What to Expect When Expecting? Experiences of Pregnant Women in Serbia during the COVID-19 Pandemic and State of Emergency

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Abstract: The aim of this paper is to shed light on the experiences of non-infected pregnant women in Serbia during the COVID-19 pandemic and the state of emergency by applying a qualitative research method. The present analysis examines four aspects of being pregnant during the COVID-19 pandemic and the state of emergency: (a) pregnant women's health and health care; (b) preparation for childbirth and the arrival of a new family member; (c) working while pregnant during the pandemic; and (d) the family atmosphere and family practices. The results show that the coronavirus pandemic affected pregnant women both psychologically and socially. The following conditions had a negative impact on pregnant women: (a) worrying about both their own health and the health of their baby; (b) a significant reduction in the level and quality of health-care support; (c) a decrease in 'external' parental support as a result of the need to socially isolate; (d) difficulties in managing their professional and family obligations; (e) missing their regular pre-pandemic activities; and (f) a decrease in total family income as a result of changes to employment conditions during the pandemic. Respondents who experienced pregnancy positively had high levels of marital adjustment and a stable family income and enjoyed spending more time with their husband and children during the pandemic.
Keywords: COVID-19 pandemic, state of emergency, pregnancy

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The COVID-19 pandemic was a major health crisis that affected both the physical and mental well-being of people worldwide. Numerous studies have revealed the

state of confusion, uncertainty, fear, and anxiety among the general population that was predominantly caused by overwhelming reports of increasing numbers of severe cases and deaths, the loss of medical staff, the shortage of essential medical and hygiene equipment, and the failure of many proposed treatments (Usher, Bhullar, Jackson 2020; Erdam, Lucey 2020; Ranney, Grieffeth, Jha 2020; Di Mascio et al. 2020). Emerging evidence suggests that the abovementioned concerns were greater among pregnant women (Chivers et al. 2020; Preis et al. 2020; Saccone et al. 2020; Aydin, Aktas 2021; Sahin, Kabakci 2021; Corbett et al. 2020; Mortazavi, Ghardashi 2021). Due to the COVID-19 pandemic, 'pregnancy and childbirth for women are taking place in utterly new and unusual circumstances' (Mortazavi, Ghardashi 2021: 193). Multiple studies (Mappa, Distefano, Rizzo 2020; Preis et al. 2020; Milne et al. 2020; Aydin, Aktas 2021; Chivers et al. 2020; Juan et al. 2020) have reported that pregnant women encountered various difficulties including disruptions in routine prenatal care. Specifically, prenatal care services were put on hold, with assistance exclusively provided to pregnant women at risk. In some countries, pregnant women only received medical care during childbirth, followed by an early hospital discharge (Aydin, Akta 2021). Pregnant women also reported disruptions in their daily lives (reduced daily routines and social interactions), feelings of frustration, helplessness, mistrust, and uncertainty about the new disease, a lack of social support, and economic difficulties (Sahin, Kabakci 2021; Chivers et al. 2020; Saccone et al. 2020; Preis et al. 2020; Mappa, Distefano, Rizzo 2020). According to certain studies, stress and depression levels in pregnant women increased during the pandemic (Ayaz et al. 2020; Zilver et al. 2020). Similar responses and negative outcomes were also reported in pregnant women during previous health crises such as the H1N1 pandemic, the Zika virus epidemic, and the Ebola epidemic (Mortazavi, Ghardashi 2021).

The first COVID-19 patient in Serbia was recorded on 06.03.2020. (COVID-19.rs). Nine days later, the Serbian government declared a state of emergency (Sl. glasnik RS, 2020) which brought major changes to citizens' everyday life: a ban on indoor public gatherings, the closure of borders, mandatory lockdowns, working and schooling from home, suspension of public transport, etc. (Čikić, Bilinović Rajačić 2020; Ristić, Pajvančić Cizelj, Čikić 2020; Čikić, Bilinović Rajačić 2021; Pešić 2020). The rigid and restrictive measures lasted for two months (Ristić, Pajvančić Cizelj, Čikić 2020). In the first wave of the pandemic, the national government 'tried to centralize information about the epidemic', which briefly disabled independent journalism and the civil right to (free) information (Kleut, Šinković 2020: 506). Also, trust in journalists was very low (Ristić, Pajvančić Cizelj, Čikić 2020). The intention to control information did not prevent circulation of often contradictory and unverified information, which caused additional stress among the population (Čikić, Bilinović Rajačić 2020).

Since the pandemic outbreak, (inter)national discussions in the field of obstetrics have mostly centred on pregnancy complications in infected women and the probability of mother-to-foetus transmission (Di Mascio et al. 2020; Zaigham, Andersson 2020; Banašević 2022; Trifunović Kubat et al. 2022; Mihajlović et al. 2022). Only a limited number of studies have investigated experiences and perceptions of COVID-19 among non-infected pregnant women (Ravaldi et al. 2020; Aydin, Aktas 2021; Mortazavi, Ghardashi 2021; Sahin, Kabakci 2021; Karavadra et al. 2020). As far as the authors know, there are no similar studies of the issue in Serbia. The purpose of this study is to fill the gap in the existing literature on this subject by shedding light on the lived experiences of pregnant women during the COVID-19 pandemic. We aimed to analyse the way women who were already pregnant at the beginning of the pandemic experienced and coped with the increased risk during first few months of the pandemic. The study focuses primarily on concerns regarding their health and upcoming childbirth, but also family economics, their professional status and parenting. We believe that a deeper understanding of women's experiences of pregnancy during the COVID-19 pandemic is essential for providing adequate support during present and future health crises.

