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# Receiving maternity care during the COVID-19 pandemic: Experiences of women's partners and support persons

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ABSTRACT

*Background:* In Australia, the provision of maternity care during the COVID-19 pandemic was significantly altered to limit transmission of the virus. Many hospitals limited face-to-face appointments to only the pregnant woman and restricted the number of support people present during labour, birth, and postnatal visits to one person. How these restrictions were experienced by partners and support persons of childbearing women are unknown.
*Aim:* To explore the experiences of partners and support persons of women receiving maternity care during the COVID-19 pandemic.
*Methods:* A two-phased qualitative study including an online survey and interviews. Analysis was undertaken using content analysis.
*Findings:* Partners and support persons experienced a sense of 'missing out' from the pregnancy and maternity care experience because of changes in the provision of care during the pandemic. They reported feelings of isolation, psychological distress, and reduced bonding time with babies. Conflicting information and processes within and across maternity services contributed to feelings of uncertainty and a perceived reduction in the quality of care. Partners and support persons were negatively impacted by restrictions on maternity wards, however they also perceived these to be of benefit to women.
*Discussion:* Many partners and support persons were negatively impacted by restrictions in maternity services during the pandemic; strategies to ensure their active involvement in maternity care are needed.
*Conclusion:* This study offers insights from the unique perspective of partners and support people of women receiving maternity care during the pandemic. Policies and processes that exclude partners and support persons need to be reconsidered.
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Statement of significance

**Problem or issue**

During the COVID-19 pandemic, changes to maternity care limited the amount of contact women's partners and support persons could have with maternity services.

**What is already known**

Women value maternity care that includes their partners or chosen support persons.

**What this paper adds**

Partners and support persons felt they missed out on the pregnancy and maternity care experience and reported feeling isolated and distressed. Even during pandemics, maternity services should reconsider policies that limit partner and support person involvement.

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Alternative strategies to include them may prevent feelings of isolation and address the needs of women and families.

## 1. Introduction

To limit the transmission of COVID-19, substantial changes in the provision of maternity care have been made worldwide, particularly in high income countries. In Australia, the number of COVID-19 positive cases and associated deaths has been relatively low compared to other regions [1]. In response to the global pandemic, physical distancing guidelines were imposed on 21 March 2020 [2]. In the first months of the pandemic, guidelines which support maternity health services changed constantly [3], as models of healthcare during the maternity period were adapted to meet physical distancing requirements.

Many antenatal education groups which traditionally include both women and their birth support partners [4] were discontinued or offered online only in Australia. Furthermore, new parents' groups [5], which are known to connect new parents socially, and facilitate parenting skills and confidence, were also cancelled or conducted remotely [6]. Many hospitals introduced a visitor restriction policy for labour and birth, which allowed either a partner or another support person (not both) to be physically present in the hospital. Doulas, who are employed by pregnant women to provide emotional support during pregnancy and birth [7], were only permitted to provide support if they were chosen as a priority before partners or other support persons. The physical distancing measures were variable depending on location, timing, and numbers of COVID-19 cases in the local community. Restrictions were also variable within different types of maternity care settings, i.e., antenatal, birthing, and postnatal. For example, some antenatal appointments continued face-to-face, while most in person postnatal maternal and child health services were discontinued and conducted remotely or via telehealth.

It is common for Australian women to have at least one (and often more) support people present during labour and birth, and this is usually encouraged by maternity service guidelines [8]. The presence of a support person is recognised internationally as an important source of support for women in labour [9]. Indeed, the Australian midwifery standards for practice stipulate that "the midwife works with the woman and her baby, partner and family as identified and negotiated by the woman herself" (p.2.) [10] However, during the COVID-19 pandemic the restriction on the presence or number of support persons has been justified as necessary for public health, as the risks of COVID-19 transmission on birth wards was perceived to be a greater concern than the psychological consequences of separating labouring women from their partners and support persons of choice [11]. Internationally, as a result of these changes, women reported disrupted expectations of pregnancy, birth, and postnatal care, decreased quality of care, and associated poor mental health [12–14]. Similar experiences were reported by pregnant women during the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak in Hong Kong [15]. In the current pandemic, women also reported that general information on COVID-19 safe behaviours did not meet their particular needs, being general in nature, ambiguous, or inconsistent [16].

Whilst there is some evidence of pregnant women's experiences, less is known about the impact of the COVID-19 maternity care restrictions on the experiences of partners or other people supporting women during pregnancy, birth, and postnatal care. Lista and Bresesti [17] suggest that the COVID-19 pandemic has reshaped the partner's role from the beginning of pregnancy; they are "forced to live this experience from an unnatural state of a spectator" (p.1). During the 2003 SARS outbreak in Hong Kong, women's partners reported that they could not attend the birth or could only see babies through windows, leading to potential concerns about lack of opportunity for bonding and attachment [15].

