well as not being able to access their social networks they would have otherwise depended upon.

Methods

Ethics & design

Ethical approvals were granted from the University of Liverpool Research Ethics Committee on 7 April 2020 [ref: IPHS/7630]. A recurrent, cross-sectional (Grossoehme and Lipstein, 2016), exploratory, qualitative design was adopted to investigate study aims. A total of 12 participants were recruited for each respective timepoint, as deemed appropriate for achieving data saturation (Guest et al., 2006). Women in their third trimester of pregnancy (>28 weeks gestation) were recruited for the current study. By the third trimester, women will have attended routine antenatal services, screening, scans, and will have discussed their birth plan within the context of COVID-19 restrictions (Jardine et al., 2020). This lived experience places women in their third trimester as knowledgeable experts on addressing study aims. Recruitment for Timepoint 1 [T1] commenced approximately 30 days after initial lockdown restrictions were first implemented in the UK (23 Mar 2020; UK Government, 2020a). Recruitment then continued until 12 participants had been interviewed. A separate sample of 12 women were interviewed for Timepoint 2 [T2] – approximately 30 days after the easing of lockdown restrictions (11 May 2020). With regard to the reflexivity of the study team, it comprised psychological researchers still in undergraduate/postgraduate training [MG, AP, SMD], an early career researcher [LJ], and senior researchers [VF, LDP, LKS, SAS] including one at professorial level [JAH]. Whilst none of the team were pregnant or gave birth during the pandemic, several authors were parents [SMD, VF, LDP, LKS, JAH], and we were all based in the UK during the pandemic and so experienced the social distancing restrictions placed on England. None of the team have clinical experience or training, but rather expertise in the psychology of the perinatal period [VF, SAS, LJ, LDP, JAH] and advanced qualitative methodological expertise [SAS, LKS]. More junior members of the team [MG, AP, SMD, LJ] received both topic area and methodological mentorship and oversight from more senior members [SAS, LKS, VF].

Recruitment and participants

Participants expressed interest in participating having completed

The Pregnancy and Motherhood [PRaM] Study survey (see Fallon et al., 2021). Specifically, women who had completed the PRaM online survey study (Fallon et al., 2021) were redirected, after being debriefed, to a separate on-line survey which was generated through the Qualtrics platform. Here, the individual was asked if they would be interested in taking part in an audio recorded interview study to talk about their experiences of pregnancy during the COVID-19 pandemic in greater detail. Eligibility criteria were as follows: maternal age 18+, in their third trimester of pregnancy (>28 weeks), English speaking, and a UK resident. Women who met the eligibility criteria were invited to leave their name, telephone number, and e-mail address so that a member of the research team could contact them in a couple of days to arrange an interview. A total of 72 women left expressions of interest. An on-line random number generator was used to select twelve eligible women from T1 expressions of interest. Once this selection had been exhausted (either through conduct of interviews or three unsuccessful attempts at contact) another twelve contacts were selected for initial contact. This process continued until all twelve T1 interviews had been conducted. The same recruitment strategy was implemented for women recruited at T2. Due to this elongated period of recruitment, all semi-structured interviews took place via telephone or video-conferencing software between 13 July 2020 – 2 September 2020. Information regarding UK social distancing restrictions implemented in the UK preceding and spanning the recruitment period for the current study are detailed in the research team's sister antenatal paper (Jackson et al., 2023). Due to timing of birth and availability to interview, some women who agreed to be interviewed antenatally, were in fact, interviewed in the postpartum period ($n = 4$), but were asked to exclusively reflect on their antenatal experiences. Table 1 presents a summary of participant characteristics, split by T1 and T2.

Data collection

Interview schedules were created with academic experts in perinatal mental health [VF, SAS, JAH, LDP]. Interview items reflected published, postnatal literature which had also used recurrent cross-sectional analysis to explore parental experiences of COVID-19 (Jackson et al., 2021; 2022; 2023). Perinatal literature was also consulted so to draw on transitional factors known to be important determinants of perinatal wellbeing, when structuring the interview schedule e.g., social network support, healthcare professional support, societal influences (e.g., Rollins et al., 2016). Included questions were chronological so to comprehensively investigate transitional experiences through different phases of social distancing restrictions. Once participants confirmed

Table 1
Demographic Characteristics.

Timepoint	Participant Pseudonym	Age (Years)	How Many Weeks Pregnant at Time of Interview?	Occupation[b]	Highest qualification[c]	First child?
T1: Initial Lockdown Restrictions	Ethel	24	39	Caring, leisure and other service occupations	Secondary School Education (incl. ALevels and BTECs)	No
	Madeline	26	31	Sales and customer service occupations	Secondary School Education (incl. ALevels and BTECs)	No
	Georgina	28	30	Skilled trades occupations	Secondary School Education (incl. ALevels and BTECs)	Yes
	Ugne	29	35	Associate professional occupations	Master's Degree	Yes
	Lindsay	29	38	Managers, directors, and senior officials	Doctoral degree	No
	Danni	32	31	Professional occupations	Bachelor's Degree (incl. Medical Degree)	Yes
	Claire	33	33	Professional occupations	Bachelor's Degree (incl. Medical Degree)	No
	Kavitha	33	33	Managers, directors, and senior officials	Bachelor's Degree (incl. Medical Degree)	Yes
	Olivia	34	39	Managers, directors, and senior officials	Bachelor's Degree (incl. Medical Degree)	Yes
	Emily	35	33	Professional occupations	Bachelor's Degree (incl. Medical Degree)	No
	Ceinwen	37	35	Administrative and secretarial occupations	Master's Degree	No
	Miriam	39	32	Professional occupations	Doctoral degree	No
	Bashita	26	37	Associate professional occupations	Master's Degree	No
T2: Lifting of Lockdown Restrictions	Xenia	30	37.5	Professional occupations	Master's Degree	Yes
	Joely	30	Postnatal[a]	Professional occupations	Bachelor's Degree (incl. Medical Degree)	No
	Lilian	31	39	Professional occupations	Doctoral degree	Yes
	Aliyah	32	38	Caring, leisure and other service occupations	Doctoral degree	No
	Francine	32	Postnatal[a]	Associate professional occupations	Bachelor's Degree (incl. Medical Degree)	Yes
	Francesca	33	35	Professional occupations	Bachelor's Degree (incl. Medical Degree)	Yes
	Emma	33	37	Professional occupations	Bachelor's Degree (incl. Medical Degree)	No
	Selina	33	Postnatal[a]	Professional occupations	Doctoral degree	No
	Chloe	34	32	Administrative and secretarial occupations	Bachelor's Degree (incl. Medical Degree)	No
	Daisy	35	Postnatal[a]	Managers, directors, and senior officials	Doctoral degree	No
	Zanthia	41	33	Associate professional occupations	Bachelor's Degree (incl. Medical Degree)	Yes