Methods

Research on pregnancy experiences during the COVID-19 pandemic was done as part of a larger study on family life in Serbia under the first wave of the pandemic as viewed from the female perspective (reference). Owing to the restrictive social conditions (lock-downs, the WHO's and the national Ministry of Health's recommendation of physical distancing) and the complexity of the research subject, we applied a mixed, qualitatively driven concurrent research design (Creswell, Plano Clark 2018; Schoonenboom, Burke Johnson 2017) that combined semi-structured interviews (main themes, open-ended questions, in-depth insight, relaxed tone) with an online survey (free access, participant-friendly, enough time to answer, closed-ended questions, simple communication between researchers and participants). Also, decisions on the research design were made bearing in mind the basic assumption of the feminist research approach (Payne, Payne 2004) aiming to highlight: (a) women's experiences of the novel social situation, (b) the specifics of their roles under pandemic circumstances, and (c) gendered relations with other social agents under the state of increased and multiple risks.

We defined a list of 45 predominantly open-ended questions on seven aspects of family life during the pandemic: (a) personal experience of the pandemic, b) managing professional and family duties, (c) everyday family life and family atmosphere, (d) parenting, (e) intergenerational solidarity, (f) intimate relations, and (g) pregnancy. Data were collected at the very beginning of the COVID-19 pandemic (March – April

2020) via Facebook and email. That period was particularly interesting as it was marked by numerous individual and collective uncertainties about the nature of the risks generated by the pandemic.

The restrictive social conditions mentioned above precluded random sampling. We therefore applied voluntary response sampling and snowball sampling. The criteria for selecting respondents were legal age and Serbian residency. All respondents were informed about the research content and aim and agreed to participate voluntarily in the research. Since our research was focused on the general female perspective of family life in Serbia during the pandemic, the total sample comprised of 265 female respondents, both pregnant and non-pregnant. This paper focuses on the responses of pregnant women (7.1% of the total sample or 19 respondents). Even though the number of pregnant respondents was small, the data saturation point was reached.

Table 1: Pregnant women – sample characteristics

Distributed by	**Category**	**%**
Age	18–29	36.8
	30–39	63.2
Employment status	Employed	78.9
	Unemployed	21.1
Marriage status	Married	78.9
	Cohabitating	21.1
Family type	Nuclear family	36.8
	Extended family	10.5
	DINK* family	52.6
Members of the household	One	0.0
	Two	52.6
	Three	26.3
	Four	15.8
	Five or more	5.3
Number of children	No children	52.6
	One child	36.8
	Two children	10.5

*DINK – Double income, no kids

Source: Research data (authors' calculations).

The average age of the pregnant women in our sample was 31.3 years. The majority of respondents were employed and married. Half of the respondents were going through their first pregnancy.

The collected data were processed using content analysis. This allowed for the identification of repetitive patterns but also of the specifics of family practices in the pregnant women's narratives. No software was used for the qualitative data processing. Additionally, basic descriptive statistics were applied to show the main characteristics of the sample and some quantitative aspects of the collected data.

Results

Our analysis encompassed four aspects of being pregnant during the COVID-19 pandemic and the state of emergency: (a) pregnant women's health and health care during the pandemic and the state of emergency, (b) preparation for childbirth and the arrival of a new family member, (c) working while pregnant during the pandemic, and (d) the family atmosphere and family practices.

Pregnant women's health and health care during the pandemic and the state of emergency

Most of the pregnant women reported regular pregnancies (73.7%) – their physical health was good, and they received no therapy other than taking the usual supplements – vitamins (B6, B9, D, and E) and minerals (Fe, Zn, Ca, and Mg):

> *I am 31 weeks pregnant. This is my second pregnancy… I feel much better now, compared to carrying my first child. I only take vitamins; I take no other therapy.* (35 y./31 w.p.[1]).

By contrast, five women reported having a pregnancy-related medical condition that required special medical treatment (e.g. hormonal therapy, hypothyroidism treatment, and therapy for preventing and slowing down labour/contractions):

> *This is my first pregnancy; I am 20 weeks pregnant. I have to take hormonal therapy. It's stressful, I feel pretty weak, but try not to be too dramatic about it.* (33 y./20 w.p.)

The results revealed three major types of experiential responses to the first wave

[1] Age of the respondent / weeks of pregnancy.

of the pandemic among pregnant women. The first response type was identified among the pregnant women in our sample who said they felt calm and tried not to overreact (36.8%). They found different ways to cope with the novel circumstances. Some of them were proactive and took additional precautionary measures, while others embraced a more passive routine while adjusting to new risks:

Before the state of emergency was introduced, we cancelled our trip. We also informed the rest of the family that we were not going to visit them, with everyone's safety in mind. We stocked up on food supplies and stayed informed via media. (33 y./10 w.p.)

I was pretty calm. The introduction of the state of emergency was quite reassuring; it seemed to be the safest solution. (33 y./37 w.p.)

