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Becoming a mother in the ‘new’ social world in Australia during the first wave of the COVID-19 pandemic

Linda Sweet a,b,c, Zoe Bradfield c,d, Vidanka Vasilevski a,b, Karen Wynter a,b, Yvonne Hauck c,d, Lesley Kuliukas c, Caroline S.E. Homer c, Rebecca A. Szabo f,g, Alyce N. Wilson e

a School of Nursing and Midwifery, Deakin University, Victoria, Australia
b Centre for Quality and Patient Safety Research, Western Health Partnership, Victoria, Australia
c School of Nursing, Midwifery and Paramedicine, Curtin University, Western Australia, Australia
d Department of Nursing, Midwifery Education and Research, King Edward Memorial Hospital, Western Australia, Australia
e Maternal, Child and Adolescents Health Program, Burnet Institute, Melbourne, Australia
f Gandel Simulation Service, Royal Women’s Hospital in partnership with The University of Melbourne, Melbourne, Victoria, Australia
g Melbourne Medical School, The University of Melbourne, Melbourne, Australia

A R T I C L E  I N F O

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A B S T R A C T

Background: Substantial public health measures occurred in Australian society during the COVID-19 pandemic to reduce the risk of community transmission. Little was known about the impact of these changes on childbearing women.

Aim: To describe childbearing women’s experiences of becoming a mother during the COVID-19 pandemic in Australia.

Methods: A qualitative exploratory design using semi-structured interviews was used. Women were recruited through social media and self-nominated to participate in an interview. Maximum variation sampling was used. A total of 27 interviews were conducted with women across Australia. Data were analysed thematically.

Findings: The thematic analysis resulted in four primary themes and ten sub-themes. The themes were ‘going it alone’ – having a baby was an isolating experience’, ‘receiving maternity care alone’, ‘dealing with government restrictions’, and ‘desiring social support’, ‘advocating for self or others’ ‘seeking reliable information’, ‘valuing peersupport’, and ‘having to be resourceful’, ‘finding a way through’ ‘a changed experience for all’, ‘managing stress and anxiety’, ‘requiring constant adjustments’, and ‘managing fear mongering’, and ‘keeping safe’.

Conclusion: Becoming a mother during the COVID-19 pandemic in Australia was a profound experience for the women. Following the public health initiatives which resulted in physical distancing restrictions, isolation, and the need to provide and receive social and peer support were common experiences. Whilst public health initiatives are implemented to keep people safe, the social and emotional toll on childbearing women should be considered by healthcare professionals. Childbearing women need to be safe but also require support and reassurance.

Introduction

Becoming a mother is a time of major adaptation for a woman and her family. The transition to parenthood is known to be a period of increased vulnerability for women. In recognition of this, public and primary health care strategies are established in Australia to support women, their families, and the broader community. National guidelines for the care of women in the perinatal period are based on evidence-informed approaches, and include regular antenatal care by midwives or doctors that provides physical as well as psychosocial assessment and screening for risk factors to enable early diagnosis, intervention, and support (Department of Health, 2020).

During the COVID-19 pandemic, jurisdictions in Australia were responsible for implementing strategies to reduce the risk of viral transmission. Non-essential businesses and activities were closed or restricted, numbers at non-essential gatherings were limited to no more than one person per 4m², 1.5m physical distancing guidelines were implemented, and recommendations were to avoid non-essential travel. Australians were advised to expect these measures to be in place for at least 6 months (Prime Minister of Australia, 22 March 2020). Over time, some states and territories had differing restrictions, which changed fre-
quently based on local case numbers. For some people these included a night-time curfew, a travel limit of 5 kilometres from home, remote learning for students, limited visiting between households, and requirement for face masks to be worn outside the home. These measures resulted in significant changes in social interactions between people and impacted on the provision and delivery of health care.

The physical distancing requirements meant that most healthcare services moved quickly from usual face-to-face service delivery to telehealth (Department of Health, 2020a). Access to acute care and birthing services was available with restricted access for support people. The formal postnatal health services, usually available to support women and their families were reduced, or in some cases, not available (Australian College of Midwives, 2020).

