The Impact of COVID-19 on Women's Maternity Choices

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KEY POINTS

- 485 parents completed the survey. Most respondents were from London, South East England and Scotland.

- 57% of the multiparous women surveyed reported experiencing a previously traumatic pregnancy and/or birth.

- Over 90% of mothers reported changes to their maternity choices in light of COVID-19. Changes also appear to be more frequently reported by first-time parents.

- Over 51% of the women surveyed reported having to make changes to their birth plans due to COVID-19. However, this is likely to be a conservative estimate due to the nature of responses.
    - *'Have been told I may have to travel to hospital due to lack of midwives and ambulances rather than have homebirth. This is scary for me as I don't live very near the hospital and have had 2 very fast previous labours. Have done what I can to mentally and practically prepare to give birth unassisted at home or on the side of the road if I can't make it in time.'*

- Almost half of all women who are seen by a specialist mental health midwife reported their support to have stopped due to COVID-19. This seems to be more frequently reported by first-time mothers.
    - *'It's hard to feel like your important, really just feel like we're inconveniencing the hospital'*

- There are considerable inconsistencies in the methods used to inform parents of changes to their maternity care due to COVID-19. A large proportion of women were informed of changes to their maternity care indirectly via social media.
    - *'Would love more information and clarity when going in. There wasn't much beyond signs and had to ask about everything. Again know how much pressure everyone is under but find knowledge is power and helps ease anxiety'*

- 55% of women provided additional information about how they were feeling, and their experiences of the current situation with COVID.
    - *'Devastated. Frightened. Powerless. Helpless. Shocked. I was having an elective c-section due to previous birth trauma. To have my support taken away 2 days before I went into theatre and be told I had to do it alone feels like it is the hardest thing I have ever been asked to do. [...] The staff were wonderful and did what they could to be as supportive as possible, but nothing could take away from the alone-ness I felt on that operating table, and the feeling that I needed to dig into resources in myself to cope that were beyond myself.'*

Introduction

Since March 2020, restrictions were implemented across the UK, in an attempt to quell the spread of COVID-19, and its devastating impact. No industry was unaffected, with constraints being placed on schools, workplaces, public transport and health services. However, being pregnant and birthing during a pandemic has potentially significant psychological implications. Having a pre-existing psychological difficulty can worsen during and after pregnancy, (Furtado, Van LiesHout, Van Ameringen, 2019), and elevated levels of anxiety can be experienced for those with a previous history of trauma (Blackmore, Côté -Arsenault, Tang et al., 2011). Having support during pregnancy has a positive impact on women's wellbeing, and can minimise the impact of experiencing birth as traumatic (Dikmen, Yildiz, 2017). At Make Birth Better, our community have shared their fears, anxieties, and concerns as maternity services implemented measures to reduce community transmission. Some of these included, suspension of maternity services; restrictions for birthing partners to attend antenatal appointments, and being unable to support women during labour; less access to some pain relief and maternal request caesareans, as well as loss of continuity of care. BirthRights also highlighted the inconsistencies made by some Trusts who were making unlawful blanket decisions about women's maternity choices, whilst negating to account for individual circumstances. Although the community restrictions imposed were necessary at that time, the increased feelings of stress, anxiety and loneliness, affected the psychological wellbeing of pregnant women (Viaux, Maurice, Cohen, 2020). The aim of this survey was to understand better the changes women had experienced to their maternity care as a result, and its impact on them.

The Survey

The Parent's Maternity Choices Survey was completed online by 485 parents across the UK. The survey consisted of nine questions regarding changes to maternity choices during the COVID-19 health crisis. Survey responses were collected from the 8th of April 2020 until the 1st of July 2020. The survey consists of both multiple-choice questions and free-text responses. The average time taken to complete the survey was 4minutes 50seconds.

The following report contains the data analysis of the responses to this survey separated by question.