Given that engaging partners and support persons in maternity care has substantial benefits for mothers [18,19], infants [20], and the partners themselves [21,22], the impacts of excluding partners from aspects of maternity care are potentially far-reaching [23]. Even before the COVID-19 pandemic, partners commonly reported feeling excluded by health professionals providing maternity care to mothers and infants [24,25]. Partners' experiences of the changed circumstances during COVID-19, and the effect on the family, including the bonding process with the infant, are as yet to be known [17].

Active support for new families, including partners, may be required to compensate for disconfirmed expectations of pregnancy, birth, and the postnatal period [16,17]. In addition to reduced health professional contact [17], in the context of social distancing in a pandemic, both parents are likely to have experienced loss of social and family affirming opportunities during the perinatal period [2]. To inform support strategies, the aim of this study was to explore the experiences of partners and support persons of women receiving maternity care in Australia during the first wave of the COVID-19 pandemic.

## 2. Methods

### 2.1. Design

This national study was designed to answer the research question: What are the experiences of partners and support persons of women receiving maternity care in Australia during the first wave of the COVID-19 pandemic? A two phased cross-sectional study including a national online survey and individual semi-structured interviews was conducted. This paper reports on qualitative data from free-text responses and from individual interviews.

### 2.2. Participants

Partners and support persons of women who were pregnant or had given birth since March 2020 amidst the first wave of the COVID-19 pandemic in Australia were invited to participate in the study. Participants had to be over the age of 18 to complete the survey. The survey included the option for participants to provide an email address, to nominate to be followed-up for an online interview. A total of 44 participants provided responses in the 'Further Comments' section of the survey. Thirty-six participants provided contact details and using a convenience sampling approach all were invited for an interview. Of these, 15 participants took part in an online interview. The mix of partners and other support people was therefore determined by those who agreed to participate.

### 2.3. Data collection

No instruments existed to collect relevant data due to the novel nature and scale of the COVID-19 pandemic healthcare response and consumer experience. The research team developed the survey questions based on the World Health Organization guidelines for respectful maternity care [26] and COVID-19 guidelines [27]. Survey design was also guided by initial reports and communications regarding maternity service changes and responses to the COVID-19 pandemic. The following wording was used to prompt

participant responses on the survey: ‘Please add any further comments that you would like to share about your experiences of supporting a pregnant woman receiving maternity care during the COVID-19 Pandemic’. The survey was advertised via social media and relevant professional organisations from May to June 2020. As described above, survey respondents had the option to self-nominate for an interview.

Interviews were conducted using a semi-structured interview schedule and the web-based video platform Zoom. The interviews were conducted by two members of the research team (VV and KW). Neither of the interviewers were midwives or maternity care professionals and neither had any relationship with any of the participants, limiting bias in the interview approach.

Participants were asked one general question regarding their experiences of providing support to a pregnant woman during COVID-19. If needed, this was followed by various prompts regarding the maternity service response, participants’ level of involvement in maternity care, and their concerns during the COVID-19 pandemic (see Table 1 for sample questions). Interview length ranged from 15 to 40 min. Interviews were audio recorded with participants’ consent, and transcribed verbatim by a professional secretariat service. Data saturation was achieved after 12 interviews, however all data were analysed and included in the study.

### 2.4. Data analysis

In this paper, we describe qualitative data from the free-text responses in the ‘Further Comments’ section of the survey and data from the conducted interviews. Qualitative data from both of these sources were entered into QSR NVivo 12 and analysed together using content analysis [28]. Content analysis is an objective method of systematically describing and quantifying qualitative data [29]. An inductive approach using open coding, to create categories and themes, and sub-themes was undertaken. To strengthen trustworthiness, the data were coded independently by two authors (VV & KW). After the coding was completed, codes, themes, and subthemes were discussed until agreement was reached between the two authors and verified with other team members.

### 2.5. Ethics

Ethical approval was obtained from the Curtin University Human Research Ethics Committee (HRE2020-0210). Reciprocal approval was also obtained from partner institutions. All potential participants were provided information to enable informed voluntary consent. Completion of the survey indicated consent, and verbal consent was obtained prior to the commencement of individual interviews.

### 2.6. Findings

Qualitative data was provided in the survey by 44 participants, and 15 individuals participated in interviews. The majority of participants were male, aged 31–40 years, were partners of and lived with a childbearing woman, were born in Australia and spoke English at home. Representation from 7 of the 8 states and territories of Australia was achieved. Sample characteristics collected from the survey, for both groups of participants are presented in Table 2.