The second response to the pandemic was the most common one among the pregnant women (52.6%): they said they experienced high stress levels, sometimes accompanied by a state of panic. Those women were terrified of the various risks and uncertainties associated with the pandemic:

I got really scared. I tried to get all the information I could. (33 y./24 w.p.)

The last type of response was characteristic of women who experienced a specific progression of emotional responses to the new situation (two respondents) – namely, a state of disbelief was followed by fear and worry. At first, those women were not convinced that the virus posed a serious health threat. With increasing numbers of COVID-19 cases and deaths across the nation and worldwide, accompanied by numerous restrictive policy measures, their stress levels rose:

At first, as with all the things that are happening far away from us, I didn't take it seriously, especially because it was a virus [an invisible enemy]. But soon enough, after the first cases were identified in our country, I changed my opinion. I got really frightened. (25 y./38 w.p.)

Regardless of their reaction to the new situation, almost all the pregnant women reported wishing to return to their regular daily pre-pandemic activities, such as walks, going to the market, and seeing relatives and friends. They further stated they missed having time for themselves and feeling safe, free, and relaxed:

I miss going out to feel the sunshine, because I have been in self-isolation for almost a month. I miss hugging my husband, taking my dog for a walk.

(33 y./20 w.p.)
I miss not thinking about whether I have touched something or somebody contagious. (25 y./38 w.p.)

I miss not being worried about my parents' health. (31 y./23 w.p.)

Despite being stressed and worried, all the pregnant women managed to see some positive aspects of the pandemic. Mainly, they enjoyed spending more time with their husband/partner and children or having more time for their hobbies. Some women emphasised the positive consequences in the larger context:

I spend more time with my husband and kids… Now we do things together that we weren't able to do before. (39 y./15 w.p.)

I have finally managed to read several books that had been on my to-read list for a long time. (33 y./20 w.p.)

Nature is renewing itself. (29 y./33 w.p.)

People have relatively changed their priorities for the better. (33 y./10 w.p.)

The pandemic brought about changes in the everyday routines of most pregnant women (94.7%). For some, those changes were minor, while for others, they were quite radical:

There are no major changes, I just adhere to the standard precautionary measures (25 y./38 w.p.)

I haven't left the house in a month! (33 y./20 w.p.)

Imposed mobility restrictions and the personal fear of infection:

a) reduced the pregnant women's daily walking routines *(Before the pandemic, I used to go for a walk more often.* 33 y./37 w.p.),
b) prevented them from going to trainings and the pregnancy school *(I don't go to pregnancy classes anymore; I attend them online. Before the pandemic, I had planned to go to yoga classes for pregnant women, but now it's off. I have registered for online yoga classes, but it's not the same.* 29 y./22 w.p.),
c) prevented them from preparing for the baby's arrival *(I can't go shopping for*

my baby! 33 y./37 w.p.) or
d) forced them to leave their jobs earlier than they had planned *(I don't go to work anymore. I started my maternity leave two months earlier than I planned.* (33 y./24 w.p.).

The pandemic altered the way the national (especially public) health-care system was functioning. Doctors, regardless of their specialty, and nurses employed in the public health sector were transferred to COVID hospitals or COVID health-care units, often without asking them if they wished to be transferred and only by verbal order (Mijatović, Đokić, Dimitrijević 2022: 51, 53). The transformation of the hospitals into COVID-19 facilities 'prevented hospital treatment of non-COVID patients and thus contributed to the reduction of the scope and content of health services' (Vuković et al. 2022: 88). During the first wave of the pandemic, 'all non-essential health procedures (including diagnostic or treatment, as well as elective surgeries), were temporarily suspended' (UN Serbia – UNDP 2020: 20).

All the above-mentioned resulted in modifications in visits to the obstetrician (further: OB) as a regular part of antenatal care. The pregnant women reported two main types of experiences when visiting their OBs after the pandemic outbreak. The first type of experience was positive (50%) – women reported receiving fully professional treatment (as usual):

I went to see the doctor when I was 29 weeks pregnant, and I was really satisfied with how things were done. When entering the polyclinic, I disinfected myself and got plastic covers for my shoes; everyone wore masks and there were no other patients, even though the clinic is large [private clinic – A.N.].
(35 y. /31 w.p.)

The other half of respondents had negative experiences because:

a) their appointments were cancelled (*My regular check-up was cancelled and now I cannot schedule an appointment for an expert ultrasound anywhere else. My doctor is great, but like most of them she's been mobilised* [to the COVID clinic – A.N.] *because of the state of emergency.* 33 y./20 w.p.)
b) they were unable to reach their OBs or had to visit another doctor/clinic (*My check-up was cancelled. The private clinic is closed, and my OB now works in a state hospital. I don't know how to contact him. I had to go to a check-up to another private clinic because I experienced severe pain.* 26 y./31 w.p.)
c) the atmosphere in the hospital was chaotic (*I went to a state hospital to start my maternity leave. The organisation of work is quite variable and often*

inconsistent. Due to changes in the pandemic situation, they often change their working hours and procedures… This negatively affects my sense of security. 36 y./27 w.p.)

d) their non-pregnancy-related health status (*No doctor or hospital is allowed to have me for a check-up because I'm in self-isolation*. 31 y./31 w.p.)