[a] Whilst these women were postnatal at the time of interview, they were asked to reflect on their antenatal experiences only.
[b] Occupation categories taken from UK Government, 2020b.
[c] Education categories taken from UK Government, 2021.

their preferred date and time of interview, they were sent an electronic consent form to sign and return. In recognition of consent as a continuous process, verbal, audio recorded consent was also obtained before the commencement of each interview. Participants were made aware of their right to withdraw, were fully debriefed after interviewing, and reimbursed £10 for their time, as a good will gesture. Individual, semi-structured interviews were conducted via telephone or video-calling [SMD, MG, AP]. Guidance for supporting field researchers and good practice for qualitative research into sensitive topics was followed (Silverio, Sheen, et al., 2022). Interviews were conducted between July and September 2020, and lasted between 68 and 114minutes (M_{Time} = 93minutes). Audio recordings were transcribed and analysed using NVivo 12 [MG, AP, LJ, SAS].

Data analysis

Transcripts were analysed using recurrent, cross-sectional, thematic analysis (Grossoehme and Lipstein, 2016; Silverio et al., 2020). Recurrent, cross-sectional thematic analysis is a longitudinal method of inquiry whereby separate samples are interviewed at different timepoints: this is appropriate when seeking to investigate the impact of an 'event', such as legislation change, on lived experiences (Grossoehme and Lipstein, 2016). This differs from traditional thematic analysis (Braun and Clarke, 2022) which, conversely, involves a cross-sectional investigation of experiences at one time point, only. To assess the impact of changing national lockdown restrictions on experiences of pregnancy, a longitudinal, recurrent method of analysis (Grossoehme and Lipstein, 2016) was deemed most suitable for addressing research aims. Firstly, a thematic structure was derived for each timepoint, independently (T1 and T2, respectively) using thematic analysis. Next, comparisons were made between timepoint thematic structures (Grossoehme and Lipstein, 2016). Then, findings were contextualised by pre-existing, pandemic-informed literature. Data saturation was achieved after analysing seven (T1) and eight (T2) transcripts. However, recruitment, interviewing, and analysis continued until twelve women had been recruited at each timepoint to ensure we had exhausted all thematic concepts across each timepoint. Analysis followed an inductive and consultative approach. The full analytic methodology can be found in previous linked papers (Jackson et al., 2021; 2022; 2023).

Results

Two themes were generated at each timepoint, each with sub-themes (see *Table 2*). Each theme is summarised narratively with supporting quotations tabulated (see *Table 3* for Timepoint 1, and *Table 4* for Timepoint 2). Quotations are accompanied by a pseudonym, associated recruitment timepoint (i.e., T1 for Timepoint 1, and T2 for Timepoint 2), gravidity/parity status (whether the child that they are pregnant with currently was to be their first child i.e., primigravida; or whether they have at least one older child i.e., multiparous), and gestational status (pregnant or postnatal at time of interview).

Table 2
Thematic summary for T1 and T2.

	Themes	Sub-themes
Timepoint 1	Maternity care as *'non-essential'*	Black-listed partners
		You have to be in crisis
	Pregnancy is cancelled	It's been a drag
		COVID brought out the worst of humanity
		Social distancing whiplash
Timepoint 2	Technology is a polarised tool	Technology as a facilitator of connection and information
		Technology is an inadequate alternative
	Clinically vulnerable, or not clinically vulnerable? That is the question	Frustrated by ill-handled restrictions
		Pregnancy behind bars
		Work-home life blurring

Timepoint 1 results

Theme 1: Maternity care as 'non-essential'

T1 participants felt deprioritised during national lockdown restrictions due to the scaling back of routine maternity care. For interviewees, restrictions placed on birthing partners attending antenatal appointments resulted in feelings of abandonment and exacerbated birth anxiety. Impersonalised and rushed care rendered pregnant women feeling unable to approach healthcare practitioners about their emotional concerns. Oftentimes these women felt the need to resort to filtering through non-regulated internet sources for guidance and support.

Sub-theme 1: Black-listed partners

During mandated lockdown restrictions, partners were regularly excluded from routine appointments and from labour wards in an effort to reduce unnecessary exposure to the novel COVID-19 virus. Although well intentioned, interviewees found this exclusion to be inhumane and unjustified. Moreso, women were insulted by the illogical and contradictory nature of excluding cohabiting partners while allowing student healthcare professionals from different households to be present. The unintended consequences of partner exclusion extended beyond the frustrations held towards inequitable social distancing policy which prohibited partners from attending maternity suites until established labour resulted in avoidable anxiety about the prospect of 'labouring alone'. Practitioner use of personal protective equipment [PPE] further intensified feelings of the medicalised, impersonal pregnancy and exacerbated feelings of abandonment and dissatisfaction with one's quality of maternity care and with their pregnancy, overall. At hospitals where maternity staff were following safety precautions and units were largely unoccupied, mothers felt safe when attending appointments. The antithesis was associated with increased anxieties about viral contraction and distrust in seemingly contradictory guidance regarding self-isolating procedures.