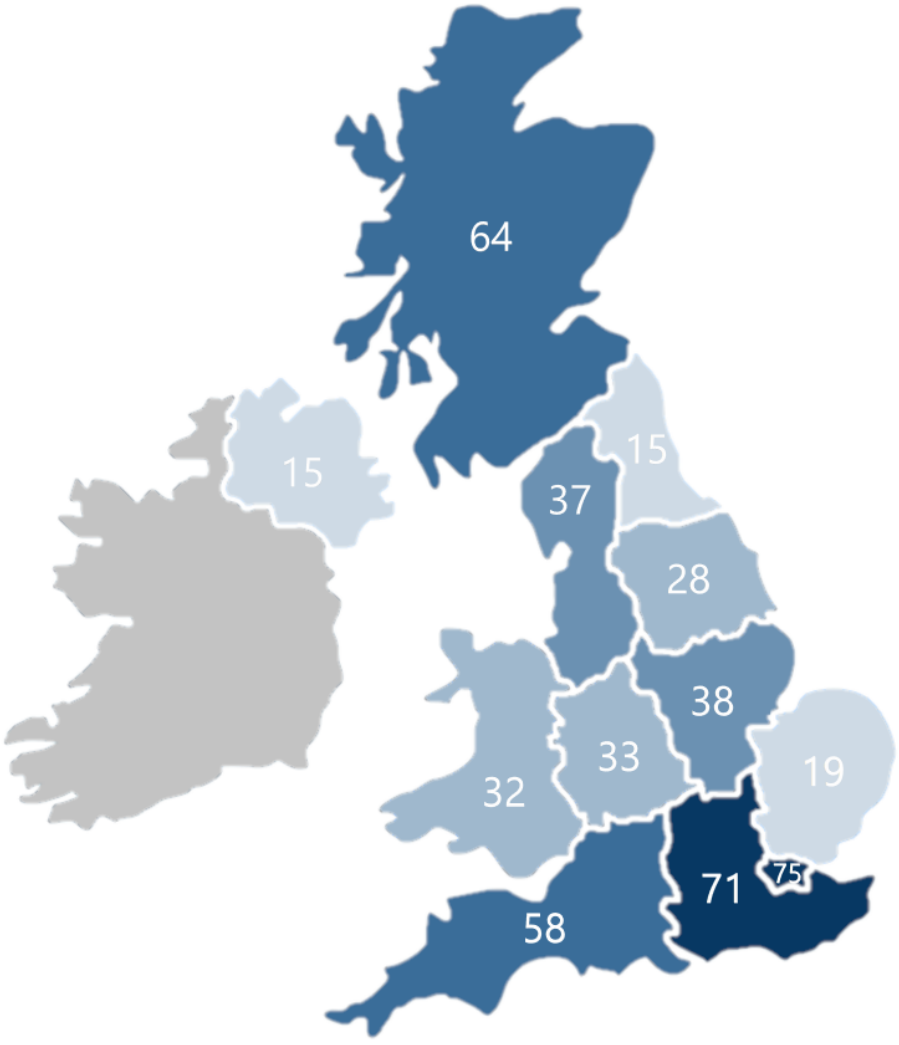
Analysis

Quantitative data was analysed using the SPSS program, and all qualitative data was analysed using thematic analysis (Braun and Clarke, 2006).

1.0 Results

1.1. Demographic Information of respondents.

Parents were asked to select which region of the UK they live in. This information is presented in *Figure 1.* The majority of respondents came from the South of England or Scotland. The regions with the lowest number of respondents were Northern Ireland, the North East and the East of England.



UK Region	Number of Respondents
London	75
South East	71
Scotland	64
South West	58
East Midlands	38
North West	37
West Midlands	33
Wales	32
Yorkshire and the Humber	27
East of England	19
Northern Ireland	15
North East	15
TOTAL	**485**

Figure 1. Map of the UK presenting number of survey respondents from each UK region.

1.2. Previous birth experience of respondents

Parents were asked if this was their first birth as well as if this birth was following a previously traumatic pregnancy or birth experience. Of the 485 women who completed the survey, 170 women reported this to be their first birth. Of the remaining 315 women, 180 reported previous experience of traumatic pregnancy or birth: 57% of the total number of multiparous women who completed the survey. The relative proportions of previous birth experience are presented in *Figure 2.*

