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Being pregnant during the first wave of the Coronavirus pandemic: Experiences and responses of vulnerable pregnant women and their caregivers in the Netherlands

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Pregnancy and social distancing

How did women facing preexisting psychological or social problems during pregnancy, as well as their caregivers, experience and respond to the Covid-19 physical distancing policies? This research brief presents findings from two ethnographic studies conducted between February and May 2020 focused broadly on pregnant women's experiences of vulnerability and providers' assessment of risk and vulnerability in pregnancy. The brief is based on interviews with fourteen care providers[1] and seven pregnant women with preexisting mental and social problems in the Netherlands. Interviewed women had different socio-economic backgrounds, were between the ages of 24 and 40 years and lived in urban as well as in rural areas around the cities of Rotterdam and Groningen, the Netherlands. The education level of respondents was generally high; six out of seven women attended secondary education or higher (HBO or university). We present those findings related to the impact of the first wave of the coronavirus pandemic in the Netherlands (March – June 2020).

We find that face-to-face contact with pregnant women is highly valued by antenatal care providers. Certain forms of information cannot be accessed in digital contact. Providers often thought of creative solutions in order to work around social distancing policies. Still, care providers worried that some families might go 'off-radar' during a lockdown. Most worrisome were the reduced social support and insight into situations of potential abuse. Women themselves often experienced higher levels of stress and anxiety during pregnancy and had concerns about the impact of the restrictions on pregnancy care. They desired to be better informed about the virus and the Covid19-policy. Women also worried about reduced social support, the absence of their partners in antenatal hospital visits and economic insecurities.

Caregivers' responses

- From March to June 2020, the policy for mental health and addiction care workers stipulated that no face-to-face contact with clients should be made unless an 'emergency' occurred. What constituted an 'emergency' was left to health care institutions themselves to define. Mental health and addiction care was primarily organized digitally: mental health caregivers used resources such as Teams, Zoom and Skype to stay in touch with their clients.

- The policy around ultrasounds for primary care midwives was to see clients for 'medically necessary' ultrasounds only; again, 'necessity' was not specified. Other consultations were limited to those strictly

[1] We interviewed two gynecologists, one midwife, two psychologists, three Safe Home physicians, one social-psychiatric nurse, and one andrologist.

needed and partly done by phone. Pregnant women were asked to come alone.

- The lack of face-to-face consultations with clients was a concern to the caregivers. The needs of the women in our study were formerly often addressed because primary care workers picked up subtle signs of distress during face-to-face consultations. One midwife, for example, testified how she discovered a client's financial needs because she wore the same underwear week after week. Another found out about domestic violence in a household because of a male partner's coercive attitude during a consultation. Caregivers feared that the limitations in face-to-face contact would lead to a cohort of pregnant women staying under the radar of psychosocial care services.

- In secondary care, face-to-face antenatal check-ups for pregnant women that were assessed to be 'high-risk' generally continued. However, partners were often not allowed anymore to accompany pregnant women to consultations. Arguably, this reflects and heightens already existing gender biases in Dutch perinatal care; pregnancy is framed as a woman's 'affair'.

- Caregivers developed creative solutions to help pregnant women in need. One psychologist, for example, offered a client to admit her to the psychiatric ward after she saw her entire social network implode due to the corona crisis. The client gladly accepted this because this way she would still have much needed social support and medical care. Other caregivers organized online peer-to-peer discussion sessions where health professionals were also present to answer questions and attend to worries about the virus, in order to sustain a feeling of community among anxious, and vulnerable, pregnant women

- The corona measures impacted many care practices. In addiction treatment for pregnant women, professionals, when performing urine analysis at women's homes, now had to wait outside to collect samples rather than waiting outside the bathroom. This complicated checking whether the urine received was truly their clients'. Addiction treatment professionals cautioned obstetricians to be especially alert with women who have had a history of drug use, since the physical distancing requirements led to more uncertainty about clients' abstinence during pregnancy.

- Caregivers often identified a weak social support system as a main factor constituting a 'vulnerable' pregnancy. Many of the risks and problems related to vulnerability during pregnancy (e.g. unemployment, lack of housing, addiction) can be alleviated through the help of family and friends. The pandemic however increased social isolation, and women experience diminished support from both their social networks and professional caregivers. In the postpartum period especially, when women deal with sleepless nights and many uncertainties, social support is highly needed.