Qualitative survey and interview data were combined in the analysis due to the commonality in responses. Three themes emerged from the qualitative data analysis: (a) experiences of the maternity service response, (b) missing out, and (d) benefits of COVID-19 restrictions. Themes and related subthemes have been presented with quotes from numbered survey responses (survey, 1–30) and interview participants (interview, 1–15). To enable succinct reporting of relevant quotes, omitted words have been indicated by an ellipsis ( . . . ) and added text to provide context/correction is indicated by words in brackets ([]). Themes and sub-themes have been illustrated in Fig. 1.

### 2.7. Theme one—experiences of the maternity service response

The experience of the maternity service response was varied amongst partners and support persons of pregnant women or women who had given birth. Within the theme of maternity service response three sub-themes emerged from the analysis: (1) level of support provided, (2) conflicting information and processes, and (3) maternity healthcare providers’ approaches to partners and support persons.

#### 2.7.1. Sub-theme one—level of support provided

It was evident that the level of support partners and support persons experienced was highly variable and dependant on the clinician, service restrictions, and changed models of service. Some participants felt that they experienced a high level of support from maternity care services, despite the challenges of restrictions, as exemplified here:

> Well I guess the obstetrician being quite forward and offering, and being very open to having me involved in those appointments, even though I couldn’t be there in person, . . . offering to have me on the phone, and then she would take videos of the scan, and so my wife could get them on her phone and text them to me . . . I guess the openness of the obstetrician to include me was massive and maybe that’s not the norm . . . but our obstetrician was really accommodating in that aspect . . . when you find out you can't attend, you . . . assume that you’re not going to be a part of it, but they made a real effort to make sure that I was still a part of it. (Partner, interview 4)

Others felt a reduction in the level of support provided as a result of changing the provision of care to virtual and telephone consultations, for example:

> A lot of the maternal child health nurse visits were conducted over phone rather than face to face, and then they’d come in very briefly to do a weight [on the baby], but they only did a

**Table 1**
Sample interview questions.

| | |
|---|---|
| Opening Question | - Please describe your experiences of supporting a woman’s maternity care during COVID-19 |
| Example Prompt Questions<br>(Adjusted according to status of the woman they were partnering- e.g., currently pregnant/postnatal/primiparous/multiparous) | - During the pregnancy/birth, what were your main concerns related to COVID-19?<br>- What was your experience of the maternity care that was provided?<br>- How do you feel about your involvement in the woman’s maternity care?<br>- Were you asked about how you were feeling during the woman’s maternity care? How did this make you feel?<br>- Were there changes to your work patterns from COVID-19? How have they impacted the level of support you can provide? |

**Table 2**
Partner and support person characteristics (n (%)).

| Characteristic | Survey respondents who provided comments (N = 44)[a] | Interview participants (N = 15) |
|---|---|---|
| Australian state/territory | | |
| New South Wales | 8 (18.2%) | 3 (20.0%) |
| Victoria | 14 (31.8%) | 3 (20.0%) |
| Queensland | 1 (2.3%) | 0 (0.0%) |
| Western Australia | 10 (22.7%) | 5 (33.3%) |
| South Australia | 5 (11.4%) | 1 (6.7%) |
| Australian Capital Territory | 6 (13.6%) | 2 (13.3%) |
| Northern Territory | 0 (0.0%) | 1 (6.7%) |
| Tasmania | 0 (0.0%) | 0 (0.0%) |
| Sex | | |
| Male | 29 (65.9%) | 10 (66.7%) |
| Female | 15 (34.1%) | 5 (33.3%) |
| Age | | |
| 18–25 years | 4 (9.1%) | 0 (0.0%) |
| 26–30 years | 4 (9.1%) | 5 (33.3%) |
| 31–35 years | 14 (31.8%) | 3 (20.0%) |
| 36–40 years | 11 (25.0%) | 2 (13.3%) |
| 41–45 years | 4 (9.1%) | 1 (6.7%) |
| 46–50 years | 7 (15.9%) | 4 (26.7%) |
| Aboriginal/Torres Strait Islander status[b] | | |
| Yes | 1 (2.3%) | 0 (0.0%) |
| No | 42 (95.5%) | 15 (100.0%) |
| Language spoken at home | | |
| English | 42 (95.5%) | 14 (93.3%) |
| Other | 2 (4.5%) | 1 (6.7%) |
| Country of birth | | |
| Australia | 37 (74.1%) | 13 (86.7%) |
| Other | 7 (15.9%) | 2 (13.3%) |
| Tested for COVID-19 | | |
| Yes, of whom | 5 (11.4%) | 1 (6.7%) |
| Positive result | 0 | 0 |
| Negative result | 5 | 1 |
| No | 39 (88.2%) | 14 (93.3%) |
| Best describes your relationship to the woman | | |
| Partner | 34 (77.3%) | 10 (66.7%) |
| First child together | 20 | 7 |
| Previous child/ren together | 14 | 3 |
| Other support person (family, doula, etc.) - Previous experience supporting this woman during pregnancy and birth? | 10 (22.7%) | 5 (33.3%) |
| No | 4 | 1 |
| Yes | 4 | 3 |
| Other | 2 | 1 |
| Usually live together with the woman | | |
| Yes | 36 (81.8%) | 10 (66.7%) |
| No | 8 (18.2%) | 5 (33.3%) |
| The woman | 23 (52.3%) | 8 (53.3%) |
| Is currently pregnant | | |
| *Weeks' gestation: Mean, median (range)* | *27.2, 27 (13 – 38)* | *29.5, 29.5 (8-18)* |
| Has had the baby | 21 (47.7%) | 7 (46.7%) |
| *Baby age in weeks: Mean, median (range)* | *5, 3 (2–12)* | *6.6, 4 (2–12)* |
| The woman will give/gave birth at | | |
| Public hospital | 29 (65.9%) | 11 (73.3%) |
| Private hospital | 14 (31.8%) | 3 (20.0%) |
| Birth centre[c] | 0 (0%) | 1 (6.7%) |
| Home | 1 (2.3%) | 0 (0.0%) |