A recent systematic review confirmed that during periods of previous pandemics, childbearing women experienced negative psychological consequences (Shorey and Chan, 2020). Similarly, data from pregnant women in the United Kingdom, the United States, and Australia demonstrated that women expressed a lack of support from health services during COVID-19 and reported feelings of isolation (Australian College of Midwives, 2020; Karavadra et al., 2020; Moyer et al., 2020). While more evidence regarding pregnant women’s experiences with healthcare is emerging, little is known about how women have navigated pregnancy and motherhood more broadly, considering the ongoing public health measures to limit community transmission of COVID-19 in Australia.

The aim of this study was to describe childbearing women’s experiences of becoming a mother during the first wave of the COVID-19 pandemic; March to June 2020. This is part of a wider study exploring the experiences of key maternity stakeholders in providing and/or receiving care during COVID-19.

Methods

Study design

A two-phased cross sectional research design (Kesmodel, 2018) was used to collect data at the end of the first wave of the COVID-19 pandemic in Australia, June 2020. Phase one was a national online survey reported elsewhere (Bradfield et al., 2020); phase two was a qualitative descriptive study (Thorne, 2016). This paper reports a secondary analysis of the phase two data, focusing on women’s experiences of becoming a mother. Human research ethics approval was gained from a university committee (Curtin University HRE2020-0210).

Recruitment

Social media was used for recruitment of participants (Facebook, Twitter, and Instagram), using both public and professional social media networks and accounts. Two professional colleges, the Australian College of Midwives (ACM) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), advertised the study. Women who completed the online survey in phase one were offered the opportunity to provide contact details if interested in participating in an interview in phase two. In order to obtain a diverse and representative sample of women maximum, variation sampling (Patton, 2015) was applied. This approached selection of women of different ethnic backgrounds, living in varied geographical locations across Australia, primiparous and multiparous women, and women seeking care from a wide variety of models of care. Selected participants were emailed the participant information and consent form, with an offer to make a time to be interviewed.

Data collection and management

Semi-structured interviews were conducted using an interview guide (see Appendix 1). The participants nominated Zoom or telephone and interviews were audio-recorded. Participants’ verbal consent was recorded prior to commencing the interview. All audio recordings were transcribed verbatim by a professional transcription company, and transcripts reviewed for accuracy and de-identified by a research assistant.

Data analysis

Data were subjected to a six step thematic analysis: i) familiarisation with the data, ii) generation of initial codes, iii) identification of themes, iv) reviewing themes, v) definition and naming of themes, vi) producing the report (Braun and Clarke, 2012). NVivo (QSR International Pty Ltd 2020) was used to manage the analysis. A research assistant undertook the initial coding, after which two experienced researchers (LS & AW) reviewed all data and codes, refining and categorizing independently and collectively, until consensus on the final themes was achieved, and ‘information power’ recognised (Malterud et al., 2016).

Results

In the phase one survey, 953 women indicated willingness to be interviewed. Following the maximum variation sampling 30 women were invited, and 27 interviews performed. The interviews ranged from 30 – 60 minutes in duration. At the time of interview, 48% were 31-35 years of age, 59% lived in a major city, 93% lived with a spouse, and 67% had given birth since the onset of the pandemic. The demographic characteristics of participants are shown in Table 1. Themes and related subthemes are supported by verbatim quotes from numbered interview participants (P1-27) indicated by italics. For brevity, removal of non-relevant segments is indicated by an ellipsis and square brackets indicate words added by the authors for clarity. The thematic analysis resulted in three primary themes and ten sub-themes (Table 2).

‘Going it alone’ – having a baby was an isolating experience

All participants described having an isolating maternity experience, encapsulated by one woman, “I sort of feel like I am going it alone” (P22). This sense of ‘going it alone’ was evidenced through the sub-themes of ‘attending care alone’, ‘experiencing government restrictions’, and ‘desiring social support’.

Receiving maternity care alone

Rapid and substantial changes to health care provision resulted in women attending their maternity care appointments on their own. One woman said, “my partner’s not able to come with me which is a bit crap [bad]” (P26). Attending on their own created the sense of isolation as their partners did not have the shared experience, as explained, “it’s been very impersonal, being pregnant for the first time, I find myself not having anyone to talk to and it does feel very alone. I’ve got my husband but he’s not going through what I’m going through” (P25). Attending alone was particularly concerning for women who were experiencing complications of pregnancy, “it was daunting, I had to go to the hospital quite a lot at the last stage for monitoring and he [partner] wasn’t allowed to be there for any of that, so that was pretty stressful, I just felt quite alone, … I’m sitting in this hospital waiting to make sure that my baby’s okay, and I have nobody to support me” (P24). The restrictions on visitors in homes caused logistical challenges for some participants who needed support with care for younger children. One woman described how she feared she would be alone in labour, as “because with all these restrictions … my husband can’t come for labour because someone has to look after our son” (P20).