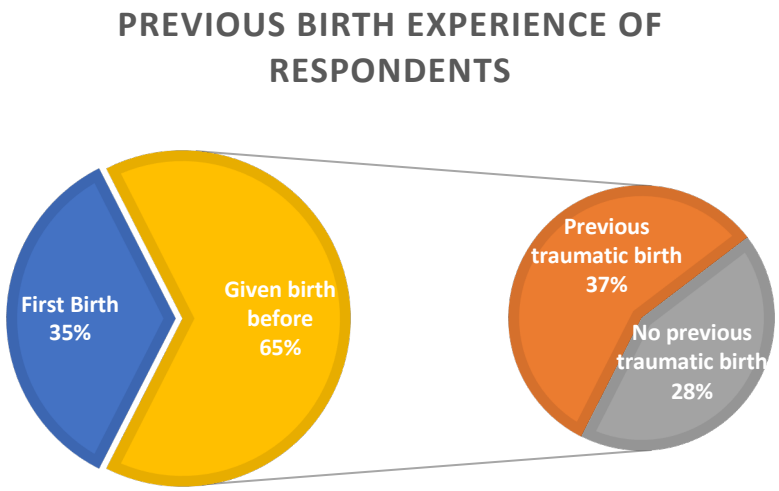


Figure 2. Pie chart representing the previous birth experience of survey respondents and proportion of multiparous women who identified a previous traumatic pregnancy or birth.

2.0 Changes caused by COVID-19

To gauge the level of disruption to maternity care caused by COVID-19, women were asked whether their maternity choices have changed as well as whether they have had to make changes to their birth plans due to COVID-19. Women were also asked whether they were being seen by a specialist mental health midwife, and if so, whether this support has continued in light of the COVID-19 situation.

2.1. Changes to maternity choices

90% of women who completed the survey reported experiencing changes to their maternity choices as a result of COVID-19. An additional 1.4% (7 women) stated that they were unsure whether there were changes to their maternity choices. Only 46 out of the 485 women who completed the survey reported no changes to their maternity choices as a result of COVID-19.

There were no statistically significant differences in changes to maternity choices between regions, however, there was evidence of differences between parity. Women who reported this as their first birth were more likely to report changes to their maternity choices as a result of COVID-19 compared to women who have given birth before (χ^2 = 6.75, *p=.009).* 95.2% of women who had not given birth before reported changes to their maternity choices, compared with 87.8% of multiparous women. The breakdown of these findings are presented in *Figure 3.*

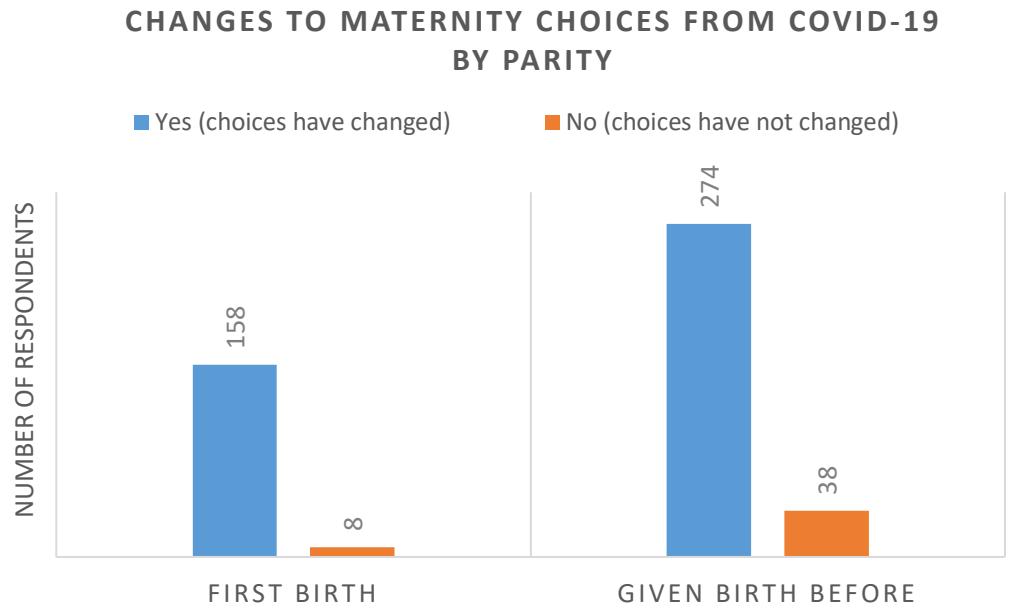


Figure 3. Bar chart to show difference between parity and self-report changes to maternity choices due to COVID-19

2.2. Changes to Birth Plans

51% of the women surveyed reported that they have had to make changes to their birth plans due to COVID-19. 64 respondents (13%) stated that this question did not apply to them as either they are too early into their pregnancy to create a plan, or they have chosen not to make a birth plan. The remaining 176 women (36%) reported that they have not had to make any changes to their birth plan as a result of COVID-19. Results are presented in *Figure 4.*