[a] Data are from participants' surveys which may have been completed up to four weeks before interviews.
[b] 1 missing value.
[c] Midwifery-led maternity care unit.

weight on . . . one occasion. So, I felt like there was potential for things to be missed or overlooked . . . (Partner, interview 8)

### 2.7.2. Sub-theme two—conflicting information and processes

Many partners and support persons spoke of the conflicting, and constantly changing, information and processes at maternity services whilst navigating care during the COVID-19 pandemic. The lack of clarity in guidelines and information presented by maternity care staff, reduced the perceived quality of care provided. One person said:

> The midwives and OBGYNs [obstetricians and gynaecologists] have been uninformed about what the rules and policies are in place at their hospital for the entire process. COVID-19 has exacerbated the poor level of care my partner and I have experienced. (Partner, survey 30)

Another participant shared similar sentiments, noting a lack of communication and knowledge amongst staff in their interactions:

> Lines of communication across the hospital, speed of information moving across the hospital, consistent information across the care providers, so you know all the staff that you deal with

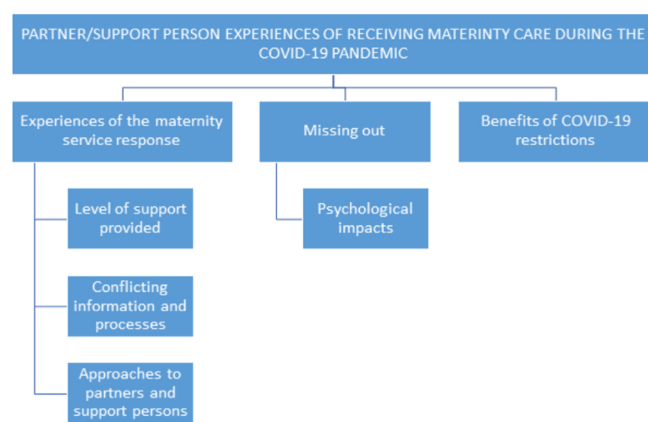


**Fig. 1.** Themes and subthemes: Partner and support person experiences of receiving maternity care during the COVID-19 pandemic in Australia.

should be on a fairly level playing field . . . Consistency of say when we were entering . . . the private hospital, every single time we went in there there's a different person on the front counter that's learning the protocols of what they want to do that day. (Partner, interview 3)

Many participants observed a considerable difference between different care providers, and this diminished the perceived quality of care.

The drop in care from hospital to council [postnatal maternal child health services] was noticeable. In addition, the level of distancing at the one council check-up my wife went to with our son seemed out of proportion to the hospital context. Twelve people were in the room during birth. The council midwife and my wife were never in the same room together for the check-up. In home care from hospital midwives was with masks and gloves in our living room. Granted, restrictions were changing through this time, but it seemed inconsistent between different providers of similar maternal care services. (Partner, survey 33)

*2.7.3. Sub-theme three—approaches to partners and support persons*

Participants described their experiences of interacting with maternity services. Many support persons (who were not intimate partners) spoke of making special requests to be present whilst the pregnant woman was receiving maternity care, and particularly during labour and birth. Doulas and parents of pregnant women spoke of writing letters and asking for exceptions, particularly for vulnerable pregnant women, however these requests were often dismissed, for example:

She [the pregnant woman I was supporting] was . . . quite nervous about not having me there . . . she wrote a lot of letters, I wrote letters to the Minister for Health, to our premier . . . to try and get special allowances you know. But it was to no avail. (Support person, interview 5)

Variable responses to partners and support people were reported in the maternity care setting; some participants reflected that they were not asked how they were feeling amidst receiving maternity care during the pandemic: *'It would have been nice [to be asked how I am] but like I said, I obviously realise I am not the focal point of the pregnancy, it's not about me and my job is much easier'* (Partner, interview 1). Others stated that their maternity care providers made an effort to consider them in their interactions, as one partner explained: *'When the midwife comes out she'll often ask me questions as well, as what I can do to support her [the woman] I guess. I've more understood that my role is very important in supporting her . . . '* (Partner, interview 13).

## *2.8. Theme two—missing out*

Partners and support persons expressed a sense of 'missing out' on various aspects of the pregnancy and maternity care experience as a result of the COVID-19 pandemic restrictions and changes in the way care was provided. A number of partners and support persons mentioned that not being able to attend maternity care appointments with the pregnant woman was a significant challenge for them. Consequently, they felt that they could not provide support and/or have an active involvement in the maternity care experience, like this partner wrote in the survey:

I was barred for close contact reasons in attending appointments with my wife and I do feel I have missed and will continue to miss almost all of the experience and knowledge that could be passed on to me to support her . . . I don't like that because of the situation I cannot be involved more. (Partner, survey 15)

The discontinuation of antenatal education was another common element of missing out for partners and support people, as exemplified here:

[I am] disappointed that we missed antenatal and BF [breastfeeding] classes, as a first time dad I was looking forward to these classes so I could be informed and have some sort of an idea of how to be a better support person to my wife during labour. Given the rough journey we've had, we felt a bit gypped [cheated] missing out on yet another part of a "normal" pregnancy. (Partner, survey 13)

A number of participants described that managing the care of other children further contributed to missing out on the maternity care experience. The maternity services did not allow siblings to attend, and other care arrangements were restricted by social distancing rules, leaving participants no choice but to stay at home to care for their children while the pregnant woman attended appointments alone. One person said:

Because before then . . . I could take him to child care . . . and I could come to the appointments, or we could . . . drop him at a friend's house and I could come, even to the scans, I missed out on, I saw the first scan . . . but not the rest. (Partner, interview 2)

The restrictions on the attendance of siblings to the maternity hospitals also contributed to the sense of missing out on a 'normal' post-birth experience. Siblings could not meet the baby until they were discharged from hospital, as explained here by a partner:

When we . . . picked him up from the hospital, he was a week old. I mean originally . . . we were very excited to bring the toddler to the hospital, he was going to be the first visitor to visit the new baby . . . we weren't able to do that unfortunately . . . (Partner, interview 6)

Doulas commonly experienced pregnant women having to choose between themselves and their partners to be the nominated support person. This left them having feelings of guilt about partners missing out on the labour and post birth experience.

I had another woman who decided to have me and not her husband there, which you know for me that made me feel a little bit uneasy . . . and uncomfortable . . . I kept thinking she's chosen me over her husband, and he's about to miss out on this vital moment of connection with his partner and seeing his child be born . . . seeing them take their first breath, seeing them be held skin to skin for the first time, having their first breastfeed, he's going to miss out on all of that afterwards, and you know witnessing that . . . (Support person, interview 14)

While this was a difficult choice for doulas to experience, they continued to offer their services as they understood how important this support was to women, particularly those with vulnerabilities. As one doula mentioned:

> I had two private clients that I supported as a doula, and they had partners, and they had to choose who they will take, and they chose to have a doula. We were supposed to be there probably all of us, but they felt like they require[d] more support in terms of labouring . . . because they both had complicated first births and wanted to lean on something more than just their husbands in terms of just getting through it. (Support person, interview 20)

Others struggled with being excluded due to attendance restrictions, before and after birth, for example this partner after his twin babies were born and placed in the neonatal intensive care unit:

> I think I felt quite detached to be honest . . . we had appointments . . . leading into before the birth . . . where I'd have to wait in the car . . . I was there, but I wasn't really there, if that makes sense . . . [After birth] once I left hospital – the only contact I got was a rundown at the end of the day as to how things are going, and a few happy snaps along the way. . . . So you get these little 10 second grabs of a child each day and that's kind of it. So it was kind of like they were real, but they weren't really real. So I think I lost a lot of that early bonding time. (Partner, interview 3)

One participant, whose partner gave birth to twins, felt left out of the process, and uninformed about what was happening during maternity care appointments. She said:

> It was more just me [not] feeling a part of the process and feeling you know like I'm involved in the decisions, and that they're my babies as well, and that I know what's happening and why it's happening, and I guess being that slightly higher risk pregnancy and birth as well, . . . I didn't really get any opportunity to ask any questions or anything. (Partner, interview 2)

Missing out on the expected maternity care experience, contributed to partners and support persons feeling isolated during pregnancy, birth and the postnatal period. A number of participants described that they did not feel like a part of the process or involved in decision making, *'I don't necessarily have a problem with not attending, but it certainly was quite isolating'* (Partner, interview 7).