Some participants described finding ways to share their experience, particularly with partners, to avoid being alone through their maternity journey. Participant 8 said, “luckily for me I am a health worker … and was able to get my husband in for that first scan just for 5 minutes at the end. But that was pretty stressful, and a bit of an ordeal, and probably took away from the moment of being first-time parents”.

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During labour and following birth most participants were limited to just one support person/visitor in the hospital, again creating the sense of ‘doing it alone’ without extended family. A woman said, “I couldn’t have my sister there who was meant to be my second support person, … it was more just that I’d be alone, that was my biggest concern” (P26).

**Dealing with government restrictions**

The government-imposed social restrictions impacted on participants’ experience in the home, with reduced visitors and loss of support further exacerbating the sense of aloneness. One woman said, “It was really rough for the first few weeks – my parents live a few hours away so they didn’t meet him until he was 6 weeks old, and the plan had originally been that mum would come up and support us, obviously that didn’t happen” (P21). Similarly, “no one saw him in that whole 6 weeks, which is a little bit stressful for a first time mum” (P24), and “the restrictions meant that we’ve lost some supports that we would’ve had otherwise” (P14).

There were some positive outcomes of the restrictions, as this person explained, “it was good to have COVID as an excuse not to have people over … because of the restrictions it’s meant that I haven’t had to politely decline people coming over, and everyone seeing the baby and wanting to cuddle her and all of that, I didn’t have to deal with any of that” (P6). Another participant said, “at the same time it was also really nice to have a reason not to leave the house and to be able to say we’re just going to stay home and have this quiet time as a family” (P21). Similarly, “we just stayed in our little bubble and we all slept when he [baby] slept, and we watched movies and cuddled … and –we probably wouldn’t have done all that … the pandemic made that part a lot nicer” (P9).

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**Table 1**

Demographic details of participants (n=27).

| Characteristic                      | Values                     | Number |
|-------------------------------------|----------------------------|--------|
| Age in years                        | 18 - 25                    | 1      |
|                                     | 26 - 30                    | 4      |
|                                     | 31 - 35                    | 13     |
|                                     | 36 - 40                    | 9      |
| State or Territory of residence     | Queensland                 | 5      |
|                                     | New South Wales            | 2      |
|                                     | Australian Capital Territory| 2      |
|                                     | Victoria                   | 8      |
|                                     | Tasmania                   | 3      |
|                                     | South Australia            | 2      |
|                                     | Western Australia          | 4      |
|                                     | Northern Territory         | 0      |
| Region by postcode                  | Very Remote                | 2      |
|                                     | Remote                     | 2      |
|                                     | Outer Regional             | 2      |
|                                     | Inner Regional             | 5      |
|                                     | Major City                 | 16     |
| Ethnicity                           | Aboriginal                 | 2      |
|                                     | Torres Strait Islander     | 1      |
|                                     | Neither Aboriginal or Torres Strait Islander | 24  |
| Country of Birth                    | Australia                  | 21     |
|                                     | Other (Belarus, Canada, Malaysia, New Zealand, Sweden, United Kingdom) | 6    |
| Living situation                    | Live with support person   | 25     |
|                                     | Live alone                 | 2      |
| Parity                              | 0                          | 3      |
|                                     | 1                          | 13     |
|                                     | 2                          | 8      |
|                                     | 3                          | 2      |
|                                     | 4 or more                  | 1      |
| Pregnancy status at time of interview | Was currently pregnant    | 9      |
|                                     | Had given birth since March 2020 | 18 |
| Place of birth (used or planned in this pregnancy) | Public Hospital | 20    |
|                                     | Private Hospital           | 5      |
|                                     | Birth Centre               | 1      |
|                                     | Other                      | 1      |
| Childbirth education classes        | No                         | 22     |
|                                     | Yes                        | 5      |
| COVID-19 tested                     | Never tested               | 23     |
|                                     | Tested once (all negative) | 4      |

**Table 2**

Themes and sub-themes.