Sub-theme 2: You have to be in crisis

Interviewees at T1 consistently reported that their routine appointments had been deprioritised to an extent whereby, unless one was unable to function day-to-day, physical and mental support was forsaken in the wake of COVID-19. Those who felt able to self-advocate their needs and who felt well supported by their healthcare professionals, expressed feeling that their views were both respected and acted upon, which enabled a sense of trust to be developed between the mother and her healthcare team. For women who were exposed to diminished routine care and who were consequently dissatisfied with the quality of maternity care that they received, in contrast, matters were often taken into one's own hands in the form of self-research. Self-education, however, proved problematic as interviewees struggled to sift through a plethora of opinionated, non-credible sources. Moreover, those women who were engaging in self-guided research to bridge the emergent gap in maternity services associated with social distancing restrictions, the importance of choosing reliable online sources of information was recognised. Some women, for example, spoke about consulting the Maternity Voices Partnership – an NHS working group which strives to represent the voices and lived experiences of women and their families in healthcare settings, nationally.

Theme 2: Pregnancy is cancelled

From a social standpoint, loss of antenatal classes diminished pregnant women's excitement for the arrival of their infant, and interviewees frequently reported feeling as though their pregnancy and pregnancy-related rituals which they would usually cherish with their social networks, were overshadowed by the concerns of others pertaining to the

Table 3
Timepoint 1 Quotations.

	Themes	Sub-themes	Quotations
Timepoint 1	Maternity care as *'non-essential'*	Black-listed partners	*"I feel like if you can have students present, why can't a partner be there [birth]? It's not limiting it to two people because there are other people in the room as well, so I feel like especially if you're from the same household, why is that risk different…I feel like our partners have been completely cut out. I think it's quite inhumane, actually…"* (Ethel, T1, pregnant, multiparous) *"The big thing that really was stressing me out…was that my husband wouldn't be with me at the birth. That's the really big one that's really stressing me out and stressed me out right from the start."* (Ceinwen, T1, pregnant, multiparous) *"If you do go in person then they're all wearing PPE so it's quite hard to connect with someone when they're covered in plastic. It's a really strange situation."* (Georgina, T1, pregnant, primigravida) *"I feel like COVID has made me wish my pregnancy away so that the baby can just be here and that's it."* (Ethel, T1, pregnant, multiparous) *"…when I went [to the hospital], it was so quiet as well because they were cutting down all their antenatal appointments. So personally, I never felt scared going to hospital."* (Ceinwen, T1, pregnant, multiparous) *"…it is a really busy clinic, lots of people, not everyone has got PPE and they're telling you to stay home and self-isolate and then you go into hospital, which is where the virus is. You just don't really want to be there."* (Georgina, T1, pregnant, primigravida)
		You have to be in crisis	*"One of my midwife appointments was cancelled, so my 26-week midwife appointment. So, I didn't actually meet my midwife until 28 weeks."* (Madeline, T1, pregnant, multiparous) *"I'm not being referred to the perinatal mental health team. I think unless you're really seriously seeing bats flying round, they're just going 'Okay, no.'"* (Ceinwen, T1, pregnant, multiparous) *"…two of our consultant midwives at the [place], are incredible. If you're in any way worried or concerned, they will get back to you, they'll sort it out. You've got to have that initial 'I'm not happy about this' and then they'll tend to sort it out for you."* (Ceinwen, T1, pregnant, multiparous) *"How do you even know what's right and what's wrong? It's an absolute minefield, so I think I would definitely struggle if I didn't have that understanding."* (Georgina, T1, pregnant, primigravida) *"If you go on the MVP YouTube page, you can go on there and our consultant midwife had done this phenomenal series of films. We've done one on the latent stage of labour, the active stage of labour, and she's done what happens if you come in and you have interventions."* (Ceinwen, T1, pregnant, multiparous)
	Pregnancy is cancelled	It's been a drag	*"I was also going to start going to an aquanatal class, that was cancelled. My pregnancy yoga is cancelled, so all of the physical things that I think are quite important and the social side of things have just disappeared really"* (Georgina, T1 pregnant, primigravida) *"I've done a hypnobirthing course online which before I would have done in person. But that was really good. I'm a yoga teacher but I've been doing quite a lot of yoga at home and connecting with others online, taking part in classes, which is something I would have never done before."* (Georgina, T1, pregnant, primigravida) *"I absolutely wouldn't have been able to do it before because I couldn't afford it and also couldn't go with a toddler."* (Ethel, T1, pregnant, multiparous) *"I was thinking what if I have issues with breastfeeding and I need support? How am I going to do that? Because again, I don't think a Zoom call would work for that."* (Ethel, T1, pregnant, multiparous) *"For my first baby people used to send me toiletries and smellies and little bits and bobs that they'd seen when they'd gone out, and of course nobody's going to do that because now you've got to post it or it's got to be an active thing that you do."* (Ceinwen, T1, pregnant, multiparous) *"I actually got sent this really lovely box by this lady who has set up a crowdfunding scheme for pregnant women and it comes with some nice little things in it. Some nice chocolate, nice teabags, perfume, little smellies and some nice, positive affirmations and things for women who are pregnant at the moment. It was just a really nice little pick-me-up, because I think it's quite hard to understand what pregnant women are going through at the moment. It is a weird time, so it was just really nice for someone to think about that and appreciate the fact that not all of us are finding it easy."* (Georgina, T1, pregnant, primigravida)
		COVID brought out the worst of humanity	*"Someone called me a degenerate for being out in the supermarket, pregnant with a two-year-old as well, and said that I was stupid for leaving the house and that I should be at home, and that I should definitely not bring a 'stupid spreader' child into the supermarket with me."* (Ethel, T1, pregnant, multiparous) *"I've seen in some Facebook groups 'You're selfish if you choose to formula-feed in the middle of this pandemic because you're choosing to not give your baby the best chance to fight coronavirus', and stuff like that. And people are quite militant with how they put it across. It's scary actually."* (Ethel, T1, pregnant, multiparous) *"I couldn't go and get food very easily, and then when I did try to go to the supermarket, it was in the panic buying period and everybody was really aggressive, and people were pushing me… It was just shocking that people would push a toddler and a very obviously pregnant woman to try and get things."* (Georgina, T1, pregnant, primigravida) *"I think at the beginning it was a bit scary because everyone was bulk buying, so you'd go to the shop and there would be no formula."* (Madeline, T1, pregnant, multiparous) *"I commented on it about my fear of not being able to find food because this was right at the beginning. And the lady who owned the pie shop made four pies and then loads of snack things and brought them to my house [laughs], which was really kind, and for free. …this has brought out the very best in some people and the very worst in others."* (Ethel, T1, pregnant, multiparous)
		Social distancing whiplash	*"No one really knows what they're doing to be honest with you…One minute they're saying that when you give birth, if this is still going on, your partner is allowed to be with you through the whole thing, and then they're saying it's just the active labour and then they have to leave. It's difficult, it's the unknown."* (Madeline, T1, pregnant, multiparous) *"I don't really trust what they [government] say anyway to be honest with you. I think everything has been muddled up and unclear. I'd probably go and find my own evidence about things"* (Georgina, T1, pregnant, primigravida) *"I was quite anxious as well because…at the beginning of it, it was 'Pregnant women are vulnerable and should shield' and then as it went on they became less vulnerable unless they had pre-existing conditions, so it was just the unknown."* (Ethel, T1, pregnant, multiparous) *"I had a baby three years ago and I nearly died with her. But because it was all normal, I got the care that I needed. But if that happened again, am I still going to get the care that I should get?"* (Madeline, T1, pregnant, (*continued on next page*)