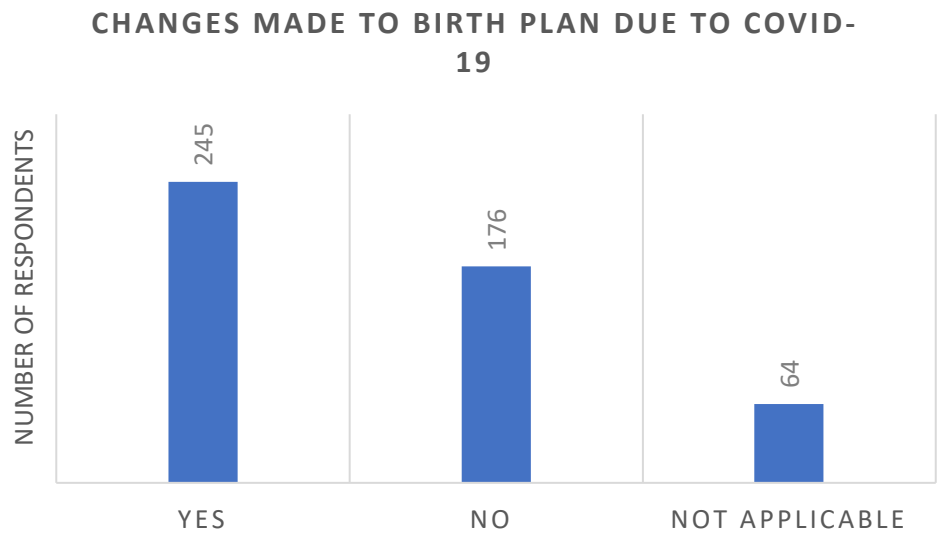


Figure 4. Bar chart to show distribution of responses to the survey question: "Have you made changes to your birth plans in light of the COVID-19 situation?"

Removal of respondents who stated that this question was not applicable to them increases the frequency of women who reported that they have had to make changes to their birth plan to 58%. However, it should be noted that this was a free-text response rather than a forced response on multiple choice, therefore, it is unclear on the exact frequencies of women who would deem this item as 'not applicable'. It would be reasonable to assume that some women would respond negatively to this question if they have not made a birth plan or do not wish to do so. Consequently, the frequency presented may very well be a conservative estimate, and the actual frequency of women who have had to change their birth plans in light of COVID-19 may be greater when only women who have made birth plans are included in analyses.

There were no statistically significant differences in self-reported changes to birth plans between region, parity or previous traumatic birth experience.

Qualitative analysis highlighted the diverse impact experienced by women having to change their birth plan.

A Different Birth – Challenges in Changes to Women's Birth Plan

This theme describes the changes that women made, anticipated making, or felt forced into making to their birth plan.

Theme 1: 'I feel as though I cannot have the birth I want or need'

Respondents described their sadness, and a sense of grief, with losing their idea of the birth they thought they would have had. Many felt sad that their partners were likely to miss out too.

'I think the general feeling from myself and amongst my peers […] at the moment is a sort of bereavement. We feel that our choices have been taken away from us, and that at a time when we should be excited and getting ready to have our babies, and looking forward to meeting them, we are consumed by huge levels of anxiety, stress and uncertainty'

'Anxious and sad. I wish my first baby wasn't going to be born like this – no visitors, limited support'

They described differences to the process of birth planning, with some questioning whether it was still relevant, or useful, and to birth plans themselves (for example, some women were less likely to try for VBAC).

'My birth plan completely changed, a number of times, I ended up not rewriting it again because when I did, more changes happened and it made me feel completely out of control'

Practical challenges acted as a barrier to achieving their hoped-for/wanted birth – for example, factoring in long travel times due to a change in birth location, or reductions in childcare meaning that chosen birth partners were not able to be present.

'Have been told I may have to travel to hospital due to lack of midwives and ambulances rather than have homebirth. This is scary for me as I don't live very near the hospital and have had 2 very fast previous labours. Have done what I can to mentally and practically prepare to give birth unassisted at home or on the side of the road if I can't make it in time.'

Theme 2: Taking control – what helps in managing changes to birth plan?

A range of measures to cope with, and manage, changes to birth plan were described. These included peer support, research and preparation, and hypnobirthing.

A number of respondents described considering, or intending, to free birth (birth at home without medical professional's present).

'I am now going to free birth at home. Both myself and my husband feel that this is the safest and most appropriate way for us to deliver our baby. […] I do not want to have to go into a hospital where coronavirus is and where my birth can be medicalised'

Others described paying for additional support, including private/independent midwives, doulas, or private scans.