| Primary theme                          | Sub-theme                                      |
|----------------------------------------|-----------------------------------------------|
| ‘Going it alone’ – having a baby as an isolating experience | Attending care alone | Dealing with government restrictions | Desiring social support |
|                                        | Advocating for self or others                 | Finding reliable information | Valuing peer support | Having to be resourceful |
|                                        | Finding a way through                          | A changed experience for all | Managing stress and anxiety | Requiring constant adjustments | Managing fear mongering |
|                                        | Keeping safe                                   |                            |                           |                           |                           |
Desiring more for social support

Participants spoke of how the social restrictions in the home and in health care settings reduced the social support received from family and friends and how this negatively impacted their experience. One woman explained, “I was planning to have some support from my family ... when the baby was born but my parents couldn’t make it from Canada ... and my partner’s parents were planning to come down too and they’re only in Queensland” (P27). Another said, “... my social life with friends, it was so important for me, their help and support, because like we don’t have family here and I have only friends, but I can’t see them” (P20).

The desired support was described in many ways. This person said, “the scans my partner couldn’t come with me ... again I just felt alone like I couldn’t share that with anyone ... just to come to an appointment with me would have been good support, ... it just does feel lonely” (P25). Another participant spoke of how important it was to have her partner with her in labour, she said “I really needed his support and I’m glad that he was able to come in. If he wasn’t at that time, I think we’d have been a much more traumatic experience not having him there” (P9).

The constant changing social restrictions resulted in changed support situations. One participant explained, “We brought my mum up here ... and then they closed the regional borders, ... so we had to send her home after three days, so I didn’t have that support that we had planned” (P15). Similarly, another spoke of using technology to reach supports and overcome loneliness, she said, “Well I guess because normally you’d go out and have coffee and just meet with other mums ... there’s been a lot of just staying at home, ... so it is quite lonely sometimes, but luckily there’s Zoom and Skype and Facetime” (P27).

Advocating for self or others

The sense of ‘going it alone’ found women feeling the need to advocate for themselves or others. Some participants found this easier to do than others. This sense of advocating for self or others was evidenced through the sub-themes of ‘finding reliable information’, ‘valuing peer support’, and ‘having to be resourceful’.

Finding reliable information

All participants spoke of the many resources they accessed to try to find reliable information about the COVID-19 virus, protecting themselves and their families, accessing health care services, keeping up to date with the government restrictions, and finding sources of support. The mainstream media was mentioned, for example, “just really on the news, which maybe isn’t the best source but just looking at what was coming up on the news” (P4). Others relied on government updates, saying “watching the live updates from the premier ... I followed the government’s Facebook website updates daily” (P6). Despite the available information, participants spoke of the uncertainty of the impact COVID-19 may have on them and their developing baby. This participant explained, “Because there wasn’t a lot of information around whether COVID was more dangerous for people that were pregnant or not. There was contradicting statements saying yes it can get to your baby through the womb and no it can’t, and so there was not much information that was 100% certain” (P26). This uncertainty left some women seeking more reliable information.

Some participants sought information from professional websites. For example, “I tend to sort of self-research a lot and I’d read the WHO [World Health Organization] guidelines” (P6). Another participant used a medical college website for information,she said, “the college of obstetrics and gynaecology, I’ve kept sort of up to date with their guidelines” (P8). Similarly, “I looked at the academic analysis that had been done on these six cases in Wuhan and I looked at things like [RANZCOG]” (P10). Some participants were told about RANZCOGs website by their doctor. This participant said, “my obstetrician was really good and said if you want more information, we’ve been accessing RANZCOG, and she said have a look there, they’ve got all the up to date stuff for pregnant people on there” (P11).

Many participants accessed information on social media, most commonly Facebook. For example, saying, “the information was very rapidly changing, and I was obviously keeping up to date on Facebook and that seemed like everyone was sharing different updates” (P26). Some groups were supported by health professionals. Another participant said, “there was a Facebook group that I was on that did a live interview with an obstetric professor answering questions about COVID which was really helpful” (P10). Similarly, “I think my obstetrician –she has like a social media page, she would publish [from] the college of obstetricians, she would post their latest guidance, because she has lots of anxious people” (P4). Some participants were sceptical of the accuracy of social media information and its impact on their wellbeing, as explained here, “because you just can’t trust them – like you’ve got to decipher through what’s true and what’s not ... Is that actually having a positive influence on me, and my mental and physical health, or not? And if it’s a no well why am I engaging in this?” (P13).

