# "COVID-19 MADE ME A SINGLE PARENT". AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF A WOMAN'S PERINATAL EXPERIENCES DURING THE COVID-19 PANDEMIC

A thesis submitted in fulfilment of the requirements of the degree of Master of Arts in Clinical Psychology in the Department of Psychology, School of Humanities.

by

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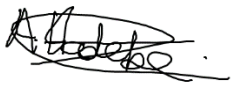

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## ABSTRACT

**Background:** The COVID-19 pandemic resulted in unprecedented challenges across various aspects of life. In particular, pregnant women encountered unique challenges and circumstances that necessitated adaptation to the experience of the perinatal period[1] Satyanarayana et al., (2011). A considerable amount of research has been conducted regarding women's experience of the perinatal period during COVID-19, especially in first world countries. However, inadequate research has been done in the South African context and specifically, there is a lack of qualitative research providing thick descriptions of experience.

**Aim:** In response, this current study provides an in-depth exploration of one South African woman's experiences of the perinatal period during COVID-19.

**Research Question:** How did the participant experience the perinatal period during the COVID-19 pandemic?

**Method:** The study took a qualitative approach and employed Interpretative Phenomenological Analysis (IPA). A single-case study approached was adopted, focusing on the participant's journey and experience of the perinatal period during the pandemic. The data was collected retrospectively, and two semi-structured interviews were conducted with the participant. The interviews were audio-recorded, transcribed and analysed using the IPA framework.

**Findings:** The analysis describes three master themes supported by subordinate themes. The main themes are (1) A sense of loss and change, (2) Managing COVID-19 and its regulations during the perinatal period, and (3) Glimmers of hope and desirable aftermaths. The study's findings expand and support the growing literature of women's experiences on the perinatal period during the COVID-19 pandemic.


[1] Perinatal -period related to pregnancy covers the period from conception to the first year of the baby post-birth.

**Conclusion:** Concurring with previous research, the study found that the perinatal period during the pandemic was associated with positive and negative experiences. The study highlights the need for further research, support systems and policy adaptation that prioritise the well-being of women during the perinatal period during times of unforeseen crisis.

*Keywords: women's experiences, perinatal period, COVID-19 pandemic, IPA, qualitative.*

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# 1. CHAPTER 1: INTRODUCTION

## 1.1 Overview

This single case study explores the perinatal experiences of a woman during the COVID-19 pandemic in the South African context, specifically in Makhanda, Eastern Cape. The perinatal period, which encompasses the months leading up to childbirth to the first-year post birth, is a crucial time for an expecting mother, child, and her family. The outbreak of the Coronavirus (COVID-19) pandemic significantly impacted how women experience the prepartum, intrapartum and postnatal period by introducing a myriad of uncertainties. This single case study provides an in-depth exploration of the unique circumstances experienced by one particular woman during this period, highlighting the various aspects that influenced her perinatal journey amid the pandemic.

The single case study delves into the emotional, physical, and social implications of the COVID-19 pandemic experienced by the participant. These experiences included the impact of the restrictive measures employed during the pandemic, such as social distancing[2] and lockdown[3]. The experiences of these measures led to changes in the delivery of healthcare services and further altered the traditional dynamics of in-person perinatal care appointments, birthing processes, and support networks. The pandemic impacted pregnant women's support networks, and this study explores the adaptability and resilience demonstrated by one woman to these changes during her perinatal period. The study also sheds some light on the psychological impact of the pandemic on an expecting woman, exploring the uncertainties, fears and anxieties she faced due to the increased risk of contracting the virus, potential complications during pregnancy, and concerns about the well-being of her unborn child.

[2] Social distancing- a public health practice that aims to prevent sick people from coming in close contact with healthy people to reduce opportunities for disease transmission.
[3] Lockdown-a state of isolation or a security measure resulting in restricted access.

Additionally, the single case study draws attention to strategies employed by the participant to cope with the challenges she encountered. Overall, this case study provides valuable insights into women's experience of the perinatal period during the COVID-19 pandemic.

## 1.2 Rationale

Honikman et al., (2021) and Mbunge (2021) emphasise the importance of exploring and understanding the experiences of the pandemic in the South African context, as limited research is available. According to Nohrstedt et al., (2021), studying the impact of pandemics and natural disasters in the context of high-income earning countries and assuming that the results apply globally is risky as the high income serves as a protective factor that low-income countries lack. Anderson et al., (2021) add that Socioeconomic Status (SES) and contextual factors impact on how a common stressor is experienced and thus need to be explored in the context in which they occur.

Honikman et al., (2021) and Malande, (2020) point out that the current existing research regarding the impact of the pandemic on the perinatal period lacks subjective experiences. Both studies highlight the need to understand how women experienced the perinatal period during COVID-19 to provide helpful maternity care during future health crises in South Africa and globally. An in-depth understanding of a single case study allows researchers to delve into specific experiences of individuals to provide a comprehensive understanding of their lived experiences. It thus provides insight into experiences that may be overlooked in a group study (Jackson et al., 2021). Understanding individual women's experiences during the perinatal period and amidst the COVID-19 pandemic is also essential for informing policy decisions and supporting women's mental well-being (Jackson et al., 2023). Single case studies allow researchers to identify specific contextual factors (socioeconomic status, cultural norms, geographic location) and challenges that were faced by the individual in a specific context to

understand how these unique factors influenced the perinatal period experiences and outcomes (Honikman et al, 2021). The above reasons also formed part of the rationale and motivation for the single case study design of the current study, which was a result of a poor response to the recruitment drive, amongst other reasons. Upon the realisation that the initial plan of the study to have six-eight participants (IPA guideline) was not surfacing, the researcher considered the above literature and the methodology employed in the study and opted for a single case study (Smith et al., 2021).

Jackson et al., (2021) highlight that most studies of the perinatal period are cross-sectional and only study the symptoms caused by disaster; they suggest that the mental health changes that may occur in response to such events are still inadequately known. Further research is needed to understand the impact of the adopted changes during the pandemic to improve perinatal care services in the context of the 'new normal' (Malande, 2020).

A study by Jackson et al., (2023) explains that the risk of maternal depression and anxiety is amplified when women experience uncontrollable stress such as those resulting from COVID-19. While symptoms of anxiety and depression were evident in non-pregnant adults, the impact of the pandemic on mental health may have been particularly pronounced in women during the perinatal period as they form part of the vulnerable population and thus require further exploration. Lastly, research of this nature may contribute to the profession of Clinical Psychology by providing an understanding of how the perinatal period was experienced during the COVID-19 pandemic and thus contribute to improving more individualised and appropriate mental health interventions for women in relation to their experiences in the South African context (Malande, 2021).

## 1.3 The purpose of the study

The purpose of the study is to explore and understand how a particular woman experienced the perinatal period during the COVID-19 pandemic in South Africa, Eastern Cape, using the single case study method. The study intends to understand how she understood and made sense of her experience.

## 1.4 Research question

How did one particular woman experience the perinatal period during the COVID-19 pandemic in the South African context?

## 1.5 Contextualising the study

This section explores the contextual factors that are relevant to the study. These contextual factors include features related to the COVID-19 pandemic in South Africa. They also relate to other features specific to the Eastern Cape province where the study is located, and other relevant features related to the broader national context.

The first COVID-19 case in South Africa was confirmed on the fifth of March 2020 shortly followed by reports of the first death relating to COVID-19 towards the end of the same month (Kaswa et al., 2021). This rapid spread of the virus had a significant impact on the health system, causing shortages in health resources designated for managing the virus in the country. According to Broadbent et al., (2020), before COVID-19 hit the South African shores, the country had 7200 critical care beds available at different health facilities, 2700 high care beds, 3500 intensive care beds out of a total of 100 000 overall hospital beds which had 75% occupancy, however, these number of beds significantly decreased with the spread of the virus as an increased number of patients who contracted the virus were admitted to health facilities.

Many areas of the country were affected by the pandemic, including Makhanda, which forms part of the semi-rural communities of the Eastern Cape (Du-Toit, 2017). Makhanda is

also part of the Sarah Baartman District Municipality (Eastern Cape Socio Economic Consultative council, 2017). The community is characterised by high levels of unemployment (34.9%) and poverty (Statistics South Africa, 2021). The poverty level is nearly 40% of the population, while the unemployment rate is 42.3% of the population. High levels of inequalities characterise Makhanda and the levels worsened during the pandemic (Hoefnagels et al., 2022). These factors primarily affect women and children due to their vulnerability (Nobles et.al., 2010). The population of Makhanda is predominantly African and isiXhosa speaking (78.9%), followed by the Coloured population (11.3%), White (8.4%), Indian/Asian (0.7%) and other (0.6%).

Maclennan (8 April, 2020) reported the first COVID-19 positive case in Makhanda in the town's Grocott's Mail Newspaper. Ever since the first COVID-19 case, the number of COVID-19 in the town fluctuated and increased significantly during the third wave of COVID-19 (Tregoning et al., 2021). In November 2020, the positive cases of COVID-19 in Makhanda rose to over 363 and negatively affected the health systems. The residents expressed concerns regarding the capacity of the local hospital, Settler's Hospital, and whether there were alternatives in place should the hospital reach its full capacity (Maclennan, 30 November, 2020). Maclennan (30 November, 2020) also reported the shortage of hospital clinical staff due to the increased demand for the health services.

## 1.6 Brief overview of the chapters

This research study consists of six chapters, namely: introduction, literature review, research methodology, research findings and conclusion. Its structure is briefly discussed below:

This current chapter, chapter entails the introduction of the research, which outlines the rationale of the study, the purpose of the study, the research question and the context of the

study. Chapter two reviews the available and relevant research, ideas and knowledge related to the research topic. Chapter three describes the research method and approach employed in this study. This study employs Interpretative Phenomenological Analysis (IPA) to explore the research question. This chapter also describes the processes employed for sampling, data collection and analysis of the data. Further, the reliability and validity of the study are discussed together with the ethical considerations and what methods were considered to manage the ethical concerns. Chapter four presents the findings of the research study. The data collected from the case study was interpreted, categorised and discussed to achieve a deeper understanding of the participant's experience of the perinatal period during COVID-19. Chapter five focuses on discussing the findings and relating them to literature by noting the findings' differences and similarities to existing literature and the gaps found in the literature review. Lastly, chapter six concludes the research study. It provides a summary of the findings and final comments and discusses the limitations of the study. This chapter also details this research study's contributions and possible direction for future research.