> *'I'm opting for home birth with a private midwife because I do not trust the quality of care I will receive'*

Theme 3: Choice, control, and consent: feeling 'forced'

Responses suggested that some women felt forced into making changes to their birth plan, or place of birth.

> *'I feel like I'm being forced to birth in a hospital where I don't feel safe. And I worry about how this will affect my birth'*

> *'Unhappy and anxious - it further limits the choice I have, so if my trust decide I cannot have a c-section, I pretty much have to do what they want'*

Others described the changes as '*inhumane*', and felt they '*violate women's rights'*. They described a sense that choice was limited, and wanted further discussion around the options available to them in order to be able to make an informed decision.

> *'there needs to be better discussions around choice rather than being told this is your only option when that is not the case'*

2.3. Changes to support from specialist mental health midwives

Women were asked whether they were being seen by a specialist mental health midwife and whether this support has continued. Out of the 485 women surveyed, 78 women reported they had been seeing a specialist mental health midwife. **Just over half (53%) of women who reported to have been seeing a specialist mental health midwife stated that this support has continued: 47% reported that this support has not continued in light of COVID-19.**

Chi-square analyses were conducted with respondents who were being seen by a specialist mental health midwife only and separated by their response to the question regarding whether their support has continued (Yes: *n=41;* No: *n=37).* There were no differences in continuation of specialist mental health support by region or by previous traumatic birth experience. There was some evidence of a difference in continuation of support between women who reported that this was their first birth and multiparous women. A greater proportion of women who reported that this was their first birth also reported that their specialist mental health support did not continue following COVID-19 compared to

multiparous women *(Figure 5)*. However, this difference did not reach statistical significance ($\chi^2 = 3.16$, *p=.076*).

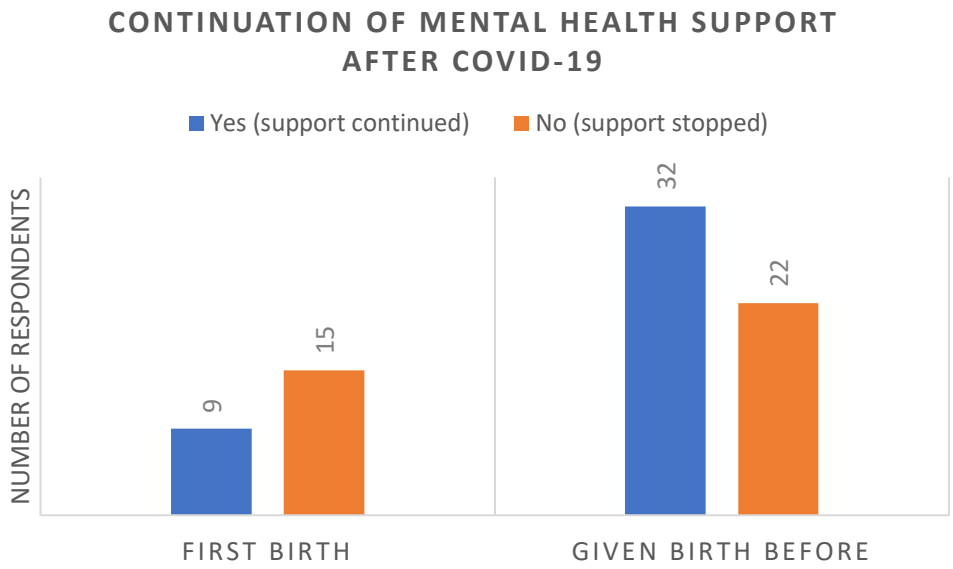


Figure 5. Bar chart to show difference between parity and self-report continuation of specialist mental health support after COVID-19 (n=78)

3.0 How changes have been communicated to parents

To better understand how information regarding changes to maternity care has been communicated to parents, women were asked how they were informed of any changes to their maternity choices. As stated in *Section 2.1*, the vast majority of women surveyed reported changes to their maternity choices in light of COVID-19. The remaining analysis was conducted on the data from respondents who stated that they had experienced changes to their maternity choices (*n=432)* and participants who provided a text-response to this question in the survey *(n=430).*

3.1. Method of communication regarding changes to maternity care

Women were asked how they were informed about any changes to their maternity care in a free-text response box. The data provided was coded into 12 specific modes of communication and an additional code was created for responses that were either unspecified or stated that the respondent 'had not been informed'. Some responses stated 'by midwife' or 'by GP' without specific reference to a mode of communication, therefore these were coded separately. The coded responses and the frequency that they were reported in the data are provided in *Table 1.*

Table 1. Coded responses regarding the method of communication parents were informed of maternity changes due to COVID-19.