Whilst most participants spoke of seeking information about the pandemic and its possible impact, some participants spoke of more general information needs about pregnancy and birth, as they felt these were not adequately covered in their telehealth appointments. This participant said, “I feel like I’ve needed to ask for more information, around ... the early signs of labour and all that sort of stuff, just because I am a first-time mum and I don’t know what to expect” (P26).

Valuing peer support

With the absence of tangible support from family and friends, participants spoke of actively engaging in peer support with other mothers, both virtually and using social media. One participant explained, “so there were a few groups that popped up [on Facebook] with women just trying to support each other during that time” (P14). Women’s support needs were both practical/instrumental and emotional, and this raised concern for some. For example, “there was even some [other women] volunteering to look after people’s children when they were meant to have ultrasounds, people they’d never met, and they were like ‘I’ve got no one to watch my kids and I can’t take them to the ultrasound because of COVID’, and people were like ‘well where do live, I can watch your kids while you go’. It’s like okay you’re going to leave your kids with someone you’ve just met on a Facebook group because you’re that desperate” (P14). The social media groups were a way to connect with peers as explained here, “just this morning I caught up with my local mothers’ group – so a lot of mums are using Facebook to arrange postcode mums’ groups” (P18).

Multiparous women shared a common concern for, and willingness to support women having their first baby. Given the constant changes and poor communication in the health system, the multiparous women expressed concern for first-time mothers. As explained, “I think if I had been a first-time mum it would have been a lot harder – this time I knew what I needed and where to get that from, ... I think definitely not knowing what services were around – how to access them and how they were being delivered differently that would have been a huge barrier” (P1). Another said, “I joined that group [on Facebook] and then found that me and other mums that had other babies were having to advise these first time mums, ... ‘hey that’s not cool’, like ‘you need to call up the clinic and go get assessed if that’s happening ‘... don’t let them brush you off’” (P14).

Having to be resourceful

Many participants spoke of advocating for themselves to achieve the care they desired and/or needed given the constant changes occurring in the health system. This participant said, “I felt like I always had to be on top of everything, and if I wasn’t going to be on top of it then things were going to get missed. So, I constantly felt like I had to advocate for me and the baby to make sure that things didn’t go awry ... if it’d been my first, I could’ve got lost in the system quite easily” (P14). Similarly, “I had to push quite hard to get what was going to work for us and just even to have it seems common sense to me, to have support in place, but apparently that’s optional or not a necessity to them” (P15).
Descriptions of women’s resourcefulness came mostly in the form of seeking clarification, following up test results, or gaining additional appointments. One woman, a farmer living in a rural area, went to the extremes to prepare for her birth. She said, “we were looking at the numbers and what’s happening in other countries around the world, and we just weren’t sure that there was going to be a hospital to go to … So, in preparation … we bought our own IV fluids and cannulas and respiratory equipment, so that if the baby wasn’t breathing then we could do something about it” (P5). Over time, this woman found a suitable birthplace with a midwife, but still had to arrange childcare for her toddler when she went into labour. She said, “I ended up finding some old friends that were living in [town] and they came around to the AirBnB and slept the night” (P5). Having previous experience of pregnancy and childbirth was helpful to know what care would be required.

Finding a way through

The constant changes to the social situation at home, in the workplace, and in health services left women having to make constant adjustments to their maternity experience to accommodate the restrictions, whilst managing their own anxiety and those of others around them. This sense of ‘finding a way through’ was evidenced through the sub-themes of ‘a changed experience for all’, ‘managing stress and anxiety’, ‘requiring constant adjustment’, and ‘managing fear mongering’.

A changed experience for all

Participants spoke of their disappointment in the changed maternity experience from what they anticipated. The changed experience was not only for themselves, but their partner, family, and friends. This participant said, “being a first time mum and first time being pregnant, I was really disappointed with how things have gone, especially with COVID, but just lack of resources and appointments” (P25). Special occasions were cancelled, as another said, “the baby shower was cancelled and all the other special things that you do as part of your pregnancy just kind of been ruined by COVID” (P11). Similarly, “I wasn’t able to have a baby shower, so it was a bit hard, but people have still posted things and all that sort of stuff” (P26). And this person summed up well saying, “it has been really hard, we haven’t been able to meet friends and family like we normally would with a new baby so that’s a bit sad” (P10).