# 2. CHAPTER TWO: LITERATURE REVIEW

## 2.1 Introduction

This chapter reviews the currently available literature to contextualise the study within existing research about the perinatal period prior to the COVID-19 pandemic and the perinatal period in the context of the COVID-19 pandemic. The literature search was conducted using the online Rhodes University Library portal to access various databases (including Google Scholar, PsychInfo and Sabinet) using various relevant keywords stipulated in the abstract. A forward and backward search of references from the key research papers was also conducted and included. Articles that were in the English Language, published, and peer reviewed were included; the focus of the literature search was articles that described women's experiences of the perinatal period prior to and during the COVID-19 pandemic in relation to mental health and, in comparison, to the general population.

### *2.1.1 Overview of the chapter*

The chapter begins by broadly discussing women's mental health experiences and the perinatal period prior to the pandemic. The chapter also explores the prevalence and screening of these mental health difficulties. Thereafter, general mental health during the pandemic is explored. Lastly, the chapter will focus on women's experiences of the different stages of the perinatal period during COVID-19 by exploring international and national research.

## 2.2 Women's mental health experiences during the perinatal period prior to the COVID-19 pandemic

According to Satyanarayana et al., (2011), mental health during the perinatal period is a topic that has received increasing attention in the literature over recent years as research has shown that it can have a significant impact on maternal and foetal outcomes. This section

explores global mental health literature related to the perinatal period before the COVID-19 pandemic to emphasize the mental health issues of women prior to the pandemic.

Biaggi et al., (2016) indicate that while the perinatal period can be a joyous time for an expecting woman, the period can also be accompanied by difficulties and stressors related to mental health. Most studies have employed quantitative methods to measure the level and impact of these mental health difficulties and, therefore, lack the subjective voice (McLeish & Redshaw, 2017). The types of mental health issues during the perinatal period that are frequently highlighted in literature include stress, anxiety, and depression (Chopra et al., 2009a; Hartley et al., 2011; Openshaw et., 2011). These mental conditions are further proposed by Kamis, (2020), and McLeish and Redshaw, (2011) to lead to various adverse outcomes for both the mother and child (Kamis, 2020; McLeish & Redshaw, 2011). For example, maternal stress and anxiety during pregnancy have been linked to an increased risk of gestational diabetes, preeclampsia, and other pregnancy complications for the mother. Additionally, maternal mental health issues can affect the mother's ability to provide adequate care for her child, which can have long-term implications for the child's health and well-being (Kamis, 2020; McLeish & Redshaw, 2011).

A systematic review by Biaggi et al., (2016) also indicates that mental issues during the perinatal period can have unfavourable outcomes; they report that these mental conditions include feelings of loneliness, guilt and excessive worry experienced by the mother, which may result in low birth weight and preterm birth of the child. For the unborn child, these conditions may contribute to developmental and behavioural problems (Biaggi et al., 2016). While systematic reviews are highly regarded in research as they provide a rigorous and comprehensive approach to synthesizing existing evidence, systematic reviews tend to lack context and currency of evidence and may also show evidence of publication bias (Biaggi et al., 2016).

Glover (2020) provides examples of the developmental and behavioural problems that are indicated by Biaggi et al., (2016) and indicates that the baby born has the likelihood of experiencing signs of anxiety and depression, attention-deficit/hyperactivity disorder, conduct disorder, and autism spectrum disorder later in life if the mother is under stress during pregnancy. There may also be other issues, such as asthma and preterm delivery. Overall, the mental health of women during the perinatal period has an impact on the well-being of the expecting woman and the child (Glover, 2020).

### *2.2.1 The impact of psychological and physiological changes in the perinatal period on women's mental health experiences prior to the COVID-19 pandemic*

Biaggi et al., (2016) and Mollard et al., (2021), explain that due to the psychological and physiological changes associated with the perinatal period of expecting women, women become vulnerable to both the onset or relapse of physical and mental health difficulties. These changes include hormonal imbalances during pregnancy, which can lead to mood swings and emotional changes, leading to some women experiencing anxiety, depression, and irritability. The results of a descriptive-analytical cross-sectional study conducted in Iran by Effati-Daryani et al., (2021) indicate that hormonal changes can also affect sleep patterns and increase fatigue, leading to further emotional and psychological challenges. However, the limitations of descriptive-analytical cross-sectional studies, such as the potential for confounding variables and limited generalisability, need to be considered. According to Colaceci et al., (2022), pregnancy can also lead to significant changes in a woman's body, including weight gain or loss and other physical changes to women's bodies. These changes can lead to body image concerns, which can, in turn, contribute to feelings of anxiety and depression (Sander et al., 2021). Overall, the literature suggests that maternity can be stressful and uncertain, with women facing various challenges that can contribute to anxiety and depression during the perinatal period (Biaggi, 2016; Schetter & Tanner, 2012).

### *2.2.2 Changes in self-perception and identity*

Numerous research studies propose that identity and self-perception also play a significant role in women's mental health during the perinatal period (Babieva et al., 2018; McNamara et al., 2022). The most common changes that occur in women's lives that have an impact on their self-perception and identity include the following: the transition from a single individual to a mother, changes in body image, and shifts in personal and professional goals (Soma-Pillay et al., 2016; Wallis et al., et al., 2021). These changes are also associated with increased levels of stress, anxiety, and depression during the perinatal period (Colaceci et al., 2022). Research also highlights the impact of societal expectations and norms around motherhood and femininity. These societal expectations and norms affect women's self-perception and mental health during pregnancy (Battulga et al., 2021; Fontein-Kuipers et al., 2021). For example, a study by Meeussen and Van Laar, (2018) conducted in the United Kingdom (UK) and the United States of America (USA) highlights the pressure expecting mothers experience to be 'the perfect mother' or the expectation to give up one's career for motherhood. Meeussen and Van Laar, (2018) further indicate that this can be a stressful experience and contribute to a negative self-perception by the expecting women. The results of the study offer guidance on how to focus efforts to lessen the difficulties of motherhood and safeguard women's career aspirations and suggest that intensive mothering norms may have serious adverse effects on women's family and work outcomes. Other studies also highlight the impact of pregnancy complications that some expecting women experience during the perinatal period, such as miscarriage or the birth of a newborn with a physical or mental disability, on a woman's self-perception and mental health (Farren et al., 2018; Meeussen & Van Laar, 2018). According to Farren et al., (2018), these experiences can lead to feelings of guilt, shame, and an impact on their identity and thus affect women's mental health during the perinatal period.

## 2.3 The prevalence of mental health issues during the perinatal period prior to the COVID-19 pandemic

A study conducted in Ireland by Hannon et al., (2022), indicates that the prevalence of mental health difficulties during the perinatal period ranges from ten to twenty per cent (10%-20%) globally. However, other studies highlight a higher prevalence of approximately twenty to thirty-five per cent (20%-35%) (Rochat et al., 2013; Tsai et al., 2014; van Heyningen et al., 2017). Further, a systematic review and meta-analysis published in JAMA Psychiatry found that the prevalence of depression among pregnant women is estimated to be around 11%, compared to 7% in the general population of women. Additionally, anxiety disorders, such as generalized anxiety disorder and panic disorder, have been reported to be twice as common during the perinatal period compared to the general population (Mitchell et al., 2023). While most studies were noted to focus on the prevalence of depression and anxiety, a small percentage highlighted the prevalence of other mental health problems within the perinatal period (Biaggi et al., 2016; Satynanarayana et al., 2011). These mental health issues included perinatal stress[4] (childbirth, financial pressure, physical discomfort, changes in family dynamics) and perinatal-specific psychiatric conditions[5] (postpartum psychosis, obsessive-Compulsive disorder, perinatal bipolar disorder). Overall, the prevalence of mental health difficulties in women during the perinatal period is reported to be higher than mental health difficulties in the general population of women (Satynanarayana et al., 2011).

### *2.3.1 The prevalence of perinatal mental health issues in the African context prior to the COVID-19*

Numerous studies highlight that minimal research is available from the African context that is related to the perinatal period prior to the COVID-19 pandemic as opposed to from the

[4] Perinatal stress-A form of stress that occurs when an expecting woman is exposed to physical or psychosocial stress that can be cause by environmental hardships or daily life events during the antenatal period.
[5] Perinatal-special psychiatric conditions: Psychiatric conditions and disorders that are prevalent during the antenatal period.

global north, (Nxiweni et al., 2022; Umuhoza & Ataguba, 2018). The results of a World Health Survey (WHS) study by Umuhoza and Ataguba, (2018), which was conducted for Zimbabwe, Malawi, Mauritius, Zambia, Swaziland and South Africa, suggests that the dearth of literature may be due to the significant socioeconomic inequalities in ill-health and health risk factors in the region in comparison to the global north. Umuhoza and Ataguba, (2018) suggest the reasons to include resource constraints, such as funding in many of these regions and the frequent prioritisation of immediate health concerns that may take precedence over perinatal care, such as infectious diseases and malnutrition.

Similarly, Heyningen et al., (2016) suggests that perinatal anxiety and depression are of higher prevalence in low- and middle-income countries (LMIC), including those in Africa, due to the psychosocial adversities that expose women to multiple risk factors that increase their vulnerability to the development of perinatal depression and anxiety. Patabendige et al., (2020) suggest a high prevalence of one to three women in five who experience mental health problems during the perinatal period in the African context.

According to Nicholas et al., (2022), Africa presents with 1.4 mental health practitioners per 100 000 people compared to the global average of nine workers per 100 000 people. As a result, Honikman et al., (2012) associate the high prevalence of mental health difficulties in the African context with the neglect of mental health in perinatal care services. An additional contributing factor to the high prevalence of mental health issues in the African context during the perinatal period includes poor socioeconomic status (SES) (Patabendige et al., 2020). Several studies associated poor SES with increased stress related to financial care and accessing healthcare resources (McMaughan, 2020; Reiss et al., 2019).

Studies have shown that the prevalence of depression and anxiety during the perinatal period in South Africa can be as high as 33% and 44%, respectively compared to other

countries in the global north, such as the USA, which has a prevalence of 10%-20% (Christodoulou et al., 2019; Garman et al., 2019). Poverty, HIV/AIDS, gender-based violence, and limited access to healthcare services are among the key factors that contribute to poor mental health during the perinatal period in South Africa (Krishnan et al., 2008; Waldron et al., 2021). In addition to depression and anxiety, studies have also found high stress levels, including trauma-related stress, among pregnant women in South Africa (Glover, 2014; Koen et al., 2016). Exposure to violence and trauma was a focal point for several studies and was found to negatively impact maternal and foetal health, including increased risk of preterm birth and low birth weight (Glover, 2014; Koen et al., 2016).