Similarly, doulas felt they could not provide the support they were hired for and felt isolated from the maternity care team. They felt they were perceived as an option to the partner, rather than part of the birthing team, and this was a new experience for them and the women they supported.

> I think a lot of hospitals were exactly that, like very dismissive of partners and I think even in my line of work, I essentially felt very undervalued, and I know other doulas felt that way as well, you know we didn't feel like we were part of the team, when in reality, when we go in and support the birth you know, we're hired by the woman, we're contracted to the woman . . . (Support person, interview 14)

Often the maternity team showed surprise to find the doula there in place of the partner, as one doula mentioned, *'I think they were very surprised that I was there and not partner, so when the midwives were . . . coming [in] . . . they were mainly surprised that I'm staying there'* (Support person, interview 20).

#### *2.8.1. Sub-theme one—psychological impacts*

Participants described increased psychological distress during this time. Not being able to attend appointments and be part of maternity care discussions meant partners and support persons had limited or no knowledge of the maternity service and staff, and did not have the opportunity to familiarise themselves with the hospital environment prior to labour and birth. This increased anxiety for many partners and support persons, as one partner explained:

> Not being allowed at appointments has made me feel more anxious about attending labour and birth. I am unfamiliar with the hospital environment and the staff and am supposed to support my wife during labour in a completely unknown setting. (Partner, survey 26)

Some described the negative impact of not being able to be present immediately after birth:

> Being separated immediately from my wife and child after the birth was traumatizing and I believe an unnecessary event. It was detrimental to both my and my wife's mental health and impacted my ability to bond with my child. (Partner, survey 16)

The limited number of support persons allowed put additional pressure on partners/support persons as they were the only source of support for pregnant women, as described below:

> I think that maternity care practitioners should focus more on the mental health side of being a new Mum during a pandemic as the usual support networks aren't available at the moment. Husbands/partners can only provide so much comfort on their own. (Partner, survey 5)

Participants described feeling unsupported and the negative impacts of their psychological distress on their relationships and families, as noted here:

> I'm trying to keep a brave face, but I feel like I'm falling apart, and no one gives a damn. Our two-year-old son is getting on the nerves of our current short fuses, as we are arguing a lot more at the moment. (Partner, survey 34)

### *2.9. Theme three—benefits of COVID-19 restrictions*

Participants noted a number of benefits of the restrictions put in place. A number of partners and support persons valued the increased hygiene measures at maternity care services, *'the temperature checks, handrubbing/hand washing, social distancing, minimising visitors and virtual obstetrician appointments are all measures that should remain for the longer term'* (Partner, survey 21). The restrictions on the number of visitors in maternity wards were also seen as a benefit, as parents had adequate time to rest and bond with their babies, *'being isolated in hospital gave us time to bond with our baby and adjust to the challenges of becoming new parents. More than we would've had under normal circumstances'* (Partner, survey 6). Similarly, changes in work patterns, and the requirement to work from home during the pandemic, was also beneficial in providing opportunities for additional support during and after pregnancy.

> I guess that's one of the benefits of COVID-19 that a lot of people have been at home and you're . . . forced to, I shouldn't say get to know each other . . . she has more of an understanding [of] what I do and then if she needs something I can help her . . . (Partner, interview 13)

Partners spoke of bonding time with their newborns and other children as an additional positive aspect of working from home:

> Karly [pseudonym] early on struggled, she was up often, milk not coming in, him not latching, that sort of stuff. So, it was nice for me just to kind of take him [the baby] and kind of give him lots of love and that sort of stuff while Karly was . . . working through all that . . . So that was a real positive too. (Partner, interview 12)

## 3. Discussion

The findings of this study showed that during the first wave of the COVID-19 pandemic in Australia, partners and support persons of pregnant women and those who had recently given birth experienced a sense of" missing out" from the pregnancy and maternity care experience. This can be ascribed to the changes in the provision of care and physical distancing measures put in place during the pandemic. Partners and support persons also reported feelings of isolation and psychological distress, and reduced bonding time with babies. Conflicting information and processes within and across maternity services contributed to heightened uncertainty and a perceived reduction in the quality of care. While partners and support persons had limited access to postnatal wards as a result of visitor restrictions, they also perceived these restrictions to be of benefit, as women had greater time to rest and bond with babies.