Method of Communication	Frequency	%
Social media	107	24.9%
Online	49	11.4%
Telephone	100	23.3%
Text	12	2.8%
Email	3	0.7%
Letter	4	0.9%
Word of mouth	16	3.7%
At appointment	47	10.9%
Antenatal class	7	1.6%
Maternity app	3	0.7%
'by GP'	5	1.2%
'by midwife'	55	12.8%
Unspecified	22	5.1%
TOTAL	**430**	**100%**

The most frequently reported methods of communication were via social media pages or over the phone. These accounted for almost half of all responses. The remaining half were comprised of a variety of different methods as listed above. There were no statistically significant differences in method of communication between regions of the UK (χ^2 = 149.64, *p=.14*) or between parity (χ^2 = 15.32, *p=.23*)

It is important to note that many responses contained more than one method of communication and these were coded in accordance of either the method that was deemed as 'the first mode of contact' or the method containing the greatest level of detail regarding how much information was garnered in that way. Many responses mentioned social media but only those that solely referenced social media without mention of any direct contact, or indicated that direct contact was not sufficient, were coded as such.

It is also important to acknowledge that many responses with reference to a telephone call contained the caveat that they had to make first contact. Similarly, many responses stating that they were informed at appointments, also acknowledge that they took initiative in asking questions to gain information. It would be interesting to investigate further any potential

differences in whether information was retrieved 'directly' or 'indirectly' between region and/or parity.

The qualitative data analysed from this question generated the theme; **Being made to feel you matter: priorities in communication**.
This theme explores respondent's experiences of communication with them about their birth, and any changes to birth plan as a result of COVID-19.

Theme 1: Relationships with professionals – wanting/needing a different approach
Respondents described changes in their relationships with health professionals. This included both concerns around how measures introduced against COVID-19 may impact interactions/feeling understood, as well as perceived changes to communication style:

> *'Do wonder if they could miss something though with fewer appointments and the social barriers created with the masks and gloves and distancing – sometimes feel staff can be a little abrupt now?'*

Respondents wanted more flexibility in the way they received support (e.g. having phone, or on-line appointments rather than them being cancelled) and more continuity (seeing the same midwife):

> *'It would be good if someone appointments could be moved to online meetings as opposed to being cancelled completely.'*

> *'I was a little disappointed as my initial care meant I would have the same midwife throughout the whole pregnancy and post natal stage too'*

Some respondents described feeling *'rushed'* and that they were '*not a priority'*– they questioned whether anyone cared, and felt they were a '*less valuable patient*'.

> *'Its hard to feel like your important, really just feel like we're inconveniencing the hospital'*

Some felt that as a result, they were less likely to go to staff with concerns.

> *'I also feel that I don't want to bother medical staff with little issues such as I had a four day rash and I've got swelling. I'm sure it's normal but as no one has been able to look at these problems I do feel unsure.'*

Many respondents described an extremely positive experience of birth, where they felt supported and held by staff.

'Our homebirth turned into a hospital transfer but we felt respected and heard throughout even with challenging discussions about our birth choices. The staff went above and beyond to make us feel safe. I had a wonderful birth'

They described being treated with compassion and empathy, and staff working flexibly to provide tailored support.

'I felt the midwives I had were very sensitive to my previous PTSD and the current situation and the birth I had was significantly better with COVID (ironically) compared to my first. Being treated kindly, as a human by someone who was competent and made us feel safe made all the difference'

Theme 2: Mistrust and confusion – wanting better information

Many respondents felt confused over the changes introduced, questioned whether they made sense, and felt mistrustful, wanting to know more about why particular decisions were made. They noted the differences in approach between NHS trusts, which increased confusion and gave a sense of unfairness.

'I am hugely distrustful of the care I will receive'

'reasons for decisions not explained […] creating confusing discrepancies between NHS trusts'

They wanted better information about changes to maternity care.

'I think a what to expect for your area guide should be issued to mothers to be we are very much in the dark'

Important factors included the tone of information, its relevance to the current situation, and how information is shared.

'Things seem to be written in such a punitive, hostile way! Information is so vague'

'Conventional antenatal isn't overly reassuring at the minute'

'Would love more information and clarity when going in. There wasn't much beyond signs and had to ask about everything. Again know how much pressure everyone is under but find knowledge is power and helps ease anxiety.'