- Physical distancing affected pregnant women who were being monitored by caregivers (e.g. for being in an abusive relationship or alcohol and drug dependencies). Lack of face-to-face contact made it harder for professionals to check women's physical and mental well-being. At the same time, contact with institutions (schools; work) also lessened, further reducing insight into people's home environment and mental health status.

- Professionals voiced much concern about the impact of physical isolation on domestic violence and abuse. In households with pre-existing tensions, living closely together for entire days might well aggravate the situation. Worldwide, a surge of reported domestic abuse led UN Women to speak of a 'shadow pandemic' (ActionAid 2020). Safe Home (*Veilig Thuis*), the most important organization in the Netherlands dealing with domestic violence, did not

report an increase in reports during the lockdown from January to April (Eshuis, 2020). Low-threshold advice services, such as anonymous call centers and chat functions of domestic violence support organizations like Fier and the Child Helpline, however, did see a significant user increase (Van Bemmel et al., 2020; Lin, 2020). According to a Safe Home employee this may be because many of the reports to Safe Home are made by medical professionals, and they had much less insight in the home environment of people. The Child Helpline and Fier, by contrast, are primarily used by victims.
Likewise, the preliminary results of a study into domestic violence during the first wave of the pandemic in the Netherlands reported that although there hasn't been an increase in victim reports, there has been a shift in content, as there are more so-called "covid-reports" from people concerned about social isolation (Boersma and M'charek 2020)

- In general, mental health professionals indicated that their clients responded stoically to the crisis, which providers attributed to 'going into survival mode', and good coping strategies. Still, professionals observed that some problems increased, like anxiety and stress, or obsessive-compulsive behavior such as excessive cleaning. The long-term implications and side-effects of the measures must also be taken into account: women may be less inclined to seek help because they do not want to burden the health care system, or fear becoming infected. It was expected that the full mental impact may only be experienced after some time, when people can no longer remain in 'survival mode'.

Women's responses

- For all women, pregnancy itself was already characterized by a time of great uncertainty. The Covid-19 outbreak heightens the feeling of uncertainty about how their pregnancy would develop and what kind of care they could get.
- Women expressed worries about getting infected with Covid-19 during pregnancy. However, all women expressed a sense of control over the risk of infection, protecting themselves by, where possible, physically isolating themselves and by adhering to other government measures and advice. Pregnancy changed the way women dealt with the coronavirus. They felt responsible for protecting not only themselves but also their fetus. One woman for example used a face mask when having to go outside, something she would not have done if not pregnant[2]. Another woman, who was already dealing with preexisting anxiety, indicated that the Covid-19 heightened her anxious thoughts. For her, the most difficult part was the uncertainty that came with the new coronavirus was how it may affect care during her delivery.
- Several women indicated that they experienced higher levels of fear and stress surrounding the delivery since the outbreak of the virus. Women felt (even) less in control over the delivery if they dependent on hospital care. Pregnant women with a medical indication for clinical delivery expressed concerns about hospital delivery: Will I be able to deliver in the hospital? Can my partner be present? How great is the risk of getting infected in the hospital? What if I get infected before the delivery? Two women described the hospital as 'the' place to get infected. On the other hand, somebody else saw her medical indication as a guarantee for a bed in the hospital. She explained how a pregnant friend who preferred a hospital delivery but who did not have a medical indication experienced much more stress and insecurity and stress regarding delivery.

- Women valued receiving up-to-date information about the hospital Covid-19

[2] Note that during study the Dutch government still advised *against* using facemasks due to a lack of evidence regarding its protective value, possibly even increasing risk. Very few people in the Netherlands used them in public until it became mandatory in public transport due to new insights.

guidelines, but indicated a difficulty in accessing clear information about the consequences of covid-19 on the course of their pregnancy and antenatal care. They desired more transparency from hospitals about what was known and what was not known about infection risk. However, women also expressed understanding that it is hard to predict how care practices would be affected in the future.

- Some medical consultations had to be cancelled, rescheduled or postponed. One pregnant woman's consultation about the use of psychotropic medication during pregnancy was cancelled, without being rescheduled. She commented: *"Well, that is something I do find unpleasant, because it is still about the health of my unborn child, and it is also about medication. And that it is not possible to discuss this with my doctor, that is something I find…that makes you uncertain whether you do the right thing, whether you make the right choice."* The woman's response indicates that caregivers and their patients may define 'necessary' care differently.