A systematic review by Dunkel and Tanner, (2012), and Burger et al., (2022) contradicts the studies mentioned above, suggesting that minimal research is available regarding the perinatal period before the COVID-19 pandemic. The study reports that within the last decade, perinatal mental health has increasingly been regarded as an essential public health issue in low and middle-income countries in Africa, such as South Africa due to the increased prevalence of perinatal mental health difficulties and the impact they have on maternal and foetal health outcomes (Dunkel & Tanner, 2012). As a result, new and continuous developments and implementation of perinatal mental health interventions have been the research focus in several recent studies (Honikman et al., 2012; Honikman et al., 2021). These include increased mental health awareness campaigns and government initiatives such as mental health hotlines for pregnant women (Dunkel & Tanner,2012). Other interventions include the perinatal mental health project and the First 1000 Days project, which focus on the mental and physical health of the mother and their baby (English et al., 2017; Honikman et al., 2012).

Despite these developments, many studies still highlight that there continues to be a significant gap in the availability of mental health services for pregnant women in South Africa

(Brown et al., 2020). Much more must be done to ensure that all women have access to the support they need to maintain good mental health during pregnancy so as to prevent and/or manage the high prevalence of perinatal mental health issues and reduce the negative impact perinatal mental health issues (Chomba et al., 2010). According to Brown et al., (2020) and Chomba et al., (2010), these mental health issues tend to have an impact on maternal and foetal health outcomes. Hence the emphasis on the need to decrease the gap in the provision of mental health services for pregnant women in South Africa (Brown et al., 2020; Chomba et al., 2010).

No research was available that relates to the screening of perinatal mental health issues in the majority of African countries at the time that the study was conducted. Most of the available research was conducted in South Africa. Nonetheless the literature in the South African context was limited compared to international research.

Heyningen et al., (2016), indicate that common perinatal mental health issues are frequently neglected during the screening phase in health care in South Africa. This neglect of common perinatal mental health issues not only results in them being secondary when compared to physical health but often can result in them remaining undetected. Further, open-ended online surveys conducted by Honikman et al., (2012) and Tsai et al., (2014) found that in LMIC such as South Africa, mental health is frequently integrated into already poor perinatal care services for physical health. While online surveys can have limitations such as lacking representativeness as not every potential participant has internet access and lack of control over the respondents, the results of the studies correlate with the findings of Dunkel and Tanner, (2012), who also indicated that this integration of mental health into services leads to mental health assuming a secondary position compared to physical maternity health.

Studies by Chopra et al., (2009b) and Heyningen et al., (2016) further found that this neglect of common perinatal mental health issues points to a significant gap in the screening

and treatment of maternal mental health issues, the gap between screening and treatment can be up to 80%, implying that 80% of the women that were screened do not receive treatment (van Heyningen et al., 2017). According to Brown et al., (2021), the vast treatment gap in South Africa's mental health public sector is a result of only 8% of the budget being spent on primary care, including perinatal mental health, and 86% of the mental health care budget spent on inpatient care. Heyningen et al., (2016) also highlight the lack of staff, facilities, preventative care, and lack of community services. Other challenges associated with implementing mental health screening programmes in South Africa include limited access to mental health services, lack of trained personnel, and stigma associated with mental health problems (Christodoulou et al., 2019).

## 2.4 The experiences of the impact of COVID-19 on global mental health

This section reviews the literature related to the overall mental health experiences of the general population during the COVID-19 pandemic. This section is intended to provide a contextual understanding and a comparative analysis of how COVID-19 affected women's mental health during the perinatal period about the general population.

A study by Gadermann et al., (2021) in Canada and Linden (2022) in the United Kingdom (UK) suggests that the COVID-19 pandemic profoundly impacted mental health globally, affecting individuals across the lifespan. The pandemic's unprecedented nature, the rapid spread of the virus, and the associated public health measures (such as lockdowns, social distancing, and widespread loss of income and employment) created a challenging and stressful environment for many people. Studies in the United States of America (USA) indicated that the pandemic increased levels or the onset of anxiety, depression, stress, insomnia, and other mental health problems (Marroquín et al., 2020; Salari et al., 2020). This was found particularly true for individuals directly impacted by the virus, such as those who had fallen ill or lost loved ones. However, numerous studies also found that even those whom the virus had not directly

impacted also experienced increased stress and anxiety related to the uncertainty and disruption caused by the pandemic (Anderson et al., 2020; Battulga et al., 2021). Other studies also highlighted the increased impact of the pandemic on the mental health of those deemed vulnerable, such as those living with a chronic illness, poverty and pregnancy due to increased stress (Arzamani et al., 2022; Nguse & Wassenaar et al., 2021). For example, pregnant women were deemed vulnerable due to their physiological vulnerability, increased stress and anxiety related to maternal and foetal health concerns that were because of the COVID-19 pandemic (Arzamani et al., 2022).

A study by Saccone et al. (2020) in China indicates that 53.8% of the participants reported the psychological impact of the pandemic to be moderate to severe, and 28.8% reported moderate to severe stress, depression, and anxiety levels. However, due to the nature of the study involving self-reporting, the study's results were considered cautiously, as self-reporting studies may contain response bias. Another study by Puertas-Gonzalez et al., (2021) in Spain indicated that the pandemic generated increased stress, anxiety, and agitation among the general population due to the fear of contagion. The pandemic exacerbated but also increased the chances of the index presentation of psychiatric illnesses such as panic attacks, psychotic symptoms, and suicidal ideation with a plan (Puertas-Gonzalez et al., 2021). This study employed online surveys to collect data and the limitations of the data collection methods include response bias.

According to Arzamani et al., (2022) and De Kock et al., (2021), another way the COVID-19 pandemic affected mental health was its impact on access to mental health services. Núñez et al., (2021) add that many individuals faced barriers to seeking care, such as financial constraints, limited availability of services, and reduced face-to-face contact with providers. While there was was a shift towards the use of teletherapy and other remote mental health services, a significant number of studies argue that it remains unclear how practical these

approaches were in meeting the needs of all individuals (Appleton et al., 2021; Gavin et al., et al., 2022).

### 2.5 COVID-19 and mental health in the South African context

In the South African context, Adelekan et al., (2020) suggest that the declaration of a national state of disaster due to the pandemic and the subsequent imposition of the lockdown on all usual activities had an indirect and direct negative impact on healthcare systems and their utilisation. Nguse and Wassenaar (2021) report that due to South Africa's history of apartheid and high rates of crime and violence, many South Africans have a history of childhood trauma, therefore placing them at a higher risk of developing depressive symptoms that may have been precipitated by the perceived risk of contracting the virus. According to the Human Sciences Research Council (2020), as cited in Pillay and Barnes (2020), 33% of South Africans were experiencing depression, 45% were experiencing fearfulness, and 29% were experiencing loneliness, especially during the first lockdown period (Pillay & Barnes, 2020).

Even though provisional access to essential services, including mental health services, was available, according to a government gazette, Lockdown regulations No: 43232, April 2020, some mental health services were unavailable due to limitations and risks associated with physical contact during contact (Aloweni et al., 2022; Chersich et al., 2020). Pillay and Barnes (2020) report an increase in the number of patients who defaulted psychotherapy appointments due to the fear and anxiety of contracting COVID-19, amongst other factors, including retrenchment. Pillay and Barnes (2020) also report that of those patients who attended psychotherapy, many reported secondary impacts of the pandemic, such as sleep disturbance, substance withdrawal symptoms due to limited access, and other symptoms. Siedner et al., (2020) also reported that the impact of the pandemic and lockdown was not only limited to outpatients but also to inpatients in mental health facilities. The patients experienced irritability that resulted from the discontinuation of patient visits and leave of absence, inability to access

tobacco and other psychological distress that resulted from the impact of lockdown regulations (Pillay & Barnes, 2020; Siedner et al., 2020).

Several studies highlighted the impact of the lack of personal protective equipment (PPE), inadequate training of healthcare workers on infection prevention and control, and the diversion of healthcare resources towards COVID-19 response as the key challenges faced by mental health services (Aloweni et al., 2022; Chersich et al., 2020). Aloweni et al., (2022) indicate that due to the lack of PPE, patients and health workers experienced anxiety and worry regarding their safety from the virus, and as a result, the service delivery of mental health was significantly negatively impacted, resulting in the delivery of services being compromised. Overall, the COVID-19 pandemic significantly affected mental health in South Africa (Aloweni et al., 2022; Mortazavi and Ghadashi, 2021).

## 2.6 Perinatal mental health during the COVID-19 pandemic

The following sections explore literature related to the experiences of women in the perinatal period during the pandemic. The sections are divided according to the different stages of the perinatal period namely: prepartum[6], intrapartum and postnatal period.

### *2.6.1 Women's prepartum experiences related to mental health during the COVID-19 pandemic*

The COVID-19 pandemic significantly impacted the prepartum period, with pregnant women facing unique challenges and stressors due to the pandemic, creating a challenging and stressful environment for many pregnant women (Hübner et al., 2022; Maison et al., 2022). While several studies highlighted the impact of the pandemic on pregnancy as being negative (Bule, 2020; Mortavazi & Ghardashi, 2021), a study by Kolker et al., (2021) and another by Mizrak Sahin and Nur Kabakci (2021) indicated that the exploration of the psychological

Prepartum period-[6]a period related to pregnancy that is before birth.

conditions of pregnancy during COVID-19 was limited due to the vulnerability of pregnant women during the pandemic which resulted in limited access to them. Nonetheless, a review of studies conducted by Puertas-Gonzalez et al., (2021) in different countries (Canada, Italy, United States, Greece, Turkey, and China) indicated that the prevalence of depression and anxiety may have increased in women in the prepartum period during the pandemic.