Such experiences were disturbing and caused the pregnant women to feel vulnerable.

The pregnant women reported both positive and negative experiences in public and private health-care sectors. Regardless of the reported type of experience, the narratives featured a strong sense of insecurity about (future) medical care during pregnancy. Only three women stated that they were confident about the way the health-care system worked:

I have to have faith in the doctors and the health-care system; I have no choice but to do so. (35 y./31 w.p.)

Conversely, a majority (84.2%) reported having no faith in the health-care system. Most of the pregnant women were scared of having a baby during the pandemic/state of emergency. Their fear was induced by both the general risks associated with a COVID-19 infection and thre risks associated with the state of the national health-care system (understaffed, inadequate hospital infrastructure, lack of hygiene, poor quality of hospital food, lack of support for new mothers, maltreatment during labour):

My greatest fear is an overcrowded maternity ward because currently in Belgrade only two maternity hospitals are working. I fear that I am not going to receive proper medical treatment. (28 y./35 w.p.)

Interestingly, some women stated they had faith in their OBs, but their opinion on the ability of the health-care system to perform under challenging circumstances was explicitly negative:

I trust my doctor, but hospital conditions are dreadful, it's a complete chaos! (25 y./38 w.p.)

They were mainly afraid of inconsistency in standard hospital procedures and the lack of availability of health-care staff. They were further afraid of not knowing the procedures applied if a mother or baby tested positive for COVID-19. Lastly, they emphasised they were particularly uncomfortable with the fact that, due to the protective measures, their partner was not allowed to attend check-ups or be present

at the labour.

Preparation for childbirth and the arrival of a new family member

One of the crucial parts of being pregnant is getting ready for the baby's arrival. This encompasses not just preparation for the parental role but also acquiring all the necessities for childbirth and the arrival of a baby. The new circumstances (e.g. closed shops, mobility restrictions, and increased health risks) potentially impacted previously established preparation routines.

Three types of preparation routines were identified among the pregnant women. The first routine type entailed already completed preparations – one in four of the pregnant women reported being fully prepared for having a baby. Some of them prepared everything they were going to need for childbirth and the baby by themselves (e.g. clothes, cosmetics, and furniture), while others had help from their partners, family, or friends:

I've bought all the necessities. My friends and family will also get me baby clothes and equipment. (33 y./37 w.p.)

*I've prepared 90% of the things I am going to need. I had a kind of a clairvoyant moment – I saw this sh*t coming and I just felt that I had to be prepared. I bought everything I'll need a month ago.* (26 y./31 w.p.)

I've bought almost everything; I panicked at the very beginning of the lockdown, so I sent my husband shopping; he also went to the attic and got all the things we saved from the first baby; now we have almost everything prepared… (35 y./31 w.p.).

The second routine was the most common one among respondents (52.6%) – it indicated being partially prepared, but not stressing over it. Women in this category were mainly in early pregnancy, emphasising that they had plenty of time left. Despite the circumstances, they had no doubt that they would be able to get everything they needed for the baby:

I am not prepared. I can buy everything I need for me and the baby in a pharmacy or online. I'll manage! (25 y./38 w.p.)

The last type of routine was identified among pregnant women who were partially prepared or completely unprepared and who found their incomplete preparations to be a major stressor (one-fifth of all respondents):

I haven't prepared at all, and it really stresses me out. To be honest, I don't have to rush but I would feel much more relaxed if I had some basic things for the baby. It really bothers me that I cannot go shopping. I was really looking forward to it. (33 y./20 w.p.)

Additionally, in contemporary societies, preparation for childbirth and the baby's arrival includes taking part in various parental trainings. Seven out of 19 respondents stated that they did not attend any kind of pregnancy school or training, mainly due to the fact they were in the first or second trimester:

I haven't gone to a pregnancy school yet. It's too early for that. (33 y./10 w.p.)

Others took part in both online and *in vivo* classes, but also exercised at home by themselves:

I go to prenatal yoga classes … We don't have online classes, but our instructor and some of us moms have started a FB group for exchanging exercising ideas. I am the one who usually initiates things ... I really miss exercising in a group. I do exercise at home, alone, but it is not the same. (35 y./31 w.p.)

Working while pregnant during the pandemic

The pandemic and the state of emergency caused several changes in the work sphere (e.g. working from home, not working at all, working in shifts, etc.). Two-thirds of the employed pregnant women were on prenatal leave. Others were not on prenatal leave because they were still in early pregnancy or because they were still working or because of their illegal position on the labour market:

My employer didn't register me; I worked as an illegal worker. (25 y./38 w.p.)

One-third of the employed pregnant women worked from home in different arrangements:

I don't go to work. I work from home. I work on weekends, because my husband works during the week while I take care of the kid and housework. On weekends, I reply to emails, grade students' papers, etc. It usually takes 3–4 hours. (35y./31 w.p.)
I work from home, attend online meetings, etc. My colleagues also work from home. The meetings are surprisingly efficient. The main problem is having a full

house and children who cannot be left alone for hours. (33 y./24 w.p.)
My online lessons and video-calls are all planned. I find some suitable spot and don't move until I finish all my tasks. My employer is more demanding than usual. He controls us on daily basis. I have no complaints because everything functions well, as far as my lessons are concerned. Still, it is harder than usual because we have more paperwork to do, on top of our regular duties. (29 y./20 w.p.)