Many described wanting overarching guidance to be more accessible, and for it to be shared centrally (e.g. by the NHS generic website/ specific hospitals) or by midwives rather than always having to ask for it.

Theme 3: 'Unique times and unique measures' – accepting changes

Other respondents acknowledged the emotional impact of the changes, but felt that they were justified, and made sense in terms of the wider context of coronavirus.

> *'Upset but accepting. These are unique times and unique measures'*
>
> *'absolutely necessary given the situation'*

Some respondents rationalised the changes, for example reflecting on prioritising the safety of staff or other birthing women. Others appeared to be more resigned, recognising that the changes were *'out of [their] control'*, or being prepared to be flexible and wait to see what happens.

> *'Understand the reasoning. The situation is bigger than my birth so I will accept the changes in place'*
>
> *'…disappointed but resigned to their inevitability'*
>
> *'…just rolling with whatever I'm advised to do'*

4.0 Experiences of the Current Situation & its Impact

In the final question, women were asked about how they were feeling, and their experiences of the current situation with COVID-19. The following themes were created from this data.

Mental health matters too – acknowledging the emotional worlds women who are pregnant, or birthing, during the pandemic

This overall theme describes the emotional experiences and responses of being pregnant and giving birth during the pandemic, and the greater weight that many felt should be given to their mental health.

Theme 1: 'Time to heal' – Women's concerns for their own, and collective future mental health

Respondents described a range of emotional responses to the pandemic, and the measures introduced by maternity services, including feeling *'powerless'*, *'petrified'*, and *'lost'*. For some women the changes re-activated feelings from previous birth trauma:

'feels really familiar to my previous birth trauma where the worst feeling was losing control'

Respondents described a concern not only for their own future mental health, but that of other birthing women. They felt that without the right support there could be a collective trauma, or a significant increase in mental health difficulties.

'my fear is that I will look back at sorrow at what we had to endure during this time. I think the trauma will be lasting and far reaching!'

'I worry that there will be a massive spike in postnatal depression for the women who birth during this pandemic […] for myself I worry that I will struggle to cope with a toddler and a newborn […] I feel sad, have cried at times, and feel that there will need to be time to heal after all of this.'

They wanted more recognition of how they might be feeling, and more emotional support.

'I feel there has been a lack of appreciation for how frightening these times are for pregnant women'

'Wish there was more focus on how supporting pregnant women emotionally and to still give a sense of reassurance and safety in continuity of support.'

The level of uncertainty, and pace of change, around COVID-19 and the measures introduced by maternity services, were a factor in raising anxiety in themselves.

'Anxious, particularly the 'unknown' in that things are likely to be different by the time I come to give birth'

Theme 2: On my own – feeling alone and forgotten

Responses suggested that pregnancy in lockdown has the potential to be a very lonely time. Respondents described feeling *'alone'*, *'abandoned'*, and *'forgotten'*, during pregnancy and antenatal care, through appointments and antenatal classes being cancelled, or held on the phone or online.

'Although it's nobody's fault, I feel incredibly alone - mental health and women's health physio appointments cancelled, my midwife has changed so don't even know who I'm seeing at next appointment. Anxiety is through the roof'

There were challenges to attending appointments/scans alone, including that it was difficult to process information and make decisions on your own, and to not have support if there was difficult news:

> *'Understand needs to be done for protection but can be very scary being told about potential issues by a consultant and having to process it all by yourself and no one else to be able to ask questions you don't think to ask'*

Many were fearful of having to birth without their chosen birth partner, or shared their experiences of the challenges of birthing alone.

> *'Devastated. Frightened. Powerless. Helpless. Shocked. I was having an elective c-section due to previous birth trauma. To have my support taken away 2 days before I went into theatre and be told I had to do it alone feels like it is the hardest thing I have ever been asked to do. [...] The staff were wonderful and did what they could to be as supportive as possible, but nothing could take away from the alone-ness I felt on that operating table, and the feeling that I needed to dig into resources in myself to cope that were beyond myself.'*

Postnatal support, both in hospital and following discharge, was reduced, leaving families feeling isolated:

> *'I was disappointed by the level of basic care on the postnatal ward […] I had to ask for help me pick up the baby, refill my water, or help me to the bathroom with my husband not being there and this required calling the buzzer and waiting'*

> *'postnatal support has been very limited. In hospital midwives reducing contact so not getting support […] extremely limited contact from health visitor (one quick call post birth) and 6-week GP check-up moved to 8 weeks to coincide with baby vaccinations […] we feel quite isolated and unsupported'*

<u>*Theme 3: People who need additional support*</u>

A number of groups of people for whom changes to maternity care may bring additional challenges, or who may require additional support, were highlighted. These included: people who had had previous pregnancy complications, miscarriages, or stillbirths; first-time parents; people who had had previous traumatic births; people experiencing mental health difficulties.