Table 3 (*continued*)

Themes	Sub-themes	Quotations
		multiparous) *"…now they've said if the birth partner comes back negative they can stay on the postnatal ward as well which is something that wasn't allowed to happen before, so that's alleviated a bit of anxiety."* (Ethel, T1, pregnant, multiparous)

COVID-19 pandemic. Furthermore, many respondents were devastated by inhumane and aggressive interactions from the general public with regards to 'panic-buying' essential shopping and adherence with social distancing restrictions, which further intensified feelings of anxiety and disappointment regarding one's own antenatal period. Frequently changing and poorly communicated guidance regarding social distancing raised frustrations and resentment towards governmental handling of the pandemic.

Sub-theme 1: It's been a drag

Reflecting maternal accounts of healthcare support, dissatisfaction was expressed pertaining to the stripping back of community-level activities which would have otherwise enriched pregnant women's mental and physical wellbeing. The withdrawal of organised health and wellbeing services was a dear loss to interviewees. For others, however, the movement of support services on-line opened new opportunities for connection and self-care, highlighting the importance of choice and ensuring appropriate accessibility when accessing essential, community-based services. This was especially apparent for mothers who would have been unable to afford private, face-to-face classes. Feelings of loss and disappointment related to depleted informal and formal support progressed to feelings of anxiety. This manifested as projecting antenatal abandonment to one's anticipated postpartum needs. Here, concerns were raised pertaining to the loss of face-to-face breastfeeding support, and cynicism surrounding the utility of technology in providing practical guidance for physical complaints. Looking then to changes and obstructions to informal support - antenatal excitement about new motherhood was dampened by lost acts of kindness from loved ones. These mothers acknowledged the extraordinary barriers placed on individuals to carry out thoughtful gestures which would have been less onerous pre-pandemic, but were regardless deeply affected by missing celebrations of their pregnancy with family and friends. Whereas receiving an act of compassion from a member of the public acknowledged and validated maternal struggles; this recognition boosted psychological wellbeing for interviewees.

Sub-theme 2: COVID brought out the worst of humanity

Raising tensions among the public regarding social distancing uncertainties led to an unfortunate rise in physical and psychological aggression (Opanasenko et al., 2021). Embodied experiences of this aggression were regrettably common among interviewees. At T1, pregnant women were exposed to verbal abuse from the public due to their decision to take their children out in public. Receiving verbal abusive was not restricted to face-to-face interactions, as other women found themselves the targets of unsolicited, morally charged judgement of other mothers, online. In an extreme case, public inconsideration led to one woman being assaulted by a member of the public. More covertly, self-centred actions pertaining to panic buying left others deprived and helpless (O'Connell et al., 2021). Although public behaviour was not exclusively self-interested, even individuals who had received acts of kindness from others conceded that public responses to the pandemic were extreme and polarised.

Sub-theme 3: Social distancing whiplash

Women at T1 were exasperated and frustrated with inconsistent social distancing provisions, which left women feeling confused as to what to believe. This led to feelings of disillusionment with governmental reputability and trustworthiness regarding the handling of the pandemic. Ill-evidenced and changeable guidelines, which were not transparently communicated, built resentment and distress. This distress then further depleted emotional wellbeing and invalidated one's pregnancy. Such anxieties also extended to fears about what to expect from one's birth, within the context of deprioritised maternity care. While fluctuating and poorly communicated restrictions were met with criticism from interviewees, the decision to reinstate partner attendance during birth was beneficial to interviewee wellbeing.