The majority of the women reported having difficulties in managing their professional and family duties. This was particularly true for the pregnant women who already had children. The results indicated several reasons for an increased work-family conflict:

a) the absence of pre-pandemic 'external' support for parents (e.g. grandparents, kindergartens, and schools) (*It's hard for me to manage work and family duties because I spend most of the day taking care of the kid and our home. Before the pandemic and the state of emergency, my son was in kindergarten and my parents used to come over to look after him when needed, so I had more spare time to do all the things I had to or wanted to.* 35 y./31 w.p.)
b) having more household duties compared to the pre-pandemic period (*I am constantly terrified that we are going to starve and not be taken care of … I am constantly tidying up, cleaning, disinfecting.* 26 y./31 w.p.)
c) more challenging professional duties (*It really bothers me that I don't have the adequate technical infrastructure for performing my professional duties the way I perform them in a regular situation. I also don't have my own peace and quiet to focus on work.* 39 y./15 w.p.).

Women who were on a prenatal leave mainly had positive experiences regarding employers' reactions to them being pregnant during the pandemic. They stated that their employers supported their decision to go on a prenatal leave; they also received their prenatal leave fee regularly:

I started my maternity leave after the state of emergency was declared. My employer is ok with that, everything's running smoothly. (36 y./27 w.p.)

Modified work arrangements, not only for the pregnant women but for their partner as well, potentially impacted their family finances. Altogether 47.4% of women described their pre-pandemic family budgets as sufficient to cover all the ongoing family needs, even mentioning the possibility to leave some money aside.

Since the research was conducted in the early stages of the pandemic, it was expected that respondents would experience only minor changes in the total family income.[2] Other women reported a significant decrease in the total family income:

My husband is on forced leave, which means that he only gets 70% of his regular wage (27 y./28 w.p.)

I stopped giving kids lessons in chemistry and physics, so I have no income at all. My boyfriend's wages are the same. (29 y./22 w.p.)

The family atmosphere and family practices during the pandemic and the state of emergency

The majority of the pregnant women (63.2%) reported a mainly positive family atmosphere in the new situation. One in four of the women stated that the prevailing mood was negative and the atmosphere was intense, whereas 10.1% of respondents described their family atmosphere as fluctuating.

The pregnant women and their family members had different experiences with adjusting to the novel circumstances. Many women faced small but negative changes in their usual family practices and dynamics (42.1%). They reported feeling more worried and nervous than usual due to the various risks associated with the pandemic (e.g. health risks and economic risks). This caused family members to be less patient with one another:

We are sadder and more nervous in anticipation of what will happen after the pandemic. (29 y./33 w.p.)

Pregnant women who experienced changes for the better (31.6%) often reported spending more time together as a family, which enriched their family atmosphere, making it warmer and cosier than usual:

The atmosphere is great! We spend lots of time together and I have more time for myself. The biggest change is the possibility to organise the day the way I like it. (30 y./20 w.p.)

One in four of the women described their family atmosphere as being very similar

[2] 63.2% of participants stated that there were no substantial changes in their income or their partner's income during the first month of the pandemic and the state of emergency:
We are both getting paid, as usual… The pandemic didn't impact our total income; good organisation is the key! (29 y./33 w.p.).

to the atmosphere before the pandemic:

Nothing's changed between us. We love each other and fight like there is no pandemic or state of emergency. (29 y./22 w.p.)

For the majority (63.1%), sustaining previously established, pre-pandemic family practices was crucial for maintaining a positive family atmosphere and adapting to the new situation. Respondents stated that pre-existing family practices gave them a sense of security and certainty – boosting their sense of control over the situation. However, the novel circumstances resulted in some alterations to regular family practices:

We try not to stray too much from our usual way of functioning, but some things are certainly different. (36 y./27 w.p.)

A total of 95% of the respondents stated that their family practices included in engaging in joint activities (e.g. playing board games, preparing meals, and watching movies). Such activities had been practised before as well as during the pandemic and the state of emergency; however, the new conditions increased their frequency:

We prepare meals together – I cook, he chops and does the dishes. We play Yahtzee, cards, Monopoly … we did all those things together before the pandemic, but less often. Now we have more spare time and enthusiasm. (30 y./20 w.p.)

Almost all the women (95%) reported having great support from their husbands. For some, this was a regular practice in the family, while for others it was a result of both being pregnant and the novel social situation:

He supports me with all his heart, like before. He takes care of me so I don't exert myself, suggests that I should rest. He takes care of the kid, always asks me how I am, what I need or what I want. (33 y./10 w.p.)

He helps me out a lot. But the main thing that has changed is him being home, which soothes me emotionally and mentally. (25 y./38 w.p.)

Half of the pregnant women explicitly stated that during the first wave of the pandemic, their relations with their partner improved. The main reasons for improvement were spending more time together than usual and having new issues

to talk about:

We now have new issues to talk about or talk about some things we hadn't had the time to discuss before. And that small change is certainly for the better. (33 y./20 w.p.)

For 42%, relations were unchanged, while only one woman stated she wished she had more support from her husband:

I wish we were closer now. His support would mean the world to me, a hug or a bit of tenderness, but those things are mainly absent … I often have to remind him that I'm pregnant. (35 y./31 w.p.)