For example, a study conducted in the USA by Mollard and Wittmaack (2021) and another by Pietromonaco and Overall (2020) reported that depression and anxiety during the prepartum period were heightened due to the uncertainties of perinatal care services. Kolker et al., (2021) also highlighted those pregnant women feared attending their perinatal visits due to the possibility of contracting the virus. However, the results of the study highlighted that this response of not attending perinatal care visits was a temporary solution to reducing the chances of contracting the virus. Kolker et al., (2021) and Puertas-Gonzalez et al., (2021) indicated that not attending perinatal care visits was found to have created long-term mental and physical challenges for pregnant women. This is because the pregnant women remained anxious and distressed regarding the state of their unborn babies and other physical difficulties, such as not having access to medication that may have been necessary for their pregnancy.

### *2.6.2 Wellbeing experiences of women during the prepartum period during the COVID-19 pandemic*

Numerous studies also highlighted the everyday life challenges that women experienced because of the COVID-19 pandemic during the prepartum period (Adam et al., 2022; Kolker et al., 2021). Research conducted by Azevedo et al., (2023) and Singh et al., (2021) found that pregnant women self-reported challenges related to employment, access to food, and transportation (Azevedo et al., 2023; Singh et al., 2021).

According to a study published in BMC Public Health, a significant number of pregnant women experienced reduced work hours or job loss due to COVID-19 as they were considered more vulnerable to COVID-19 (Anderson et al., 2021). As a result, this significantly impacted pregnant women's ability to access healthcare and to afford necessary items for their pregnancies. Furthermore, financial hardship as a result of the pandemic was a major source of stress, anxiety and depression as it impacted job security, particularly for pregnant women working in informal sectors; the financial hardships also resulted in increased healthcare costs and caused uncertainty about the future (Gamberini et al., 2023). The financial hardship also limited access to resources such as the ability to access the essentials (PPE, nutritious food, medication and supplements) to assist in preventing them from contracting the virus (Anderson et al., 2021). Additionally, pregnant women who worked in essential jobs, such as healthcare or retail, were at increased risk of contracting COVID-19 due to their exposure to the public, thus creating additional stress and anxiety (Anderson et al., 2020; Galvin et al., 2022). Pregnant women were also initially advised not to take the COVID-19 vaccination and were not in the clinical trial as there was limited data available regarding the safety and efficacy of the vaccine on pregnant women, thus resulting in pregnant women being more vulnerable when compared to the general population (Adam et al., 2022; Tavares et al., 2021). All of these factors were major sources of stress for women during the prepartum period in the context of the pandemic (Anderson et al., 2020).

Other studies highlighted food access as a significant concern for many pregnant women during the pandemic (Campos-Garzón et al., 2021; Dolin et al., 2021). According to a study published in the Journal of Nutrition, pregnant women experienced food insecurity at higher rates during the pandemic than before (Dolin et al., 2021; Johnson, 2021). This was due to a combination of factors, including job loss, reduced income, increased food prices, and insufficient food availability due to the increased demand and lack of supply due to the

pandemic. Additionally, pregnant women who were required to self-quarantine due to COVID-19 exposure or symptoms faced challenges accessing food due to limited mobility (Riley et al., 2021).

Pregnant women were also reported to have faced challenges related to transportation during the pandemic due to COVID-19 restrictions (Riley et al., 2021). According to a study published in the Journal of Obstetrics and Gynaecology Canada, pregnant women avoided seeking healthcare due to concerns about public transportation or the risk of exposure to COVID-19 in healthcare settings. This may have resulted in delays in prepartum care or other healthcare necessities (Riley et al., 2021).

Kolker et al., (2021) highlight that limited research uses the qualitative lens to understand the lived experiences of pregnant individuals during the COVID-19 pandemic. Mortazavi and Ghadashi, (2021) further indicate a lack of case study research about pregnant women's experiences during the COVID-19 pandemic. According to Kolker et al., (2021), many empirical, quantitative studies have measured the psychological distress and other difficulties that pregnant women experienced during the COVID-19 pandemic, however, most studies were done using large samples. A qualitative lens is thus essential to provide unique and detailed experiences of pregnancy during the COVID-19 pandemic (Ghadashi, 2021).

### *2.6.3 Women's experiences of the prepartum period in the South African context during the COVID-19 pandemic*

One of the significant challenges that pregnant women in South Africa faced during the COVID-19 pandemic was the disruption of prepartum care services; pregnant women experienced difficulties accessing routine prepartum care and prepartum screening tests (Burke et al., 2020; Goyal et al, 2021). Another study by Ghadashi, (2021) found that pregnant women in South Africa faced several barriers to accessing prepartum care during the pandemic,

including transportation difficulties due to lockdown restrictions, fear of contracting COVID-19 at health facilities, and a lack of information about how to access care during the pandemic. These challenges were not unique to the South African context but were also experienced in other countries such as the USA, China, and Tanzania (Marroquín et al., 2020; Salari et al., 2020).

Despite these challenges, there were some efforts to support pregnant women during the pandemic in South Africa, these included telehealth services and remote support programmes (Farrell et al., 2022; Fryer et al., 2020). These interventions aimed to provide pregnant women access to essential care and support during the pandemic. However, the interventions mentioned above were reported to be less effective due to lack of resources, specifically lack of internet access experienced in South Africa (Farrell et al., 2021; Fryer et al., 2020). Overall, much of the literature suggests that pregnancy during the COVID-19 pandemic was unpleasant for many women due to the additional challenges posed by the pandemic (Bertholdt et al., 2020; Viaux et al., 2020).

### *2.6.4 Global positive experiences of the prepartum period during COVID-19*

Despite most literature highlighting negative prepartum experiences of women during the COVID-19 pandemic, a significant amount of literature indicates positive experiences by some women as a result of the pandemic (Guatimosim, 2020; Joy et al., 2020; Kotlar et al., 2021). Meaney et al., (2022) suggest that many studies focused on the negative impact of COVID-19 on pregnancy; however, a growing body of literature highlights positive experiences of pregnancy during the pandemic. For example, some women were glad to have a reason to be away from the public and family as this allowed them 'peace' and enjoyment of the pregnancy (Eri et al., 2022; Kotlar, 2021). Bertholdt et al. (2020) and Gamberini et al., (2023) add that some women enjoy the convenience of having perinatal care services online. It was noted that these experiences were predominantly found in the literature from research

conducted in the global north (Bertholdt et al. (2020; Joy et al., 2020). Possible reasons include that the global north generally includes countries with better healthcare infrastructure and higher socio-economic development than the global South. As a result, women during the prepartum period in the global north may have had better online access to quality healthcare facilities, prepartum care, and support services contributing to positive experiences during pregnancy (Bradfield et al., 2021).

A systematic review in the UK conducted by Flaherty et al. (2022) indicated that pregnant women experienced reduced stress levels during the pandemic due to reduced exposure to pollution, increased time spent with family, and more flexible work arrangements. Another study by Zhou et al., (2021) in the USA that employed an online survey found that some pregnant women experienced improved mental health during the pandemic due to increased social support, reduced work-related stress, and more time for self-care activities. In addition, some pregnant women reported feeling more connected to their unborn babies during the pandemic due to the increased time spent at home (Sherin et al., 2021; Zhou et al., 2021). A cross-sectional study done in the USA by Liu et al. (2021) also found that pregnant women who had to adapt to changes in their prepartum care, such as virtual appointments, reported feeling more connected to their babies due to increased focus on self-monitoring and home monitoring. Furthermore, the pandemic also provided opportunities for pregnant women to engage in new activities, such as online prepartum yoga and childbirth classes, and to connect with other pregnant women through virtual support groups. Lebel et al., (2020) and Potharst et al. (2022) found that pregnant women who participated in a virtual support group during the pandemic reported improved mental health and increased social support.

Overall, while the pandemic brought many challenges for pregnant women, there are also positive experiences acknowledged in the literature. Both positive and negative experiences can provide insight into how healthcare providers could support pregnant women

during challenging times and can inform future research on maternal health during pandemics (Meaney et al., 2022; Zanhour & Sumpter, 2022). The presence of both positive and negative experiences in literature was considered significant to note during the data collection phase to ensure that I did not only focus on the negative experience of the participant but also prompted and explored the positive experience.

## 2.7 Women's experiences of the intrapartum[7] period during the COVID-19 pandemic

According to the literature, the COVID-19 pandemic significantly impacted the experience of giving birth. A European study by Coxon et al., (2020) found that the measures employed to contain the spread of COVID-19 in perinatal healthcare facilities impacted the provision of healthcare during birth. These measures included the restrictions of support persons, which resulted in women feeling lonely, anxious, and stressed during childbirth; the reduced availability of birth options such as water births; and the use of PPE, which resulted in communication challenges and further limited the ability of healthcare workers to provide reassurance and comfort during childbirth (Coxon et al., 2020; Maison et al., 2021). The literature further noted that research related to the intrapartum period was limited as opposed to the other perinatal periods. The limited available research related to the intrapartum period highlights the lack of qualitative exploratory studies done at that time (Coxon et al., 2020; Ryan et al., 2020).

### *2.7.1 Women's experiences of adverse pregnancy outcomes during the intrapartum period during the COVID-19 pandemic*

Research by Simeone et al., (2022) and Wei et al., (2021) that was conducted in the USA highlighted the impact of the pandemic on the birth process in various contexts and suggests that the pandemic contributed to an increase in adverse pregnancy outcomes due to

[7] Intrapartum- The period from the onset of labour to the delivery of the placenta during childbirth.

the increased stress and uncertainty that many women experienced during the intrapartum period. These adverse outcomes included increased preterm delivery (Calvert et al., 2023; Lin et al., 2021), stillbirth and miscarriages (Magnus et al., 2022; Ravaldi, 2019), which were associated with the increased stress caused by the pandemic. Further, a study by Savasi et al. (2020) suggested that COVID-19 infection during pregnancy was associated with an increased risk of preterm delivery, especially in the third trimester. The study attributed this increased risk to the inflammatory response associated with COVID-19 infection. Other factors that were suggested by other studies to contribute to the increased risk of adverse pregnancy outcomes during the COVID-19 pandemic were similar to the prepartum period. These included reduced access to healthcare, limited social support, and increased stress and anxiety during the intrapartum period due to changes in birth plans, fear of contracting the virus and other stressors that were related to the COVID-19 pandemic (Araya er al., 2023; Kolker et al., 2021). Another factor linked to the increase in birth complications was the decrease in perinatal care visits during pregnancy and the shutdown of health facilities due to COVID-19 cases in health facilities such as in South Africa (Mbunge, 2020; Naidu et al., 2020).