Managing stress and anxiety

Women described their experience as stressful and anxiety provoking. The constant unknowns left them needing to find ways to manage these emotions. One participant said, “I think it’s because it was unknown. … I was feeling anxious and scared” (P20). Another said, “I rang my Mum, I can’t see her either at the moment … I had this big meltdown; this is not how it was supposed to be. But I kind of just try to get on with it” (P2). Seeking information and reassurance were ways women described to manage their situations. This participant explained “I think it was just that anxiety. … [so I was] trying to find out as much information as I could. … I think there was a lot of anxiety on my part … I’d ask questions like ‘is this going to affect my pregnancy?’ and they’d say, ‘we just don’t know’” (P10). Having the ability to have face-to-face healthcare was helpful to overcome stress. Another explained, “it was all negative kind of how you had to deal with everything and the stresses of all of that. I think seeing a maternal nurse in person and having a chat is very important” (P9).

Requiring constant adjustments

To find a way through the experience, women spoke of needing to make frequent adjustments to their plans. One participant said, “we had to change our plans massively, because my Mum was going to come down and look after her, which is not going to happen” (P2). Another summed up the constant adjustment, saying, “And when you’re not being supported it does amp [amplify] up that anxiety as well, about what’s happening in the world, and how’s it going to be when I go to hospital, can my husband come with me? What am I going to do with the other children?, they’re not allowed to go to their grandparents at the moment… it just changes all the time … we’ll just roll with it and wing it” (P9). Adjusting plans required consideration of themselves and others in meeting the public health pandemic requirements. Yet another explained that her plans needed to change as her parents were elderly and in an at risk group, “there was a lot of concern around what I would do with my children when I went into labour because the plan we had was for them to go with my parents but my parents are in their seventies” (P10). Participant 16 described it as problem solving, “it’s the problem solving, because on top of being tired and having to do all this newborn stuff there’s an additional level of problem solving on top of that”. Similarly, another participant spoke of her adjustment as a reframing; “we knew that my daughter wouldn’t be able to visit in hospital which is what we had envisioned … but instead we kind of reframed all of that to be like it will just be us and we’ll sort of see how we go from there” (P17).

Managing fear mongering

Participants described experiencing and managing fear mongering from others. With so much unknown about the risk of COVID-19 in pregnancy, the women described pressures from other people around them. One said her obstetrician told her “basically go home, stay home, don’t go out, don’t see anyone” (P27) to stay safe. Another wanted to keep working and found “there was no black and white, and I found that really inconsistent because people were making me feel worried and ‘oh should you be working?’, ‘are you okay?’” (P11). To manage this constant pressure, she described speaking to her doctor about it who reassured her; “And my doctor said technically you’re okay unless you are immunocompromised or worried or stressing out about this … I’ll write you a letter if you need it, but at this stage I’m happy for you to continue [working]!” (P11). Similarly, this participant was told “these are the musts: do not go on public transport, you need to reduce significantly your activity, [and] he did encourage me to work from home” (P13). To manage the fear mongering she explained “I try to stay offline as much as possible because I noticed that there was a lot of negativity. … I felt other people’s experiences is not the experience or journey that I’m going through … I have had quite a few people say to me ‘are you nervous, are you anxious about this whole pandemic and being pregnant?’, and I’m like ‘no’” (P13).

Keeping safe

The pandemic raised the participants’ awareness of risk and the need for infection prevention measures in their everyday lives. Keeping themselves and their family safe became an important daily activity. As one said, “all you want to do is keep safe” (P9), and another explained “we kind of came up with our own plan to stay safe” (P15). This participant was conscious of minimising physical contact with others, saying, “I wasn’t hugging, I wasn’t touching, they weren’t touching me, they weren’t touching my belly, there was none of that” (P13). This participant focused on hand hygiene, “being better with our hygiene, especially with the kids, we’ve put sanitiser near the door, so everyone bathes in it on the way in … we wash them [children] after childcare before going into our house … just being really good with them about touching and being around the baby” (P11).