Discussion

The pregnancy experiences of the women in this study during the COVID-19 pandemic and state of emergency were discussed in reference to four issues mentioned above. The selected issues correspond to topics that have been analysed in studies with a similar research theme: (a) physical health, psychosocial health, adaptation to pregnancy, pregnancy follow-ups, social life, spouse relationships and coping methods (Aydin, Aktas 2021; Karawarda et al. 2020); (b) disturbing the peace and regular routine of everyday life, new challenges caused by the epidemic, resilience and strength in dealing with the crisis and adapting to new conditions (Mortazavi, Ghardashi 2021; McLeish 2022); (c) not understanding the seriousness and fear of the unknown, the coronavirus pandemic and the disruption of routine prenatal care and disrupted routines and social life (Sahin, Kabakci 2021).

When it comes to pregnant women's health, our results showed that the COVID-19 pandemic had significant potential for creating (additional) stress, anxiety, and fear. Other studies also reported a higher percentage of pregnant women experiencing (extreme) anxiety, fear, and panic during the COVID-19 epidemic compared to normal times (Mortazavi, Ghardashi 2021; Ravaldi et al. 2020; Aydin, Aktas 2021; Sahin, Kabakci 2021; McLeish 2022; Karawadra et al. 2020). Similar responses have also been reported in pregnant women during previous epidemics/pandemics (Mortazavi, Ghardashi 2021). In our respondents, these conditions were mainly caused by concern for their own health and the health of their loved ones, by changes to and/or the cancellation of certain aspects of their daily routine, and by the general uncertainty surrounding the new situation caused by the pandemic. These data attest to the occurrence of multiple stresses during pregnancy that are significantly more intense than what (in normal circumstances) would be caused by changes in the mother's body and identity or as a result of fears about childbirth, the child's health, and

approaching parenthood.

Several studies (Ravaldi et al. 2020; Zilver et al. 2021; Ayaz et al. 2020; McLeish 2022) reported changes in emotional and physical experiences and constructs related to childbirth expectations due to the COVID-19 pandemic. While 'joy' was the most common emotion expressed before COVID-19, 'fear' was the one most commonly reported during the pandemic (Ravaldi et al. 2020). The same study concluded that positive constructs were largely prevalent before COVID-19, while negative ones were dominant after. The findings from our study were somewhat milder on this issue. Although the pandemic brought changes to the everyday life of most of the pregnant women and, due to the increased risks and uncertainty, increased their stress, all the respondents managed to find positive aspects of the novel social situation (e.g. spending more time with their husband and children, having more time for their hobbies).

When it comes to the health care of pregnant women during the pandemic and the state of emergency, the results of our study are consistent with the results of other studies on this topic. The new social circumstances caused a significant reduction in the level of health care support in general (Kazi et al. 2020; Erdam, Lucey 2020; Ranney, Grieffeth, Jha 2020). The transformation of hospitals into COVID-19 facilities resulted in a reduction in the scope and content of health services for non-COVID patients. Korolczuk (2020) stated that the economic crisis caused by COVID-19 resulted in cuts to health-care spending in those areas not directly related to the fight against the coronavirus. This was the case with perinatal and postnatal services. In this regard, she stated that 'the crisis associated with the COVID-19 pandemic has a gender' (Korolczuk 2020: 1). Similarly, some authors (Blanton, Blanton, Peksen 2019) have found that in hard times families tend to 'save' on women's needs that are perceived as non-essential.

The responses gathered in our study express a strong lack of faith in the national health-care system and its capacity to alleviate pregnant women's difficulties. Pregnant women reported the cancellation or re-scheduling of appointments, being unable to reach their OBs and, consequently, the need to visit another doctor/clinic. Other studies reported similar problems. Participants in one study (Karavadra et al. 2020) felt that health-care workers were more concerned about COVID-19 than issues related to their pregnancy and that some aspects of their care may have been missed. Pregnant women who were able to contact their OBs, midwives, and nurses or received telephone or online support stated that they felt calmer (Karavadra et al. 2020). Drandić et al. (2022: 63) stated that even though 'many international and European institutions and organizations called for action supporting respectful, family-centred care during the pandemic, measures adopted in the field did not always reflect these recommendations'. Their research also showed that the majority

of pregnant women in Serbia experienced the following: difficulties in attending routine antenatal visits, inadequate wards and room reorganisation, communication inadequate to contain COVID-19-related stress – all of which led to a decline in the quality of maternal and new-born care due to the pandemic (Drandić et al. 2022).

Some studies indicated that some pregnant women preferred private hospitals or family health centres, which they thought had a smaller risk of coronavirus transmission (Aydin, Aktas 2021) and were more organised and safe. In our study there was no clear distinction between the experiences of patients of private and public clinics.

The above-mentioned disruptions in routine prenatal care have the potential to intensify anxieties in pregnant women in a way that may make them feel that there is no longer a system in place they can trust to protect them. This is also consistent with the theory of uncertainty in illness (Michel 1988), which some authors (Hui Choi et al. 2021) have applied to pregnancy to emphasise how trust and confidence in one's health-care provider as a reliable authority can reduce uncertainty. Previous analysis (Oakley 2016) showed how the provision of social support for pregnant women by various health care workers improved their overall experience of pregnancy and childbirth. This is especially important for first-time pregnant women as an effective stress-reducing strategy.