### *2.7.2 Women's experiences of changes in birth plans because of the pandemic*

Despite having a few studies exploring and highlighting the impact of the pandemic on women's experiences with changes in birth plans, a study conducted in Russia by Suarez and Yakupova (2022) indicated that the alteration of birth plans was the source of anxiety and worry that was frequently neglected. The study indicated that the pandemic led to changes in birth plans, including increased use of caesarean, delayed, or cancelled elective procedures, and reduced access to midwifery and doula support, which left many women during the intrapartum with uncertainty and anxiety (Suarez & Yakupova 2022).

In countries like Brazil, caesarean birth became prominent if women were exposed to or contracted the virus because the process allowed the patient to wear a mask and thus reduced

COVID-19 transmission (Freitas-Jesus, 2020; Pustulka & Buler, 2020). For example, Saccone et al., (2020) indicated that an increase of 16.7% in birth via caesarean was noted. According to Blakeway et al., (2020) and Saccone et al., (2020), the change from natural birth to caesarean birth was also due to women voluntarily requesting the change in birth plan during the intrapartum period. The caesarean was upon request by the mothers due to considerable anxiety about possible foetal death or injury (Saccone et al., 2020). Riley et al., (2021) and Suarez and Yakupova et al., (2022), explained that many women reported increased levels of fear and anxiety due to the risk of contracting COVID-19 while giving birth and the possibility of being separated from their newborns if they tested positive and as a result opted for caesarean birth since it was reported to have reduced chances of the spread of the virus from the health workers but also from the mother to child during birth. They further highlighted the impact of limited support due to COVID-19 restrictions and argued that the experience of reduced support from family and friends during labour and delivery led to feelings of isolation and stress, especially for women going through the birth experience for the first time.

### *2.7.3 Positive experiences of the intrapartum period during the COVID-19 pandemic*

However, despite the above-mentioned challenges, some studies highlighted the positive experiences of some women giving birth during the COVID-19 pandemic. A qualitative study by Suares and Yakupova (2022) conducted in Russia found that women felt more supported and cared for by healthcare professionals during the birth process in the context of the pandemic. They also reported feeling a greater sense of control during the birth process due to fewer distractions and interruptions (Suares & Yakupova, 2022). The findings by Suares and Yakupova (2022) were supported by a thematic analysis conducted in the UK by Jackson et al. (2023), which found that women felt more connected to their babies and partners during the intrapartum period as the limitations on visitors allowed them more time to bond with their newborns. Janevic et al., (2021) also found that women who gave birth during the pandemic

reported higher satisfaction levels with their childbirth experience than women who gave birth before the pandemic. These positive experiences of the intrapartum period during the pandemic were noted to be in the global north predominately. Possible reasons for the positive experiences in the global north include those women in the above contexts had access to the following: developed health infrastructure and medical professionals, which result in greater access to interventions and technologies that improve childbirth experiences; socioeconomic factors play a significant role in shaping the experiences of childbirth (Janevic et al., 2021). The global north generally has higher socioeconomic development, which can lead to better access to health care. In contrast, the global South often encounters economic challenges, including limited access to healthcare services, which can negatively impact childbirth experiences (Suares & Yakupova, 2022).

Another reason for the positive experiences reported in the global north may include research bias and reporting (Saccone et al., 2020). Research bias and reporting might occur because of studies conducted in the global north receiving more attention and funding, leading to more publications and a higher likelihood of positive findings (Saccone et al., 2020). In contrast, studies in the global South frequently encounter resource challenges and limitations in data collection and dissemination, which can result in a relative underrepresentation of positive experiences (Saccone et al., 2020).

### 2.8 Women's postpartum experiences of the perinatal period during COVID-19

Like prepartum experiences, literature concerning the postpartum period included positive and negative experiences. However, negative experiences were predominant (Joy et al., 2020; Kotlar et al., 2021). Further, according to a study conducted in the UK by Jackson et al., (2021), there is a lack of qualitative studies related to the postpartum period as most studies focused on the initial phase of the lockdown restrictions. Qualitative research can produce

richer insights into the impact of the pandemic and its regulations on maternal emotional well-being, (Jackson et al., 2021).

A descriptive analysis by Dib et al., (2021) conducted in the UK and another by Jungari (2020) conducted in Indi highlighted an increase in mental health issues amongst women during the postpartum period when compared to the post-partum period pre-pandemic. These mental health issues included anxiety and postnatal depression after women gave birth during COVID-19. According to Saccone et al., (2020), the rates of postpartum anxiety were as high as 23.6% compared to 15.4% prior to the pandemic; depression was 24.6% compared to 15.9% prior to the pandemic. The factors that contributed to the increased prevalence of mental health issues are explored below.

### *2.8.1 Women's experiences of changes in postpartum care during the COVID-19 pandemic*

A self-report questionnaire conducted in Poland by Kołomańska-Bogucka et al., (2023), together with a study by Tauqeer et al., (2023) conducted in the UK highlighted that woman experienced changes in postpartum care during the pandemic. These included changes in hospital policies, such as shortened hospital stays and limited access to face-to-face consultants. Women also reported feeling unsupported and anxious after giving birth due to reduced access to healthcare providers, particularly in cases of postpartum depression (Ashby et al., 2022; Chrzan-Dętkoś & Walczak-Kozłowska, 2022). In the study by Tauqeer et al., (2023), women reported feeling as though their mental health was downplayed as a result of the pandemic. The physical health of the mother and child was prioritised more than their mental health, and as a result the women reported feeling as though the quality of postpartum care was altered. For example, women reported a lack of communication and information provision from healthcare providers regarding mental health (Afulani et al., 2020; Oosthuizen et al., 2022). Some women reported telehealth consultations as inadequate and preferred face-

to-face consultations. Overall, a significant number of changes were implemented in postpartum care as a result of the pandemic which impacted women (Oosthuizen et al., 2022).

### *2.8.2 Women's postpartum experiences of social support during the pandemic*

According to a study done in the USA by Mollard and Wittmaack (2021), one of the precipitating factors of mental health issues experienced by women during the pandemic was the lack of social support due to lockdown restrictions[8]. The lack of support was not only limited to family and friends, but also to the healthcare services. Further, according to a study conducted in India by Jungari, (2020) and another in China by Saccone et al., (2020) the lack of social support, isolation, and Quarantine[9] during the postpartum period contributed to an increase in self-harming thoughts with plan that women during this period experienced. Liu et al., (2021) explained that the postpartum period is when women are particularly vulnerable to mental health challenges, such as depression, anxiety, and suicidal ideation due to contributors such as sleep deprivation, rapid hormonal changes, physical recovery and other life adjustments. Subsequently, social support is crucial during this time, and the lack of it is identified as a risk factor for mental health issues for women, such as postpartum depression and anxiety (Bauer et al., 2022; Bedaso et al., 2021). Whaley and Pfefferbaum (2023) indicate that COVID-19 and the lockdown exacerbated the parenting challenges experienced by women during the postpartum period. Having a child and living through COVID-19 required increased and intensive support to ensure positive outcomes for the child and mother (Saccone et al., 2020).

[9] Quarantine- occurs when people exposed to an infectious or contagious disease are absent from the public for a certain period.

### *2.8.3 Women's postpartum experiences of breastfeeding during the COVID-19 pandemic*

A narrative review conducted in five countries (Australia, the UK, the US, New Zealand and Canada) revealed that the pandemic presented new challenges for breastfeeding mothers during the postpartum period (Turner et al., 2022). These challenges included limited access to lactation consultants and insufficient knowledge regarding the transmission of COVID-19 through breast milk (Huang et al., (2022); Turner et al., 2022). The results of an online survey study conducted in the UK by Brown and Shenker, (2020) found that the pandemic contributed to changes in breastfeeding practices. These changes included a decrease in exclusive breastfeeding and an increase in formula feeding (Brown & Shenker, 2020). A study conducted in Brazil found that the prevalence of exclusive breastfeeding decreased from 46.9% to 34.5% during the pandemic (Gonçalves-Ferri et al., 2021). Similarly, a study conducted in Italy found that the prevalence of exclusive breastfeeding decreased from 39.1% to 25.6% during the pandemic (Ravaldi et al., 2022). The decrease in breastfeeding was reported to have the potential for long- and short-term outcomes on the health of the children born. While several studies highlighted that the virus could not be transmitted through breast milk, women were reported to experience the fear of transmitting the virus to their babies via breast milk if they tested positive (Al-Kuraishy et al., 2021; Bhatt, 2021).

Additionally, studies conducted in the USA by Spatz et al., (2021) and Yip et al., (2022) highlighted the impact of the lack of support on breastfeeding due to the pandemic. The studies found that the COVID-19 pandemic created numerous barriers to breastfeeding, including restrictions on hospital visitors and support persons and reduced access to lactation support (Spatz et al., 2021; Yip et al., 2022). According to Spatz et al., (2020), many hospitals had implemented visitor restrictions that prevented support persons from being present during labour and delivery, affecting mothers' ability to initiate and continue breastfeeding (Spatz et al., 2020). Overall, the pandemic created multiple barriers that hindered the support and

promotion of breastfeeding (Spatz et al., 2021). Another study conducted in the United States found that the pandemic had increased anxiety and depression among postpartum mothers, which may have affected their breastfeeding ability (Shuman et al., 2022). According to Shuman et al., (2022), the negative impact of the pandemic on women's mental health during the postpartum period contributed to reduced milk supply and disrupted breastfeeding patterns, amongst other contributions. Overall, the pandemic negatively affected the process of breastfeeding (Shuman et al., 2022).

### *2.8.4 Concerns about the safety and welfare of the newborn*

A cross-sectional study conducted in Cyprus by Hadjigeorgiou et al., (2022) found that the mothers' concerns during the postpartum period in the study were related to the health and welfare of their newborn. According to Kobi (2021), newborns and their mothers are particularly susceptible to illness and injuries during a hazardous event such as a pandemic. Systematic reviews conducted in India and Turkey reported that the fear of their babies contracting COVID-19 increased anxiety, depression, and posttraumatic stress disorder (PTSD) symptoms among women, especially new mothers (Dubey et al., 2020; Yildiz et al., 2022). The fear of transmitting the virus to their babies was further reported to have also affected the attachment and bonding process between mother and child (Liu et al., 2022; Sariboga et al., 2022). Two cross-sectional studies conducted in the USA by Liu et al., (2022) and another in Turkey by Sariboga et al., (20220 showed that new mothers were afraid of transmitting the virus avoid physical contact with their babies and, thus leading to difficulties in breastfeeding and a decreased likelihood of developing a secure attachment.