Timepoint 2 results

Theme 1: Technology is a polarised tool

For some pregnant women the benefits of technology comprised: remaining socially connected, maintaining structure to one's day, and gaining information regarding their birth plan. For others, searching the internet for maternity-related information exposed them to misleading, false, and polarised parenting discourse. For those dissatisfied with hybrid delivery of support groups and antenatal appointments, exhaustion was expressed in relation to one's mounting *'screen time'*.

Sub-theme 1: Technology as a facilitator of connection and information

Mandated national lockdown restrictions led to a shift in healthcare provision to incorporate hybrid delivery. Technology was used to obtain essential, local information pertaining to their routine maternity care. The transition of antenatal classes on-line was well received by interviewees who otherwise would have been stripped of opportunities to connect with other local mothers-to-be. Parenting classes being moved on-line also added benefits of flexibility and comfort. Indeed, many interviewees focused on the positives of virtual classes when compared with pre-lockdown restrictions. On-line group provision also gave mothers structure to their days, breaking up relentless feelings of living in 'Groundhog Day'. Informally, acts of kindness from one's loved ones reinstated excitement about one's pregnancy. Evidently, focusing on the positives to be drawn from mandated social distancing restrictions enhanced emotional wellbeing.

Sub-theme 2: Technology is an inadequate alternative

While T2 interviewees appreciated virtual support and guidance above its complete absence, it was recognised that technology paled in comparison with face-to-face interactions, both for healthcare appointments and for socialising with other mothers. Interviewees noted the pitfalls of using technology to obtain information while routine healthcare remained restricted and identified barriers to socialising during virtual antenatal support groups when compared with the ability to mingle in face-to-face classes. Some mothers felt especially exhausted with mounting screen time as a result of social and healthcare professional meetings being moved online. Poor accessibility of parenting support services was determined as being particularly concerning. To the same avail, a pressing need for healthcare professionals to proactively signpost women to reputable sources to gain local and national information, between routine appointments, was believed to be imperative for ensuring equity of care. During periods of restricted and reconsolidated maternity care. Transparent communication was key for preventing the emergence of inequality depending on technological competence to sieve through mis and false information on-line. Voided classes which were patched by inappropriate, minimalistic informational resources contributed to intense feelings of distress experienced by T2 interviewees.

Theme 2: Clinically vulnerable, or not clinically vulnerable? That is the question

Clinical vulnerability refers to people who, *"have a weakened immune system due to a particular health condition or because [they] are on medication or treatment that suppresses [their] immune system"* (pg.1, UK Government, 2023). During initial social distancing restrictions in the UK (March 2020 – May 2020; UK Government and Public Health England, 2021) antenatal women were classed as clinically vulnerable, and advised to 'shield' so to protect themselves and their unborn babies from infection (RCOG & RCM, 2020). At T2 interviewees were notably frustrated by the government's poorly justified and communicated social distancing guidance, which was intensified by their prioritisation of economic-generating establishments over parental support services during the easing of non-essential services. Prolonged periods of isolation led to feelings of loneliness and entrapment for pregnant women. Furthermore, variations existed in the respect and sensitivity pregnant workers were greeted with from their employer in relation to return to work as social distancing restrictions eased. Working from home, too, caused conflicts between one's work and childcare responsibilities in the absence of essential informal support from one's family.

Sub-theme 1: Frustrated by ill-handled restrictions

At T2 growing frustrations were raised regarding the government's lack of accountability for conflicting and poorly evidenced guidance. This dissatisfaction with handling of social distancing restrictions was held despite recognitions of the unprecedented nature of the novel virus. Many women felt *'left in the dark'* regarding initial social distancing guidelines for pregnant mothers to 'shield' due to clinical vulnerabilities. Lack of acknowledgement for amended guidance and wrongdoings exacerbated feelings of injustice. Furthermore, easing of economic-generating non-essential services was perceived to be arbitrarily decided on when compared with 'high risk' maternity care, and served to exacerbate feelings that their pregnancy had been shadowed by the pandemic.

Sub-theme 2: Pregnancy behind bars

Participants at T2 struggled with extended periods of imposed isolation, often likening their experiences to feelings of entrapment and depersonalisation, reflected in stripped personal freedoms. Paralleling with T1, T2 interviewees felt their pregnancy had been devoid of social interaction and celebration, which negatively affected mental health.

Table 4
Timepoint 2 Quotations.