The Australian Midwife Standards for Practice state that a midwife's scope of practice includes providing care for women's partners and other support persons [10]. The Australian National Men's Health Strategy 2020–2030 recommends expanding the maternal and child health infrastructure to include fathers [30]. Thus, prior to the COVID-19 pandemic, it was increasingly being recognised that inclusion of partners and other support persons in health services before and after childbirth is best-practice. Midwives report that when fathers and other support people are involved in health care episodes, this has benefits for women and infants [31,32]. This is supported by evidence of improved maternal, paternal, and infant health outcomes when women's partners are engaged in pregnancy, birth, and postnatal health services [21,22].

The provision of maternity care in Australia has been challenged by the rapidly evolving COVID-19 pandemic. Early reports have suggested that the changes have had a profound impact on pregnant women [33], however, very little is known about the effects on those supporting them. To our knowledge, this is the first study to examine the experiences of partners and support persons of women receiving maternity care during the COVID-19 pandemic in Australia.

The findings of our study highlight that restrictions placed on partners and support persons in Australian maternity services impacted their maternity care and pregnancy experience. Even prior to the pandemic, partners reported that they often felt marginalised, overlooked and excluded from the maternity care experience [24,34,35]. Similar experiences have been reported by non-biological mothers in same-sex relationships [25,36]. Our study shows that the COVID-19 restrictions potentially exacerbated partners' experience of "mother-centric" health services. Partners and support persons reported that they were often not permitted to even attend episodes of care, and thus would not even have had the opportunity to listen to conversations and decisions about maternal and infant care, let alone participate in these.

Participants in our study also experienced feelings of isolation and heightened psychological distress. It is not possible to speculate whether these experiences are more severe than, or different to, experiences of partners or support persons in non-pandemic circumstances. However, in usual circumstances when restrictions on partner or support person attendance are not in place, routine antenatal and postnatal care provides unique opportunities to engage partners in health services [25,37] at a time when they would not usually seek help for themselves [38]. This allows health professionals to briefly "check in" to assess the mental health and wellbeing of partners and support persons and refer them for further assessment or assistance if required. When partners and support persons are not in attendance, this opportunity does not exist. If depression and anxiety symptoms are present among partners and support persons, these will not be picked up and these symptoms can potentially escalate to mental health disorders. Paternal depression and anxiety can have significant negative impacts on the mental health of pregnant women or new mothers [39], and on the subsequent cognitive, emotional, and social development of children [40].

Another experience reported by participants who were partners in our study, was anxiety about not being able to be present for extended periods to bond with their babies or provide their partners adequate support after birth. It is not possible to compare these experiences to those of partners and support people before the COVID-19 pandemic; however, international observations of reduced partner involvement in maternity care during both SARS and COVID-19 have been accompanied by concerns regarding the impact of restrictions on bonding and long term attachment with their newborn babies [15,17].

Doulas and support persons, as key pregnancy and birthing partners for some women, echoed these feelings of isolation, as they were not able to conduct the services or provide support they would have ordinarily provided. The long-term effects of this are unknown. Doulas were faced with feelings of guilt when women chose them as a primary support person, rather than their partners. Despite this discomfort, doulas continued to support women who made this choice, and especially prioritised the needs of those who were vulnerable. Studies have shown that women with prior traumatic experiences (both psychosocial and birthing related) are more likely to develop mental health problems [41]. For these reasons, women often elect to have the additional support of a doula or other companion to help them navigate the maternity care system, pregnancy and birthing experience [19]. It is possible that restricting additional support is potentially damaging to women, their babies, and the support person themselves, warranting further investigation.

The participants had variable experiences of the altered provision of maternity care as a result of the pandemic. Some felt actively included in antenatal appointments, even though they could not physically attend. In these instances, maternity care staff made special efforts to facilitate interaction via video and telephone calls. Other studies have also found benefits of providing maternity care using telehealth during the pandemic [42]; however including partners and support people within these interactions is necessary, and ensuring it is the most appropriate means for providing care under the circumstances is paramount. Including partners and support people within maternity care interactions has the potential to enhance the support of pregnant women in circumstances when their ordinary support networks cannot be accessed. Providing pregnancy education and information to partners and support persons of pregnant women, positions them to be valuable sources of support, and can facilitate their personal sense of connection with the pregnancy and newborn baby.