### *2.8.5 Women's experiences of the postpartum period in the South African context*

Several studies highlighted women's experiences related explicitly to Sub-Saharan Africa (Kobi et al., 2021; Ogunkola et al., 2021). The studies reported an increase in numbers of unemployment and violence on women during the postpartum period (Kobi et al., 2021;

Ogunkola et al., 2021). A study conducted by Mbunge (2021) in South Africa showed an increased prevalence of women experiencing gender-based violence (GBV) due to quarantine and lockdown. Women who experienced GBV during the pandemic were found to be more likely to experience postpartum depression, anxiety, and stress (Mahlangu et al., 2022; Keynejad, 2023). The stressors associated with the COVID-19 pandemic, such as financial strain, social isolation, and lack of access to healthcare, were also found to exacerbate the impact of GBV on the mental health of women during the postpartum period in the South African context (Keynejad, 2023).

### *2.8.6 Transitioning into motherhood during the COVID-19 pandemic*

An online self-report questionnaire conducted in Italy by Molgora and Accordini, (2020) revealed that the transition to motherhood is a significant event for women expecting for the first time. First time mothers are regarded as more vulnerable to psychological distress due to the new responsibility, task, and shift in their sense of self (Molgora & Accordini, 2020). The COVID-19 pandemic led to significant disruptions in the healthcare system and social support networks, impacting new mothers' mental health (Yip et al., 2022). However, despite the above being known, a descriptive phenomenological study conducted in China, Hong Kong by Yip et al., (2022) reported that studies related to the experience of first-time mothers during the COVID-19 pandemic are limited. According to Keely et al., (2023), the global COVID-19 pandemic undermined the mental health of first-time expecting mothers. Navigating motherhood for the first time for many new mothers was lonely and difficult for many women due to the restrictions imposed in response to the pandemic (Yip et al., 2022). Yirmiya et al., (2021) note elevated rates of depression, anxiety, and stress in first time mothers compared to other women who were not expecting for the first time. In a narrative review study by Schoenmakers et al., (2022) conducted in the Netherlands, most women expecting for the first-time experienced distress due to COVID-19 related prepartum changes. Additionally, an online

survey conducted in the USA by Devoto et al., (2022) also indicated that pandemic-related increases in intimate partner violence, alcohol use, and other life demands, such as caring for someone who was infected by the virus, predicted worse mental health for first time mothers.

### *2.8.7 Women's positive postpartum experiences during the COVID-19 pandemic*

International literature, such as literature from the UK and the USA, indicated that some mothers coped despite the changes brought about by COVID-19 (Dib et al., 2020; Kobi et al., 2021). A descriptive analysis conducted by Dib et al. (2020) reported that some new mothers experienced the postpartum period during the pandemic as a time to gain confidence in maternity. A thematic analysis study by Fumagalli et al. (2022) found that women who gave birth during the pandemic in Italy reported positive experiences, including increased bonding and attachment time with their new-born due to extended maternity leave, increased family support, and improved communication with healthcare providers via telehealth. Other studies highlighted the reduced pressure to socialise and attend events, which were argued to result in less stress and anxiety by Dawes et al., (2021). Most studies that were related to positive postpartum experiences were noted to be international studies however, a thematic analysis conducted in South Africa by October et al., (2021) highlighted women's experiences of the benefits of increased flexibility in working hours and less pressure to return to work after their maternity leave as they could work from home (October et al., 2021).

## 2.9 Conclusion

This chapter reviewed the currently available literature related on women's experiences of the perinatal period during the COVID-19 pandemic. The chapter highlighted the need for research that is from a qualitative stance and focuses on subjective experiences. The literature also highlighted that all stages of the perinatal period which consisted of both positive and negative experiences during the COVID-19 pandemic and that the global North tends to be portrayed as having more positive experiences due to the access to resources for research. The

impact of the pandemic on health facilities has affected all stages of the perinatal period, leading to multiple sources of stress and anxiety, such as uncertainty of perinatal care services, changes in birth plans and service delivery. The financial impact of the pandemic was one of the major sources of stress and anxiety for women during the perinatal period.

# 3. CHAPTER 3: RESEARCH METHODOLOGY

## 3.1 Introduction

This chapter outlines the research methodology employed in the study. This includes a discussion of the study's theoretical framework (IPA), including the history of IPA and its current status in research. Thereafter, the single case study research design is described, including the motivation for the research design and theoretical framework. Lastly, the chapter describes the research aim, provides details of the participants, describes the process of data analysis, and discusses the ethical considerations and the reliability and validity of the study.

## 3.2 Theoretical Framework

### *3.2.1 Interpretative Phenomenological Analysis (IPA)*

IPA is a qualitative approach developed by Jonathan Smith (Smith & Nizza, 2022; Smith et al, 2021). The approach was designed to understand people's lived experiences and how they make sense of experiences in the context of their social and personal worlds (Shinebourne & Smith, 2011). IPA aims to achieve insight into participants' experiences from their point of view; it is interested in rich descriptions of experience together with the emotions surrounding the experience (Eatough & Smith, 2008).

IPA does not intend to test hypotheses but rather to understand personal experiences. Using this theoretical framework, the researcher aimed to acquire insight into what it may be like to have had the particular experiences in question from the participants' point of view by trying to capture the emotions surrounding the particular experience and how the participant makes sense of them (Smith & Nizza 2022). IPA regards humans not as passive object perceivers of their reality but with the ability to make meaning of their experiences in a manner that makes sense to them (Smith et al., 2021). Smith et al., (2012) indicate that experience is a concept that is complex. As a result, IPA is particularly interested in what occurs when our

everyday lived experiences become significant to us, such as when something significant occurs in our lives, for example pregnancy during COVID-19, as in the case of the participant of the current study. Smith et al., (2012) reported that we are constantly caught up unconsciously in our everyday flow of experience, and the moment we become aware of what is happening, we have 'an experience'.

### *3.2.2 Theoretical underpinnings of IPA*

The following three theoretical and philosophical underpinnings of IPA are employed in this study: hermeneutics, phenomenology and idiography (Eatough & Smith, 2008). Employing these theoretical underpinnings involve withholding prior theories held by the researcher and exploring the participant's meaning of their experience as it emerges (Smith, 1999). IPA is an inductive approach; it is a bottom-up process (Larkin et al., 2006). IPA does not assume prior knowledge or aim to test hypotheses; rather it intends to explore and capture the meaning that the participant assigns to their experience. Therefore, these philosophical principles enable the analysis and examination of the participant's account. The theoretical underpinnings are explored below.

#### *3.2.2.1 Phenomenology*

Phenomenology is a philosophical approach that aims to study lived human experiences (Smith & Nizza 2022). This theoretical underpinning is interested in the experience of being a human being by considering the different aspects of humanity and more specifically, things that matter to us as humans and form part of the world we live in (Smith et al., 2021). Smith et al., (2009) highlight that in psychology, the main value of phenomenological philosophy is that it supplies us with ideas of comprehending and examining lived experiences.

According to Smith et al., (2009), phenomenology involves two approaches: descriptive and interpretive phenomenology. Descriptive phenomenology involves the researcher describing the essence of the participant's lived experiences through suspending

their prior knowledge to reflect on the current phenomenon and avoiding the inclination of assigning meaning. In the case of the current study, descriptive analysis was employed to capture the detailed descriptions of the participant's experiences by transcribing the interviews and analysing the textual data (Smith, 2009). Interpretative analysis was employed with the aim of going beyond mere descriptions, which entailed interpreting the underlying patterns, structures, and themes that emerged from the data (Shinebourne, 2011). The researcher also employed phenomenology as they were concerned with the participant's account and their perception of their experience instead of producing objective statements (Larkin & Thompson, 2012).

Phenomenology is further founded on the principle that experiences should be explored in the manner that they occur rather than according to predefined theoretical categories (Shinebourne, 2011). The emphasis of phenomenology is on the world lived by the individuals as opposed to a world or reality separate from the individual (Smith & Nizza 2022). This principle was useful during the analysis of the data and the writing of the findings of the study in instances where the participant's experience and interpretation was particularly distinct from her actual world and reality. Below the researcher considers the work of the two major phenomenological philosophers, Husserl and Heidegger. Together, these philosophers work in a manner that is consistent with the core of phenomenology. However, they are also noted to work distinctively (Smith et al., 2021).

According to Edmund Husserl (1859-1938), who developed phenomenology, phenomenology involves examining human experiences carefully and understanding how the experience of a given phenomenon can be accurately known enough for its essential qualities to be determined. Phenomenology for Husserl involved stepping out of our ordinary and everyday experience, 'our natural attitude' (being unreflective), in order to allow ourselves to examine every day experiences (Smith et al., 2021). Husserl was particularly interested in how

a person comes to accurately become aware of their experience, which is achieved using rigour and depth during the interview process, as this allows the participants to identify the essential traits of their experience (Smith et al., (2021).

Husserl also believed that phenomenology requires focus on the experience that is in the conscious of the individual (Smith et al., 2009). He employed the term intentionality[10] to describe the relationship between the processing in the consciousness and the object attended to in the process - our consciousness is always conscious of something (Smith et al., 2012). This concept allowed the researcher to focus on understanding the intentional acts and meanings behind the participant's experiences to examine how the participant interprets, perceives, and makes sense of her experiences and uncover the underlying motivations and intentions (Smith et al., 2021). The researcher was also able to explore the participant's experience in-depth due to its emphasis on studying phenomena as directly experienced by individuals but also understanding the essence of experiences and the meanings they held by the individuals (Smith., 2009). Overall, intentionality permitted the researcher to go beyond surface-level descriptions and delve deep into the underlying motivations and interpretations that shape the experiences (Shinebourne, 2011).

Husserl also developed a phenomenological method to help us obtain our phenomenological attitude (Smith et al., 2021). The method also assists with determining the core features and structures of our human experience. He suggested that researchers need to practice bracketing/epoché[11]. This process of bracketing takes place through a series of reductions intended to move us away from our preconceptions and assumptions to take us to the experience of a given phenomenon (Smith., 2009). Through the suspension of judgement,

[10] Intentionality-the conscious is believed to always be directed towards something.
[11] Bracketing/epoché-a process involving setting aside preconceived assumptions, notions and biases during data analysis.

the researcher is enabled to engage in an open exploration of the participants' experiences without imposing their own interpretations (Smith & Nizza 2022). The use of epoché and phenomenological reduction[12] is another significant aspect of phenomenology in IPA. These practices allow researchers to distil the core meanings and essences of participants' experiences (Eatough & Smith, 2008). For Husserl, the task is to establish the core of subjective experience: the essence, the eidos or idea (Smith et al., 2021). A technique that was employed to achieve this essence is 'free imaginative variation' where the researcher carefully explored multiple instances of experience. According to Smith et al., (2012), the process is likely to attend to the meaning of the particular lived experience.