	Themes	Sub-themes	Quotations
Timepoint 2	Technology is a polarised tool	Technology as a facilitator of connection and information	*"I'm in a couple of them [Facebook groups] and one of them is quite a local group and so, that one was particularly helpful in finding out people's birth experiences from the local hospitals"* (Selina, T2, postnatal, multiparous) *"…when I did the hypnobirthing course, I was in like a WhatsApp group with the whole class which was really good"* (Francesca, T2, pregnant, primigravida) *"I remember my sister and my sister-in-law saying, "ugh they're always after work at 7 o'clock until 9 o'clock and you're absolutely knackered when you go, and some of the stuff is quite self-explanatory" …just got to be positive about it really and think at least we were able to do it within the comfort of our home."* (Xenia, T2, pregnant, primigravida) *"I signed up for an 8-week block [of online pregnancy yoga] and did classes twice a week, a Wednesday night and a Sunday night. And I really looked forward to that because it started to bring back the structure that I like in the week"* (Emma, T2, pregnant, multiparous) *"My sister and sister-in-law and my mum and mother-in-law did like a little baby shower for me, where the four of them came around but all my friends popped up on Zoom, so like they organized a virtual baby shower for me – which was really nice"* (Xenia, T2, pregnant, primigravida) *"I just felt so much more comfortable because I could work from home."* (Zanthia, T2, antenatal, primigravida)
		Technology is an inadequate alternative	*"Google has not been my friend. I've googled everything and I've read things that I didn't want to read, that made me feel worse."* (Xenia, T2, pregnant, primigravida) *"It was quite difficult to be motivated to do any video classes or whatever when I just really needed that social side of things actually… I think that really affected my mood."* (Selina, T2, postnatal, multiparous) *"I was so exhausted by the end of the day and having so many face-to-face calls on my phone that I didn't – the last thing I wanted to do was to be on the screen anymore."* (Chloe, T2, pregnant, multiparous) *"I think that my care provider could have provided kind of a couple of antenatal classes online…I have accessed it elsewhere but obviously probably not always people are able to do that."* (Lilian, T2, pregnant, primigravida) *"…they [NHS antenatal classes] just got cancelled full stop, and there was no replacement option… they [clinicians] didn't create a video or anything as an alternative, they just had a set of slides…they just had a lot of terrifying pictures and things that weren't explained, so it was really unhelpful and quite upsetting, I felt quite angry about it."* (Francesca, T2, pregnant, primigravida)
	Clinically vulnerable, or not clinically vulnerable? That is the question	Frustrated by ill-handled restrictions	*"I'd just like the government to take accountability really for how they've handled the situation, because I don't think it's been handled well at all, and I don't think we would have been in this situation if they had reacted sooner."* (Xenia, T2, pregnant, primigravida) *"…no one knew… I don't know… I think it would have been nice to have had all of it sooner, more prompt response from the government earlier."* (Francesca, T2, pregnant, primigravida) *"…when they [government] started talking about easing lockdown they should have given advice to clinically vulnerable - pregnant women, over 70's. That group were never discussed again after the week before lockdown …"* (Emma, T2, pregnant, multiparous) *"I got really annoyed when they started lifting lockdown restrictions, opening pubs and beer gardens and they never improved the guidance for pregnant women nor did they even say that partners could come to antenatal appointments…"* (Emma, T2, pregnant, multiparous)
		Pregnancy behind bars	*"I hated it, it was horrible, it certainly felt like a prison sentence."* (Emma, T2, pregnant, multiparous)

(*continued on next page*)

Table 4 (*continued*)

Themes	Sub-themes	Quotations
	Work-home life blurring	*"…especially when you're quite isolated, it all felt a bit like an echo chamber and everything [with my mental wellbeing] just got worse."* (Joely, T2, postnatal, multiparous) *"I think it just made it more of a solitary experience, whereas when the first one you kind of you see people and everyone is excited to see that you're pregnant… This time it's kind of just been me preparing for birth by myself, potentially giving birth without my partner and so yeah, it's just been a bit more lonely."* (Chloe, T2, pregnant, multiparous) *"I've had a lot of positives during coronavirus, so spending time with my partner and we've had a lot of fun together and a lot of laughter and stuff"* (Francine, T2, postnatal, primiparous) *"I've got more time to bond with my bump because I'm in the house a lot more, so that side of it is nice."* ((Zanthia, T2, antenatal, primigravida) *"…the threat of it all and not knowing what was going to happen being so vulnerable. So, when they actually said oh were in lockdown now everyone stay at home I felt safer, because I was in control of my bubble."* (Emma, T2, pregnant, multiparous) *"…there was a debate at school whether I could not go in… they were saying that all stuff would result in a disciplinary action, if I can turn up, so that was all really stressful and upsetting."* (Francesca, T2, pregnant, primigravida) *"I feel I'm more protected so my work been amazing, and they've said I don't have to go back into the office now, I can do all my work from home which is absolutely brilliant."* (Zanthia, T2, antenatal, primigravida) *"I'm used to either giving my work all of my attention or my son all of my attention, but I kind of was divided between both and I couldn't focus on anything."* (Chloe, T2, pregnant, multiparous) *"I needed my mum, to be honest, I needed the practical support of my mum I needed someone to take my daughter for a walk sometimes so I could have a lie down, so that physical support … I really missed that."* (Emma, T2, pregnant, multiparous) *"When I'm in work I work very hard, like I'm always overachieving at work whereas when I'm at home I'm doing the bare minimum. Yeah, so there is a sense of guilt in that."* (Xenia, T2, pregnant, primigravida) *"I felt really removed from the team…sometimes I felt quite useless because teachers without children were able to do all this wonderful work and I obviously just couldn't put the hours in, and give it enough attention to see things through so I just felt like I'm not very good at my job."* (Emma, T2, pregnant, multiparous) *"…when everyone was on FaceTime all the time, and I felt like I wasn't really doing loads of that because I was just so frazzled and having loads of calls with work during the day I didn't really want to."* (Chloe, T2, pregnant, multiparous)

Psychologically, the inability to socialise during this lifecourse transition made one's experience of pregnancy anticlimactic, embodying a sense of loss. On the other hand, interviewees reported on the benefits of the pandemic, which included developing a stronger bond with one's partner and with one's baby. In less frequent cases, interviewees were thankful for social distancing restrictions. For these individuals, mandated restrictions were a welcome alleviation from anxieties about contracting the novel virus.

Sub-theme 3: Work-home life blurring

As work life resumed to a 'new normal', quality of support and respect received from one's employer varied drastically on return to work, which significantly impacted on emotional wellbeing. Interviewees who were able to work from home, however, struggled to balance competing responsibilities of their work role while also fulfilling childcare responsibilities. In these moments, participants reflected on the desire for support from one's wider social network, serving as a reminder for one's atypical, isolated experience of pregnancy. This again intensified feelings of loss related to the pregnancy experience which interviewees would have liked to have had, compared with what they were actually tasked with enduring. The increasing difficulty to balanced workplace, homelife, and childcare roles resulted in parental guilt at T2. Due to blurred home and work-life roles, many interviewees felt they were failing in all domains of their competing commitments. T2 women found themselves withdrawing socially, feeling isolated in their work, and feeling exhausted with unsustainably high responsibilities.