The onset of the pandemic resulted in a range of voluntary physical distancing behaviours. One participant said, “we’d actually pulled our kids out a week earlier from school, because we kind of saw the writing on the wall, we’ve got a baby coming, obviously we were like we don’t want to risk it” (P23). Similarly, another was vigilant about minimising exposure, she said “I knew before he was born that I didn’t want him meeting people straight away – I wanted to continue with social distancing even with family, grandparents-I was quite panicked about it” (P7). Another participant’s partner was anxious about her safety, she explained “my husband sort of put me in lockdown about 2 months before I was due, about 3 weeks before
you actually weren’t allowed to leave your house, I was in lockdown, he said ‘I don’t want you going anywhere’” (P9). Routine activities such as grocery shopping changed to minimise risk. “We did a lot of ordering online, but the things that I couldn’t order online I’d go like at stupid times of the week, like at 7am on a Sunday morning” (P13). The desire to keep themselves and their baby safe did cause some conflict. This participant explained, “but it surprises me that ... you have to tell your own aunty, nanna, cousin to do or not do something and feel awkward about like the social relationships with them, whereas you’re just doing your job looking after your baby” (P11).

Discussion
This novel study has produced new evidence describing Australian women’s experiences of becoming a mother during the COVID-19 pandemic. As a large continental island, Australia was able to swiftly close its international boarders which significantly limited the number of cases and associated deaths in comparison to other high income countries (World Health Organization, 2021). Despite having much lower prevalence of COVID-19 to other high income countries, the pandemic has resulted in these Australian women having similar challenges regarding becoming a mother as women from the United Kingdom (Karavadra et al., 2020) and Italy (Ravaldi et al., 2020).

Our findings have demonstrated that women felt isolated and alone as they navigated maternity care with limited involvement from partners and other support persons. They found themselves having to advocate for themselves to receive timely and appropriate care. Being resourceful and taking measures to limit the risk of exposure to the virus were key to alleviating concerns. Women also had to manage fear driven by, and inaccurate information coming from, their close contacts and media sources. Taken together, these experiences elicited significant stress and anxiety, compounded by limited support, and inadequate access to health services.

Social support is known to moderate stress (Barkway and O’Kane, 2019). Social support that positively influences health outcomes, may come in forms of emotional, esteem, instrumental, information, and network support (Barkway and O’Kane, 2019). In this study, the public health measures and changed healthcare provision impacted women’s experiences of all five forms of support. The fear mongering experienced was a negative esteem support, and women proactively sought alternatives to their usual supports, such as network support through online communities.

As the world enters a second year of the pandemic, it is apparent that women and families are likely to have an increased need for psychological and parenting support (Beyond Blue, 2020; Sokolovic, 2020). It is however, already clear that the demand outweighs access to such professional services with some services experiencing unprecedented demand (Mitchell, 2020; Riga, 2020). There is a need to explore options of continuing support during the pandemic and prepare for future health crises by increasing the digital literacy of both healthcare providers and women (Rasmussen et al., 2020). Whilst there is evidence that telehealth may be comparable to traditional in-person care, there is much room for improvement (Fryer et al., 2020; Isautier et al., 2020). In the United Kingdom, social media outlets were seen as effective strategies for providing antenatal support (Chatwin et al., 2021). Understanding digital platforms and programs for delivering healthcare and parenting support that are acceptable to Australian women warrants further investigation. However, it is also important to acknowledge the need for ensuring safe face-to-face interactions continue to occur, with the involvement of partners and support persons (WHO, 2020).

Maternity care providers are in the ideal position to ensure that women’s rights are upheld during pandemic times reducing further risk in the vulnerable transition to parenthood/motherhood (Jolivet et al., 2020). In the face of limited maternity care, women in this study had to advocate for themselves for appropriate and timely healthcare. While several women had the confidence to do this for themselves, there are likely many more who do not, and the impacts of this are unknown.

Strengths and limitations
This participants in this study were drawn from a convenience non-random selection of survey respondents. The use of maximum variation sampling enabled participation of a diverse group of women from across Australia which is a strength. The large number of participants and multiple researchers contributing to the analysis add strength to the findings.

Conclusion
Australian public health initiatives which resulted in social restrictions had a profound effect on women’s experiences of becoming a mother during the first wave of COVID-19. Whilst public health initiatives are implemented to keep people safe, the social and emotional toll on childbearing women should be considered. Childbearing women need to be safe, but also require support and reassurance.

Ethical Approval
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Declaration of Competing Interest
Not applicable.

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Supplementary materials
Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2021.102996.

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