IPA is also influenced by the existential and phenomenological perspective of Heidegger, (Smith et al., (2021). Heidegger was primarily concerned about the ontological question of existence. He believed firstly that humans are thrown into a world of relationships, objects and language. Secondly, our existence is always in relation to something; it is temporal, and the interpretation and meaning that people make from their experiences is central to psychology and the phenomenological inquiry (Smith et al., 2021). Heidegger seeks reflection and deep engagement with the participant's lived experience by the researcher. The participant is considered embedded and embodied in a particular historical, cultural and social context (Shinebourne, 2011). In essence, Heidegger articulated the significance of seeing phenomenology as an interpretative aspiration (Smith & Nizza 2022). He indicated that phenomenology enables the researcher to uncover the essence of the phenomenon being studied, within its specific context to provide a unique perspective and in-depth insights that other approaches may not capture. He believed that meaning in experiences is not always visible and self-evident but rather involves penetrating deeper through the surface appearance.

[12] Phenomenological reduction- a systematic process that involves focusing on the essential aspects of an experience while bracketing irrelevant and distracting elements.

Phenomenology involves closely engaging with what is heard or seen and seeking clues to find the actual meaning (Eatough & Smith, 2008). This is particularly possible when employing a single case study design since it allows for deep engagement with one participant's experience as per their context to produce a rich case description and interpretation (Smith & Nizza 2022).

#### *3.2.2.2 Hermeneutics*

Smith et al., (2022) indicate that hermeneutics also influences IPA. According to Shinebourne (2012), hermeneutics is a theory of interpretation and understanding. The theory intends to explore the purpose and methods of interpretation. Interpretation in hermeneutics involves revealing what is hidden where a phenomenon comes to light (Shinebourne, 2012). Shinebourne (2011) suggests that the way our human experiences appear to us may be by virtue of existing in a particular context and can, therefore, mask aspects of the experience. Therefore, the task of interpreting involves engaging with the dynamic of what is hidden. According to Heidegger, this process of interpretation involved in hermeneutics occurs through discourse; the process allows the researcher to assume an active role in the dynamic process of interpretation. While the participant makes sense of their subjective experiences, the analytic process of interpretation allowed the researcher to get close to the participant's world while being empathetic, critical and curious. Further, hermeneutics allows the researcher to employ their own experience of the phenomena explored to make sense of the participant's 'inside world' (Eatough & Smith, 2006). The dual process of interpretation is referred to as the hermeneutic circle theory or double hermeneutics (Smith et al., 2009). Smith et al., (2022) indicate that the hermeneutic circle is the most echoed idea in hermeneutics. The theory concerns with the dynamic relationship that occurs between the part and the whole at different levels. To understand a part, one looks at the whole and vice versa. In analytic terms, the idea describes the process of interpretation and the non-linear, dynamic style of thinking.

The hermeneutic circle was deemed useful for this current study as the researcher also experienced the perinatal period during the COVID-19 pandemic. Unlike other qualitative methods, hermeneutics in IPA allows the analyst to become part of the research process explicitly (Shinebourne & Smith, 2009). This technique allowed me as the researcher to engage in a reflexive process to reflect on my own biases and preconceptions and how these shaped my interpretations of the participant's experiences (Smith et al., 2022). This self-reflection process enhances the rigour and transparency of the research process and further enables a contextualised and nuanced understanding of the participant's experience (Shinebourne, 2012).

The process of multiple hermeneutics also takes place when combining different levels of interpretation. According to Smith (2009), to understand the participants' lived experience holistically of the perinatal period during the COVID-19, two hermeneutic modes of engagement are applied. The first involves empathetic engagement and hermeneutic meaning-making. The second involves critical engagement and hermeneutic suspicion. Thus, to holistically understand the lived perinatal experiences of a woman during the COVID-19 pandemic, the two modes need to be applied. To employ the two hermeneutic modes, the researcher assumes an empathetic stance by imagining what it is like to be the participant. Simultaneously, the researcher must be critical of what the participant reveals and probe for the meaning of the participant's experience, which the participant might not be able and/or willing to do (Eatough & Smith, 2008). The first mode aims to produce an experiential understanding of the phenomenon that is rich while also remaining close to how the participant makes sense of their experience. The second mode enables the researcher to withhold what they may have previously accepted at face value to produce a multi-layered and textured narrative of all possible meanings (Eatough & Smith, 2008).

Smith et al., (2021) highlight that IPA requires both phenomenological and hermeneutic insight. Phenomenology intends to get close to the participant's personal experience; however,

it acknowledges that the process inevitably involves interpretation, which forms part of hermeneutics. Without phenomenology, there would be nothing to be interpreted, and without the hermeneutics, the phenomenon would not be known or seen (Smith et al., 2021). Hermeneutics is important in single case study approaches due to its focus on interpretating and understanding of symbols, texts and other forms of communication (Smith et al., 2022). When hermeneutics is employed in single case studies, it allows the researcher to delve into the interpretations and meanings that the participant assigns to their experience as they express them through their narrative during the interview process (Eatough and Smith, 2008). Through the analysis of the symbols, language, and cultural references that the participant employs, the researcher gains insight into the participant's values, beliefs and worldview (Smith et al., 2021). This interpretative approach allows the researcher to uncover the underlying significance and meaning attached to the particular case. This theoretical underpinning facilitates a more comprehensive interpretation and analysis of the participant's experiences (Crotty, 1998, cited in McNamara, 2022).

Hermeneutics in IPA intends to interpret and understand phenomena through the lens of the participant (Crotty, 1998 cited in McNamara, 2022). It draws on what the participant was concerned about and what she cared for. The method assumes that the participant is the expert of their own experience and thus offers the researcher an understanding of their feelings, thoughts and commitments through the participant telling their own story, in their own words and in as much detail as possible. Hence, during the recruitment phase, participants are carefully selected according to the phenomena explored (Smith et al, 2009).

#### *3.2.2.3 Idiography*

The last theoretical underpinning of IPA is idiography, which is concerned with the particular (Smith et al.,2021). Idiography is often discussed in contrast to nomothetic approaches, which involve establishing generalisations and laws that are valid for a specific

population group (Larkin et al., 2011), rather idiography focuses on the particular (Smith et al., 2022). This theoretical underpinning involves closely focusing and analysing each individual case and the individual involved to consider their account in detail in their specific context. This is achieved as idiography concerns itself with understanding the particular and unique while the integrity of the person is maintained (Eatough & Smith, 2008). For the above reasons, single case studies are not uncommon in IPA, and in this study, a single case was used to explore and understand the participant's perspective of her experience of the perinatal period during the COVID-19 pandemic (Smith et al., 2021).

An idiographic approach has the potential to reveal factors that may be neglected in a group context such as the details of a particular experience and idiosyncratic behaviours (Eatough & Smith, 2008). According to Smith et al., (2009), individuals can contribute unique perspectives of a particular phenomenon; the individual can become the unit of study. Thus, a commitment to idiography is closely linked to the rationale for a case study design. Smith et al., (2009) further indicate that a detailed analysis of a case study is justified when the case is rich and compelling. This was important for the researcher to keep in mind during the data collection phase to ensure that detailed and sufficient data was collected to ensure that the case was rich and compelling (Smith et al., 2009).

According to Smith et al., (2022), the commitment of IPA to the particular operates at two levels. The first commitment relates to the sense of detail and therefore focuses on the depth of analysis. The first commitment was applied during the analysis phase, where the researcher considered as much detail of the data collected as possible, such as the language, tone, and non-verbal expressions. This first commitment ensured that the analysis was done thoroughly and systematically. The second commitment is concerned with understanding how a particular phenomenon has been understood through the participant's perspective and in a particular context (Smith et al., 2022).

When idiography is employed in single case study approaches, it highlights the specific details and unique qualities of the case (Shinebourne 2011). Idiography acknowledges each case with its own specific characteristics as a unit of understanding and recognises that it should be studied in its own right (Larkin et al., 2011). In case studies, idiography encourages the researcher to explore the specific details, complexities, and nuances of the individual case (Smith et al., 2009). An idiographic analysis of a case study provides a comprehensive understanding of the case being studied, including factors that make the case unique and potential implications of the findings of other similar cases. IPA offers the researcher an opportunity to engage with the research question at an idiographic level unlike other traditional qualitative research methods (Pietkiewicz, 2012). The richness, texture and depth of a participant's account provides an opportunity to conduct a detailed idiographic case study (Smith et al., 2022).

### 3.3 The development and history of IPA

According to Biggerstaff and Thompson (2008) and Shinebourne (2011), IPA was initially introduced as a distinctive methodology in psychology in the mid-1990s at a time when Jonathan Smith made use of phenomenological and hermeneutic theoretical views to engage with subjective experiences and personal accounts. These theoretical views were inspired by Martin Heidegger, Edmund Husserl and Maurice Mearleau-Ponty. Smith et al., (2022) argue that the method made its first mark precisely in 1996 in a publication by Smith in Psychology and Health, where he argued for a psychological approach that is able to capture the qualitative and experiential while maintaining dialogue with mainstream psychology. The aim was to establish a qualitative approach that is centred on psychology instead of an approach adopted from different disciplines. Thereafter, IPA widened its reach and has become one of the best-established qualitative approaches in psychology especially in clinical and counselling psychology (Larkin et al., 2006). A key motivation for the development of IPA was the demand

for a qualitative approach located firmly within psychology and simultaneously acknowledges the discipline's lineage history regarding qualitative approaches (Eatough, 2012).

### 3.4 Current status of IPA in research

Smith (2009) indicates that IPA has become one of the most employed qualitative methodologies in psychology and other academic disciplines, including healthcare, sociology and organisational studies. One of the reasons for IPA's enduring popularity is its emphasis on understanding and interpreting individual's subjective experiences such as its use in single case studies. IPA allows the researcher to delve deeply into the interpretations and meanings attributed by the participant to their experience and thus provides valuable insights that other qualitative methods may not be able to capture (Smith, 2011). Further, IPA offers an in-depth and flexible analytical framework that allows the researcher to explore the lived reality of the participant (Smith et al., 2022). Smith et al., (2021) add that the mission of IPA is to examine nuanced and detailed experiences of a small number of participants.