The decline in the quality of maternal and new-born care due to the pandemic can also be analysed in terms of women's ability to exercise their rights to social security. Ristić, Pajvančić Cizelj and Čikić (2020: 532) wrote that the 'pandemic raises the question of how certain categories of people or the emergent 'biosocial categories' (Rabinow and Rose 2006) are treated during the pandemic' due to the 'specific biopolitical measures'. The modified, restrictive, and often unfamiliar medical protocols of prenatal care and childbirth during the pandemic reduced not only the sense of security among pregnant women but also their right to have control over their own body. As a consequence, we can raise the question of a decline in women's body and reproductive rights during the pandemic or, in broader terms, their political and civil rights (Kulawick 2014).

The negative effects of COVID-19 on the health of pregnant women could be mitigated by the promotion of health care. Oakley (1985) pointed out the disparity that exists between the promotion of medical care and health care. Bearing in mind the severe cutbacks in medical care provision in the context of the current pandemic, there is a clear need to find ways to help people that do not exclusively rely upon medical examinations and procedures, but instead involve such activities as health education, preventive health care, self-help, and community support (Oakley 1985).

When it comes to preparing for childbirth and the arrival of a new-born, the majority of the women in our study had all or most of the supplies they needed for having a baby. The few pregnant women who were not expressed concern and

stress, but also sadness due to the fact that they would not be able to enjoy buying things for their new-born because of the new situation. It can thus be assumed that these conditions intensified the negative experiences of pregnant women during the pandemic. This aspect has yet to be addressed in other similar studies.

Our results suggested that the respondents working from home (especially those who already had children) had several difficulties in managing their professional and family obligations. Moreover, the pandemic and the state of emergency temporarily suspended any external childcare support (e.g. grandparents, kindergartens, schools). Čikić and Bilinović Rajačić (2021) showed that, under such circumstances, women, and mothers especially, not only lost any external help they had, they also had to take on additional duties (acting as teachers, nurses, etc.). This stems from the fact that, despite occasional exceptions (mainly among couples with an urban background and university education), traditional family and parental models still prevail in Serbia, where women are designated women as the primary caregivers (Blagojević Hjuson 2013; Sekulić 2016). Gendered differences in parental and family practices again shifted the tide of the traditional conflict women face between professional and family duties. The work–family conflict that prevailed before the pandemic gave way to a family–work conflict (Čikić and Bilincoviović Rajačić 2021).

Results from other studies (Sahin, Kabakci 2021; Karavadra et al. 2020) also indicated a significant decrease in support from family and friends because of the need to socially isolate. These circumstances were particularly unfavourable in the post-delivery period (Ravaldi et al. 2020; Chivers et al. 2020). Previous research among young parents in Serbia indicated that young mothers and fathers greatly rely on their parents' help (Tomanović, Stanojević, Ljubičić 2016). Parental support – both instrumental and emotional - is particularly important for pregnant women and young mothers because prenatal and postpartum help is often inadequate (UNICEF, 2020). Such support is also gendered – mothers-to-be and young mothers often rely on female informal support networks (e.g. mothers, sisters, mothers-in-law), which make up for structural limitations and a lack of institutional support (Tomanović, Stanojević, Ljubičić 2016). However, Aydin and Aktas (2021) indicated that being at home during the pandemic allowed some of the working women to rest, eat regularly, and find time for themselves, and thus positively affected their adaptation to pregnancy. The same study found that pregnant women who were housewives or unemployed reported negative effects on their adaptation to pregnancy, mainly because of the long period of time spent at home during the pandemic period.

The majority of our study's respondents reported a mainly positive family atmosphere in the new social situation. The results from other studies also indicated that the COVID-19 pandemic had a positive effect on family atmosphere and spousal relationships for employed pregnant women (Aydin, Aktas 2020) and for those whose

family income was unchanged since the pandemic outbreak, which is consistent with the results of this study. Almost all of this study's respondents claimed to have considerable support from their husbands and the majority of them stated that relations with their partner improved during the pandemic. The main reasons stated for this were that they were able to spend more time together than usual and had new issues to discuss. This is in line with the results of most studies on this topic (Mortazavi, Ghardashi 2021; Sahin, Kabakci 2021; Cheng, Rifas–Shiman, Perkins 2016; Rominov et al. 2017). Interestingly, Aydin and Aktas (2021) have reported that having to spend a lot of time together negatively affected spousal relations, which is contrary to the findings of our study. Any negative changes in typical family practices and dynamics in the new circumstances were reported to be mild. Our study's respondents reported feeling worried and nervous more than usual over various pandemic risks (health risks, economic risks), which caused family members to be less patient with each other. The results of other studies indicated that economic factors negatively affected spousal relations, which is in line with the results of our study (Aydin, Aktas 2021).