- Pregnancy was often described as a social experience. However, the Covid-19 outbreak changed this, since women had to reduce their social contacts. Some expressed regret that their relatives and friends could not be part of their pregnancy experience and were unable to see their pregnant bodies transform. By contrast, another woman emphasized how not much had changed in terms of social contacts and isolation; even before the outbreak she spent most of her time inside and had very limited social contact.

- Women interviewed also emphasized the significance of partner support. Three women, for instance, indicated that the decision to become a mother, while having mental health problems, depended on whether their partners were willing to support them and to take over the care of their child in case of worsening of illness symptoms. Or as one participant described, *"for me it was very important to do this together"*. Bearing this in mind, it is particularly difficult for these women if their partners cannot be present during antenatal hospital visits or the delivery. Furthermore, this might impact the paternal bonding to the child (Plantin, Olukoya & Ny 2011) and reproduces unequal gender roles according to which women are the main and indeed sole 'target' of pregnancy care, with (male) partners merely playing a minor supportive part.

- In addition to social consequences, for some women the pandemic had economic consequences, or increased their economic hardship and associated mental distress. One woman indicated that she depended on the social services (*Voedselbank*) for food. Due to 'panic buying', especially during the first weeks of the outbreak, supermarkets had limited leftovers to donate to the food bank, creating food insecurity amongst those who live below the income threshold. Another woman expressed her insecurities about extension of her employment contract.

Concluding Remarks

What constitutes "essential care" during a pandemic is not obvious and will be seen differently by different organizations and individuals. This leads to a discussion of what is 'necessary' for a healthy pregnancy. As Yuill (5, 2020) argues: 'some care, viewed as fundamental by those who receive it, is not viewed as a 'priority' by those who provide it.'

Some health care providers feared that the corona-outbreak might lead to health care re-organization, with reduced face-to-face contact with clients. Digital consultations may have advantages, like cost reduction and time efficiency, but their effectiveness needs to be investigated (Greenhalgh et al. 2016). Although pregnancy care has now returned to normal, and face to face contact is allowed, the new 1.5 meter norm is likely to remain in place for some time. Moreover, other pandemics

and public health crises may emerge. How one can care at 1.5 meter distances needs to be thought through and studied. Anthropological and other qualitative social science studies will be particularly helpful here.

De Vries and colleagues argue that the Covid-19 policy should not just be aimed at preventing contamination, but also guarantee "essential social interaction" (2020). We argue here that face-to-face antenatal care for vulnerable pregnant women counts as essential social interaction. Digital care has limitations as it is weak in picking up signals of abuse and socio-economic problems. Moreover, Covid-19 restrictions shift the focus more towards mothers as fathers are often not allowed to join in for 'necessary' hospital visits and sometimes even the delivery itself. Through this brief, we hope to raise awareness for the impact that the Covid-19 restrictions have on women with preexisting social, psychological and economic problems, mainly because of lessened social support, increased anxiety and stress, and economic insecurity.

Recommendations: what can be done?

This was a small-scale study and results may not be fully generalizable. Still, based on our findings and interdisciplinary team reflections, we formulate the following recommendations**:**

Practitioners & facilities:

1. Evaluate mental health (stress, depressive symptoms) and Covid19-related stress during antenatal care check-ups.
2. Actively enquire into and if necessary engage clients' social network, and partners in particular.
3. Pay special attention to psychosocial complaints at the first antenatal care booking visit.
4. Offer clear information to pregnant women and inform them about the safety of delivering in a hospital
5. Stay in touch with socially vulnerable pregnant women, if needed by alternative ways, e.g. phone or digital.
6. Provide tailored care: assess in each individual case the advantages and disadvantages of face-to-face consultation and act accordingly.

Policy-makers:

7. Reduce collateral damage of the measures aimed at reducing transmission, such as impact on care for medical complications, isolation and stress among already vulnerable pregnant women.
8. Commission multi-disciplinary research into the broader impact of the corona crisis and associated measures on care and psycho-social well-being for vulnerable populations.
9. The presence of partners is highly important; don't allocate them the same status as other visitors, who were not allowed to enter maternity wards during the lockdown.
10. Create accessible information materials about the risks of COVID19 on pregnancy and delivery in clinical facilities.
11. Allow professionals to balance the need for to prevent the spread of infection with the provision of essential face-to-face care. Face-to-face consultations have additional value to phone or digital consultation. Create space for personalized, person-centered care, tailored to individual needs

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