> *'Having had one premature baby and one second trimester loss, having my weekly monitoring withdrawn and midwife appointments only over the phone has made me feel very anxious all the time'*

'Very upset and anxious that I might have to give birth in an environment where I previously had a traumatic experience'

5.0 Discussion

Results from this survey have shown that first time mothers were more likely to have changes made to their maternity choices, compared to women who had previously birthed. Although over half of those receiving specialist mental health midwife support pre COVID-19 continued to receive this support, there were many who did not, and again these seemed more likely to be first time mums. Evidence suggests that not only is birth associated with an increased risk of first-time episodes of psychiatrist disorders (Munk-Olsen, Laursen, Pedersen, et al., 2006), but that 15% of first-time mums will experience mild to moderate episode of postnatal depression (Wisner KL, Sit DK, McShea et al., 2013). Therefore, this is a potentially vulnerable time for women, compounded also by factors associated with transitioning to motherhood, and being pregnant or birthing during a pandemic.

Many were confused about why the changes to their maternity choices were being made, which created feelings of confusion and mistrust. It is well evidenced that sharing clear and transparent information at times of crisis can create feelings of safety and trust (Harms, Credé, Tynan, 2017). So, one possible way to mitigate the confusion and mistrust women experienced, was for their midwife to deliver clearer information. Although women were informed by social media of the changes, many initiated these discussions with their midwives either by phoning them, or asking them at their appointment. It is well evidenced that having continuity of carer and a quality relationship between mum and midwife, facilitates feelings of security, trust and can minimise difficult feelings related to the birth (Dahlberg & Aune, 2013; Lyberg & Severinsson, 2010). Some women discussed the anxiety caused with having a different midwife at each appointment. It was unavoidable with the pandemic that some midwives were dispatched to other roles and Trusts. However, the lack of communication and ambiguity about the services women could expect further added to an already anxiety-provoking time for many. Women understood that some of their appointments would need to be cancelled. They proposed that midwives needed to work flexibly and rather than cancelling, using other platforms, like online or telephone calls, to facilitate the appointment going ahead.

Before COVID-19, women, birthing people and their partners entered services that were disjointed and reactive. As a result, traumatised services were creating traumatised parents (Make Birth Better, 2020). When a woman has experienced a previous birth-related trauma, her subsequent pregnancy can provide an opportunity to heal some of these wounds (Patterson, Martin, & Karatzias, 2019). However, this needs to be sensitively managed, where women feel they are in control, communication is clear, and they are being supported. One

participant reported that her current birthing experience healed some of her previous birth trauma because of the interpersonal relationship with the maternity staff. Most women surveyed had to make some changes to their birth plans, including not having their partner present. This resulted in some parents feeling forced into making choices, like free birthing, which potentially compromises the safety of the mum and her baby.

Some women are at a higher risk of experiencing birth-related trauma particularly, if they have had a history of trauma, have pregnancy or birth complications, and have not felt supported during their labour (Dikmen Yildiz et al, 2017). Postnatally, some families reported feeling isolated, and required more support than what was being offered, particularly in the absence of their partner (on wards). Also, women with a previous history of perinatal trauma, and/or mental health difficulties required additional support than what they received. It is unclear the psychological impact birthing during COVID-19 has had on women, birthing people and their partners. The pandemic has not ended for many, and maternity services continue to be disrupted. What is evident from our findings is that the conditions in which women are at risk of having a traumatic birth is present, and little has been implemented to counter these.

5.1 Implications for Practice

- Clear communication about how maternity services are changing, and what women can expect. That this information is accessible to all women.

- Maternity staff to initiate conversations when changes are being made about women's maternity choices.

- Antenatal appointments should be offered either online or by telephone. This would contribute to women feeling supported, and create an opportunity for her midwife to ease any anxieties.

- Perinatal services need to prepare for a rise in referrals for those women, birthing people, and partners whose mental health have undoubtedly been affected during this time. This could involve providing online group spaces, peer-to-peer support schemes, and increased recruitment of specialist staff.

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