Discussion

The current study used a recurrent, cross-sectional, thematic analysis to explore pregnant women's experiences of social and healthcare professional support during the initial lockdown of the COVID-19 pandemic and after initial lockdown restrictions were eased in the UK.

Social experiences

During initial lockdown restrictions in the UK, support persons were routinely excluded from maternity care, unless the woman was in established labour. Interviewees at T1 expressed heightened levels of birth anxiety which were ascribed to the exclusion of partners from antenatal appointments and from maternity suites. These findings corroborate with a now well-established body of literature which has linked the exclusion of support persons with heightened maternal distress (Atmuri et al., 2022; Crowther et al., 2022; Jackson et al., 2021, 2022; Montgomery et al., 2023; Panda et al., 2021; Silverio, De Backer, et al., 2021). Active paternal and partner involvement during pregnancy has positive outcomes for the emotional wellbeing of the mother and family unit (Forbes et al., 2018), and for father-infant attachment (Walsh et al., 2014). Exclusion from this transitional period subscribed fathers to feelings of isolation, grief, and disconnect from pregnancy (Andrews et al., 2022; Crowther et al., 2022).

At both timepoints pregnant women felt their mental wellbeing had suffered due to implemented social distancing restrictions, corresponding with reports from other qualitative literature (Huynh et al., 2023; Riley et al., 2021). At T1, loss of antenatal classes coupled with perceptions that their family and friends were distracted by pandemic-related concerns resulted in these interviewees feeling as though their pregnancy had been overshadowed (Bolgeo et al., 2022; Bradfield et al., 2021; Zheng et al., 2022). These adverse effects on mood were reported to be more pronounced at T2, and findings marry postpartum accounts reported elsewhere (Jackson et al., 2021, 2022). Current findings reinforce calls to action for a pro-active campaign to validate, signpost, and support antenatal women (Jackson et al., 2023), and to improve quality and accessibility of perinatal mental health

services during times of national strain (Bridle et al., 2022; Jackson et al., 2024; Pilav et al., 2022). Regarding the loss of antenatal classes and their consequential impacts on maternal mental health, recommendations are made for policy makers to reframe social wellbeing as being of equal importance to economic generating services during the re-opening of *'non-essential'* services, and to campaign for kindness (Ford et al., 2022; Walsh and Foster, 2021).

As social distancing restrictions eased at T2, quality of employer co-operation when dealing with concerns regarding the return-to-work was varied and contributed towards elevated distress when it was perceived to be poor. Inequalities existed during the pandemic pertaining to the working lives of new parents: working mothers faced more significant disruption to working hours, due to extraordinary childcare responsibilities, than did males (O'Sullivan, 2020). Struggling to manage these conflicting caregiver and employee identities resulted in feelings of guilt, inadequacy, stress, and parenting overwhelm (Hertz et al., 2020). Pre-pandemic, it was an unfortunate reality that new mothers commonly faced workplace discrimination (Equality and Human Rights Commission, 2018) and experienced a 'motherhood-tax' or 'baby--penalty' in terms of career development and job permanency (Mason et al., 2013). During the pandemic, mothers were more likely to leave the workforce and to become unemployed than fathers (Landivar et al., 2020). Although the Family and Medical Leave Act provides job protection for employees to care for family or their own health (UK Government, n.d.), vague parameters around frequency and duration of protected leave opens legislation to interpretation and to malpractice.

Current findings highlight the foregrounding of workplace discrimination and inequality by national lockdown restrictions, globally (Cummins and Brannon, 2022; Moo-Reci and Risman, 2021; Zamarro and Prados, 2021). The following recommendations are made with an aim to improve parenting and workplace equity: to propose a new, national compassionate leave policy to elevate the social status of caregiving (Miller, 2020); to better enforce family-friendly workplace protection e.g., through implementing harsher fines for malpractice; and to reflect on 'what works' e.g., offering hybrid working where possible, in recognition of caregiving responsibilities (Okuyan and Begen, 2021), and encouraging compassionate and cooperative conversations about returning to work between employers and employees (Holtzman and Glass, 1999).

Experiences with healthcare professional support

At both timepoints pregnant women felt abandoned and inadequately supported by scaled back maternity care. These findings are unanimously supported by pre-existing pandemic literature which has identified widespread dissatisfaction and distress caused by restructured maternity care in light of the COVID-19 pandemic (Iacobucci, 2020; Keating et al., 2022; Montgomery et al., 2023; Saleh et al., 2023; Silverio, De Backer, et al., 2021). During initial lockdown restrictions many healthcare practitioners were redeployed to address pandemic efforts and routine care was consolidated and/or held virtually when possible (De Backer et al., 2022; Silverio, De Backer, et al., 2022; Silverio et al., 2023). At timepoint T1 technology was described as disrupting the rapport between the mother and healthcare practitioner which inhibited ability to disclose emotional concerns, which has also been reported in postpartum accounts (Jackson et al., 2021, 2022). Pregnant women at T1 were concerned about potential breastfeeding challenges, and the insufficiency of technology in providing adequate observational, hands-on support. This mirrors work with postnatal women (Jackson et al., 2021), where breastfeeding experiences were said to be polarised: those with sufficient confidence and knowledge thrived postpartum, while women at greatest need of breastfeeding support were disadvantaged most by national lockdown restrictions.