For the majority, a perceived reduction in the quality of care was noted, as face-to-face appointments were no longer occurring in settings where physical assessments usually take place, such as antenatal appointments, breastfeeding support, and reviewing the growth and development of the baby. Perceptions of quality of care provided may have been impacted by conflicting and constantly changing information and processes within and across maternity services, which was repeatedly mentioned by study participants. This can make it difficult for pregnant women and support persons to determine the trustworthiness of information. A large international study [43] of maternity care providers illustrated the challenges of informing and educating staff about changes in guidelines and care protocols for women with and without COVID-19. Moving forward, consistent guidelines need to be presented to maternity service staff for effective translation to women and their

support persons; however, it is acknowledged that this is challenging when government health advice is constantly changing. How participants experienced the changing guidelines may also have been impacted by the stage at which they were at in terms of their pregnancy, birth or postnatal experience. Some participants were impacted by the restrictions only postnatally, while others had experienced the effects through antenatal care and birth. The differential effects on experiences needs to be considered, nonetheless it is apparent that the changing guidelines and restrictions in relation to partners and support persons had an impact across the pregnancy and postnatal experience as represented by the range of participant narratives.

While there were many challenges of being a partner or a support person of a woman receiving maternity care during the pandemic, a number of benefits of the COVID-19 restrictions were noted. Partners and support persons valued the increased hygiene measures and limited visitors on wards, which encouraged rest and bonding time for the women and babies. Furthermore, participants expressed that working from home allowed them greater opportunity to provide support to their partners during pregnancy and offered more time to bond with their babies once they were home from hospital.

## 4. Strengths and limitations

The study highlights the unique experiences of receiving maternity care from the perspective of partners and support persons of pregnant women during the COVID-19 pandemic. It was strengthened by its national reach with respondents from most states and territories in Australia. The research was however limited by the online recruitment and convenience sampling approaches; therefore, the sample may not be representative of the experiences of all partners and support persons. The online interview format may also be considered a limitation, however this was conducted in the context of the physical distancing protocols mandated by the Australian government at the time, and was the only method available to reach participants from different states and territories. This approach may have also strengthened the study by broadening accessibility to participants due to greater convenience in participation. Combining the qualitative survey and interview data strengthened the themes and conclusions drawn from the study. The interviews, in particular, added greater depth and richness to the data set.

## 5. Conclusion

The findings of this study highlight that partners and support persons were negatively impacted by restrictions posed in maternity services as a result of the COVID-19 pandemic. Under pre-pandemic circumstances, research suggests that partners feel excluded from the maternity experience, and practice changes during the pandemic may have exacerbated this exclusion. The sense of missing out was particularly prominent in settings where partners and support people were not actively included in the provision of maternity care. There were, however, instances where care was adapted to include partners and support people, and this was received positively. As Australian midwife practice standards stipulate that the midwife's role encompasses the care of the woman, baby and her chosen support persons, strategies to maintain inclusive practice in the context of physical distancing measures are needed. Involving partners and support persons in maternity care discussions, asking about their own wellbeing and encouraging their attendance in video and telehealth appointments are some ways of achieving this. The risks and benefits of face-to-face versus virtual appointments, should also be considered; while each has risks, in the long term, carrying out virtual consultations instead of physical assessment may have negative impacts in some circumstances. This change in care provision warrants further research. Moving beyond the pandemic, maternity services may consider maintaining increased hygiene measures and limiting visitors (other than partners or women's chosen support persons) on postnatal wards to improve the health and wellbeing of women, support persons and babies.

## 6. Conflict of interest

Caroline Homer and Linda Sweet, as Editor in Chief and Deputy Editor of Women and Birth declare a conflict of interest in relation to this paper.

## 7. Author contributions

Vidanka Vasilevski: Conceptualisation, Methodology, Formal Analysis, Writing-Original draft preparation. Karen Wynter: Conceptualisation, Methodology, Formal Analysis, Writing-Original draft preparation. Linda Sweet.: Conceptualisation, Methodology, Writing- Reviewing and Editing. Zoe Bradfield.: Conceptualisation, Methodology, Writing- Reviewing and Editing. Alyce N Wilson.:

Conceptualisation, Methodology, Writing- Reviewing and Editing. Yvonne Hauck.: Conceptualisation, Methodology, Writing-Reviewing and Editing. Lesley Kuliukas.: Conceptualisation, Methodology, Writing- Reviewing and Editing. Caroline SE Homer.: Conceptualisation, Methodology, Writing-Reviewing and Editing. Rebecca A Szabo.: Conceptualisation, Methodology, Writing-Reviewing and Editing.

## 8. Author agreement

The article is the authors original work and had not received prior publication or under consideration for publication elsewhere. All the authors have seen and approved the submitted manuscript. The authors abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

## 9. Ethical statement

Please accept this as confirmation that the 'Experiences of Receiving or Providing Maternity Care during the CoVID-19 Pandemic Study' obtained ethical approval from the Curtin University Human Research Ethics Committee, approval number (HRE2020-0210), dated 07/05/2020.

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