Conclusion

The results of this study show that the COVID-19 pandemic affected pregnant women's everyday life overall. The results are consistent with those of other studies on same subject. This study found that the following conditions had a negative impact on pregnant women: (a) worrying about both their own and the health of their baby; (b) the significant decline in the level and quality of health-care support; (c) the reduction of 'external' parental support due to the need to socially isolate; (d) difficulties in managing their professional and family obligations; (e) missing their regular pre-pandemic activities; and (f) the decrease in total family income as a result of changes to employment conditions during the pandemic. The respondents from the study largely expressed a loss of trust and faith in the health-care system in terms of it providing pregnant women with adequate support. This finding is not surprising given the many problems the health-care system faced from the start of the pandemic. Prenatal and postnatal care services underwent significant changes. While some of these changes may be temporary, they highlight significant questions as to how services should be delivered in the future to minimise the negative impact of a pandemic on pregnant women. Health personnel could provide pregnant women with information using of virtual prenatal care (telehealth), as pregnant women need reliable support in this process. Free online psychological support lines and birth preparation training should be established. Additionally, women with a history of pre-existing psychological conditions need special consideration since they are likely to experience a worsening of symptoms during and after pregnancy, which would

undoubtedly be exacerbated by COVID-19 concerns.

The restrictions imposed on female reproductive rights have both direct and indirect consequences. Directly, cutbacks in the quantity and quality of prenatal and postpartum services provided push both the health of women and foetal health into uncertainty, thus jeopardising positive pregnancy outcomes. Indirectly, restrictions could lead to the lack of prenatal and postnatal female bonding, further compounding the lack of opportunity for women to exchange experiences, raise questions, and get answers. This could deepen women`s sense of isolation, fear, and insecurity (especially among first-time mothers), fuel postnatal depression, etc. Still, the effects of the reduction of female reproductive rights under the pandemic were not homogenous. Gender's association with unfavourable structural features certainly puts women from underprivileged classes and high-risk environments (e.g. Roma women, rural women, migrants, black women) at a greater risk of being additionally deprived in reproductive health care (Wenham 2020; McMillian-Bohler, Bell 2022; Bankar, Gosh 2022).

Like others (Drandić et al. 2022; Wenham 2020), the Serbian health-care system failed to address specific gender needs adequately during the pandemic. This put into focus the issue of the accountability of the system itself (Schaaf et al. 2020). The pandemic circumstances led to what Smith (2019: 357) has called the '"tyranny of the urgent", which puts aside structural issues in favour of addressing immediate biomedical needs'. However, decisions on what was urgent and essential in gendered health care were embedded in 'political and ideological rifts about sex, reproduction, and sexualities" (Schaaf et al. 2020: 49) and had the potential to deepen the gaps in gendered rights.

The respondents in this study who experienced their pregnancy positively had high levels of marital adjustment and enjoyed spending more time with their husbands and children during the pandemic. Family support (especially a partner's/husband's support) is very important during pregnancy as well as during the postpartum process, and even more so in the midst of a pandemic. Considering the negative impact reduced 'external' parental support has on the pregnancy experience, it is very important to engage partners and support persons in the various aspects of the pregnancy, especially prenatal and postnatal education. This would have substantial benefits for future mothers, infants, and the partners themselves.

The applied research design enabled us to obtain insight into both the public and private aspects of pregnancy during the pandemic. The flexibility of the methods applied allowed the women to have more control over the data collecting process in terms of the timing, scope, and depth of the information provided. They were also encouraged to broaden the topics and to speak of their experiences, emotions, fears, and hopes, which is in line with the 'third dimension of feminist work' (Payne, Payne 2004: 91). The collected narratives can be regarded as a specific form of

diaries, providing us with the gendered testimony of a specific personal life stage (pregnancy) in a specific public situation (the pandemic). The women's participation in the research can be seen as a means of enabling them to connect their individual experiences and personal understanding of the situation to the broader social context (Thompson 1992). It could also help raise awareness of women's rights as mothers, patients, partners, and workers. This especially refers to a pregnant woman's right to body sovereignty.

This study has some limitations. Because of the small sample size and the participant recruitment method, the results should be interpreted with caution. However, it should be emphasised that several pioneering qualitative studies on the same topic (e.g. Mortazavi, Ghardashi 2021; Aydin, Aktas 2020; Sahin, Kabakci 2021) were conducted on similar (even smaller) samples. Also, recruiting respondents on-line (by social media, online applications) was a common method for studies conducted in the first months/year of the pandemic (Groulx et al. 2021; Fransson et al. 2022; Liu et al. 2021).

Despite the study's limitations, the results highlighted several interesting issues that should be addressed in the future. First, there is the question of (in)adequate social support – both for women and babies – during the pandemic. It would be useful to analyse how the pandemic impacted women's decision on a new pregnancy. Some demographic analysis (Vasić 2021: 29) has shown 'that the pandemic impact could reduce the number of live births between 3.55 and 8.70 percent [in 2021 – A.N.]'. Second, it would be interesting (both for the scientists and policy makers) to investigate what are pregnant women's proposals for filling the gaps in prenatal and postnatal care in pandemic conditions, in order to make them more humane and effective at stress reduction (both for women and health-care providers). Third, it would be important to review maternal and new-born health-care providers' experiences in providing health services during the pandemic.

Bearing in mind the previously mentioned limitations, but also the results, it should be noted that this is the first study to assess how the experiences of pregnant women in Serbia were affected by the COVID-19 pandemic. Thus, this study should be regarded as an initial step towards further prospective research on the experience of pregnancy during the COVID-19 pandemic.

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