T2 interviewees expressed concerns about how scaled-back maternity care had increased their exposure to unregulated, emotionally charged information on-line, in efforts to self-seek guidance. Current findings further corroborate postpartum recommendations made for healthcare practitioners to signpost mothers to reputable, up-to-date sources of maternity guidance between routine appointments and to fact-check misconceptions and myths (Combellick et al., 2023; Jackson et al., 2021, 2022). Work with postpartum women at the same timepoints during the pandemic revealed inequalities in visibility of community services (Jackson et al., 2022) – in light of which recommendations are also made for healthcare staff to signpost to local sources of support e.g., parenting groups, in aim to provide better quality universal care standards. Where possible, face-to-face maternity care should be reinstated in recognition of the importance of physical closeness and dedicated time for rapport building and disclosure of emotional distress perinatally (Combellick et al., 2023; Jackson et al., 2022; Silverio, De Backer, et al., 2021; Sweet et al., 2021; Pilav et al., 2022; Wilson et al., 2021).

Strengths, limitations, and future directions

Nuances in experiences of social and healthcare professional support during different phases of social distancing experiences were able to be captured by the recurrent, cross-sectional thematic analysis approach adopted. Findings from the current study bolster pre-existing perinatal reports which have identified that the loss of social and healthcare professional support, due to mandated social distancing restrictions, have had adverse and longstanding psychosocial impacts on new mothers. Current findings pose novel considerations for policy and practice to provide universal standards of quality maternity care during health crises. The voices of women from diverse counties were captured due to virtual modes of recruitment (i.e., via telephone or video conferencing software).

However, there are some limitations which must be taken into consideration. Firstly, recruitment fatigue was experienced for perinatal women generally during the pandemic and T2 recruitment and scheduling proved challenging, which resulted in the inclusion of four women who had to be interviewed in the early postpartum period. Although efforts were made to anticipate the effects of this (i.e., participants were asked during the interview to only reflect on their experience of pregnancy) the research team cannot concretely assert the extent to which one's early postpartum experiences may have confounded their construction and recollection of their antenatal period. Unexpected difficulties reaching participants to arrange a time and date for interviewing resulted in interviewing timepoints falling inconsistently with implemented lockdown restrictions under investigation. Inappropriate timing of interviews is likely to have resulted in aspects of recall bias and warrants caution to be taken from drawn conclusions.

The recruited sample was representative in that the sample was well balanced in terms of parity, which is known to play a role in psychological adjustment to new motherhood (Dol et al., 2021). Additionally, most interviewees coincided with the average age of first birth in the UK, currently sitting at 30.7 for females (Office of National Statistics, 2022). Other participant qualities, however, limited transferability of findings. For example, the final sample consisted mainly of highly educated women. Also problematic was the fact that Ethnicity, was not routinely recorded, as we know Black, Asian, and other Minority Ethnic women have poorer maternity care experiences and perinatal outcomes (MacLellan et al., 2022).

We recognise the criticisms of virtual interviewing such as inhibiting rapport between the participant and interviewer, being more distractible than face-to-face interviewing; and for technological disruption disturbing interview flow (Novick, 2008; Oliffe et al., 2021; Saavedra, 2022); but the circumstances were such that we were only able to use this method, which has also been seen to be increasingly viable, flexible, and cost-effective mode of delivery since the COVID-19 pandemic (Archibald et al., 2019; Chandratre and Soman, 2020).

Conclusion

Emotional distress for pregnant women at both timepoints was elevated, which was attributed to the isolating effects of implemented social distancing guidelines. For mothers at both timepoints the exclusion of partners from routine healthcare was a source of avoidable distress and uncertainty. Scaled-back maternity care was perceived dissatisfactory by pregnant women at both timepoints, and the use of technology to bridge lost face-to-face support was an insufficient alternative for meeting antenatal needs. In recognition of study findings, recommendations are made: to protect maternal choice (to have a support person present in all aspects of routine perinatal care, to *'bubble'* with a support household, to exercise flexibility regarding hybrid working conditions); to establish a pro-active campaign (which validates, signposts, and supports antenatal women with emotional distress; and which encourages sensitivity and kindness across the public); to prioritise and protect provision of parental support services in the community in the re-opening of *'non-essential'* services; for healthcare practitioners to signpost mothers to reputable, up-to-date sources of maternity guidance between routine appointments and to fact-check misconceptions and myths; to prioritise the option for face-to-face maternity care where safe and legal to do so; and for policy makers to communicate with transparency and accountability with regards to changing policy and its effects on maternity care. We are cognisant the pandemic was officially declassified some time ago (5 May 2023), but we believe our findings contribute to ongoing work to rebuild and recover maternity care systems in the post-pandemic era.

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Ethics approval and consent to participate

Ethical approvals were sought and granted from the University of Liverpool Research Ethics Committee [ref: IPHS/7630]. Verbal, audio recorded consent was also taken before the commencement of each interview to ensure the participant was still happy to participate in the current study. Participants were made aware of their right to withdraw and were fully debriefed after interviewing.

Consent for publication

All participants consented to their data being published as part of this study's analysis.

Data availability

The datasets used and/or analysed during the current study are part of a common dataset from The PRaM Study. The datasets are not publicly available due to the sensitive nature of the interviews however they are available upon reasonable request from the corresponding author.

CRediT authorship contribution statement

Leanne Jackson: Writing – original draft, Software, Methodology, Investigation, Formal analysis, Data curation. **Siân M. Davies:** Writing – review & editing, Methodology. **Monic Gaspar:** Writing – review & editing, Methodology, Formal analysis. **Anastasija Podkujko:** Writing – review & editing, Methodology, Formal analysis. **Joanne A. Harrold:** Writing – review & editing, Resources, Conceptualization. **Leonardo DE Pascalis:** Conceptualization, Writing – review & editing. **Victoria Fallon:** Conceptualization, Writing – review & editing, Validation, Resources, Project administration. **Laura K. Soulsby:** Writing – original draft, Supervision, Software. **Sergio A. Silverio:** Writing – original draft, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Conceptualization.

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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