Researchers continue to employ IPA to investigate diverse topics, such as chronic illnesses, mental health, trauma, identity formation, interpersonal relationships, cultural phenomena and organisational behaviour as it has proven to be appealing to researchers (Smith et al., 2021). According to Smith et al., (2022), IPA has been increasingly utilized in various research designs, including single-case studies, longitudinal studies, multiple-case studies, and mixed-methods approaches. Researchers also combined IPA with other qualitative methods, such as discourse analysis, narrative analysis, and grounded theory, to enhance their understanding of the participants' experiences (Smith et al., 2021). Moreover, advancements in data analysis and technology software have facilitated IPA studies' analysis and data management processes in IPA studies (Smith et al., 2021). Transcription software and data

analysis software such as NVivo[13], and online platforms for data collection streamline the coding, data handling, and interpretation phases of IPA research (Smith et al., 2021).

## 3.5 Research design

### *3.5.1 Research aim and question*

The purpose of the study was to understand how a South African woman experienced the perinatal period during the COVID-19 pandemic by exploring a single case study. The study aims to provide an extensive interpretative analysis of the experience of an individual woman who experienced the perinatal period during COVID-19. The study intends to understand how she made sense of her experience.

The research question that the study aims to answer is: How did the participant experience the perinatal period during the COVID-19 pandemic in the context of South Africa particularly in Makhanda? Research questions in IPA studies tend to be framed openly and broadly; this is because the researcher does not intend to test a predetermined hypothesis; instead, the aim is to flexibly explore the area of concern in detail (Smith et al., 2009).

### *3.5.2 Single Case Study*

According to Shinebourne and Smith (2009), focusing in depth on a specific experience of an individual in relation to a particular phenomenon, such as the perinatal period, builds on the limited number of qualitative studies in the literature and contributes to further understanding of the impact of COVID-19 on the experience of the perinatal period. Smith (2004), as cited in Shinebourne and Smith (2009), indicates that a detailed analysis of a single case study is justified when a researcher has a particularly compelling and rich case. A detailed single case study provides an opportunity to learn significantly about the participant and their

[13] NVivo-a computer software that is used to analyse, manage and visualise qualitative documents and data systematically and individually.

response in relation to a specific experience or situation. It provides an opportunity to connect different aspects of the particular participant's account (Rhodes & Smith, 2010). According to Smith et al., (2009), the holistic nature of the single person case study permits what Mischler (1984) referred to as 'the voice of the lifeworld' to become visible. Suggesting that the case is a portrayal of the participant's way of being in the world.

The idiographic approach employed also assisted in achieving an in-depth understanding of the participant that is not possible to achieve in nomothetic research which does not provide access to certain explorations of the individual but focuses on aggregate data. Idiographic studies, such as the current single case study, consider the individual participant as a unit of analysis.

Case studies in IPA also offer a perspective that affirms and illuminates the centrality of certain general themes in the lives of the particular participant, (Evans, 1999) as cited in Rhodes & Smith, 2010). Thackery (2015) added that the commitment to detailing the variability and diversity of human experience while attempting to demonstrate that participant's the shared experiences can create a tension that can be avoided in single case studies. Platt (1988) as cited in Smith et al., (2022) argue that case studies demonstrate existence and not incidence; single case studies show us how a phenomenon is and, as a result unfold the phenomena in an insightful manner. Case studies can also point to the flaws in existing literature and theoretical claims regarding populations. They provide means to shake our preconceptions, assumptions, and theories as they pay attention to detail. Lastly, Smith (2004) indicates that most studies in IPA involve a small sample size. The value of a case study is that its detail tends to be twofold. The reader is provided with the opportunity to learn about the participant and how they responded to a particular experience, and more so there is an opportunity to witness the connections between different aspects of the participant's account. Warnock, (1987) as cited in Smith (2004), argues that the details of a single case study tend to

draw us closer to the important aspects of a shared humanity as the particular case can be described as containing an essence: the 'essence' that links idiography to phenomenology in psychology.

### *3.5.3 Sampling and Recruitment*

Due to IPA's idiographic nature and its aim to illuminate individual lived experiences, the purposive sampling method was employed (Smith & Nizza 2022; Smith & Shinebourne, 2012b). The process involved direct reference to the research question when selecting the participant (Smith et al., 1999). Upon receiving the required ethical permission, recruitment advertisements (appendix A & B) that stated the description and purpose of the study, method for data collection and approximate timeline were advertised in General Practitioner's offices and Early Childhood Development (ECD) centres within Makhanda for potential participants who were interested in the study to contact the researcher. The inclusion criteria for the study included: women who were 18 years or older, who were a first-time mother, currently residing in Makhanda, and who gave birth in a public hospital during the third wave of COVID-19 in South Africa (June/July/August 2021). The rationale for the selection of the third wave was that this wave the most recent wave of COVID-19 at the time that the study was proposed and subsequently conducted. Therefore the selected participant's experience would be recent hopefully providing richer interviews as the participant's experience would be less challenging for them to recall.

General medical practitioners and ECD centres were identified as appropriate gatekeepers (Appendix C) for women during the perinatal period, is likely to visit medical practitioners for reasons relating to their unborn or born child; they are also likely to be seen in ECD centres.

Through these recruitment methods, only one participant made contact with the researcher. In hindsight, the advertisement may not have effectively reached the target audience

for numerous reasons. In consideration of the above recruitment methods, general practitioner offices and ECDs tend to have a smaller population of the target audience in comparison to other facilities that may have a larger population, such as hospitals and clinics. Further, the study may not have been adequately publicised and as a result potential participants were not aware of its existence. Other reasons include that women during the perinatal period frequently have busy schedules, and finding time for the study may have been challenging. Considering the above challenges, the researcher decided to proceed with a single case study design, given that the IPA permits the nature of such a study. The researcher then requested consent to conduct two individual interviews with the participant to ensure that sufficient data was collected for the single case study.

### *3.5.4 Details of the participant*

The participant, Sunita (pseudonym), is a female in her early 20s. The participant is fluent in English and Afrikaans, with Afrikaans being her home language, while English was the language she used as a medium of instruction at the ECD. She was a first-time mother. At the time of the interviews, she was residing with her family; her daughter, her mother and siblings. The participant initially resided in a city in South Africa in an apartment together with the father of her child. She was then dismissed from work and as a result, they temporarily resided with her then partner's family. Her partner shortly thereafter had to move to another City for employment purposes. Sunita later temporarily followed her partner to when she was five months pregnant and travelled during the second wave of the COVID-19 pandemic when the Beta (501Y. V2) COVID-19 variant was dominant (Hunter et al., 2021). She later moved back to Makhanda which she referred to as "home" (the family home where she was born and raised) when she was eight months pregnant. During this time, the country was experiencing the third wave of the pandemic, which was from May 2021-October 2021. South Africa was also experiencing the spread of the highly mutated Delta (C.1.2) lineage COVID-19 variant

that was initially detected in May 2021 (Hunter et al., 2021). On the 17th of February 2021, the national vaccine programme against COVID-19 began (Hunter et al., 2021). During this time, the vaccination programme targeted high-risk populations such as people over the age of fifty, health workers and those with comorbidities (Hunter et al., 2021). Despite the target population being high-risk individuals, pregnant individuals such as the participants were excluded due to the lack of research data about the efficacy and safety of the vaccine on them (Hunter et al., 2021).

Sunita gave birth via caesarean at home in August 2021 during the adjusted level 3 COVID-19 restrictions which were announced on the 25th of July 2021. The restrictions affected the movement of persons and the use of public transport amongst other areas of life. She has since resided with her daughter, mother, and siblings.

### *3.5.5 Pilot interview*

Prior to conducting the interviews with the participant, the researcher conducted a pilot interview with a colleague who best met the criteria of the study. The idea was inspired by the advice of Smith et al., (2009) who he indicated that a 'pilot study' may assist the researcher in familiarising themselves with the interview schedule; this was considered important because this was a single case study and the researcher needed to optimise the interviews conducted. The pilot interview was also particularly useful because the researcher was a novice IPA researcher and interviewer. After conducting the pilot interview, the recording was sent to the researcher's supervisor and subsequently discussed during supervision. Thereafter, the researcher made the following adjustments prior to conducting the first interview (appendix D). The researcher refined the interview questions to be less directive and specific focusing on effectively capturing the participant's subjective experiences and facilitating an in-depth exploration (Smith et al., 2022). The researcher also incorporated the COVID-19 timeline of

South Africa to understand deeper the participant's experience in relation to the context of the pandemic at the time that the participant's particular experience occurred.

## 3.6 Data collection

### *3.6.1 Semi-structured interviews*

The study employed one-on-one semi-structured interviews. Two interviews were conducted, and the participant was interviewed for approximately an hour per interview (Pietkiewicz, 2012). The interval between the first and second interview was a week to allow enough time for the researcher and supervisor to individually listen to the first interview and subsequent supervision relating to the interview. The process also allowed the participant to have enough time to reflect on the first interview. Both interviews were conducted during the postpartum period of the participant's peripartum journey.

The detailed and rich account of Sunita's narrative provided the material for this study (Shinebourne & Smith, 2009). Semi-structured interviews are recommended for IPA studies (Smith & Osborne, 2008) as they allow real-time dialogue and the conversation to be flexible (Smith & Conrey, 2009). For the semi-structured interviews, an interview guide with open-ended questions was deemed suitable for this study (appendix D). The focus of the interview questions was related to participants' mental health and experiences during the perinatal period in the context of the pandemic (Krefting, 1991). Open-ended questions were employed as according to Pietkiewicz, (2012), open-ended questions result in the generation of in-depth and richer data as the participant is guided but not restricted.

The two interviews conducted with the participant were deemed sufficient, as suggested by Harper and Thompson, (2012) and Smith and Osborn, (2003). The interviews resulted in two hours of data. Following the first interview, the researcher listened to the audio recording of the first interview and noted down specific questions that were used to follow up in greater

detail to ensure that the interviews produced in-depth and rich data that is sufficient (Smith et al., 2009). The second interview was also used to allow the participant to add additional details to her experience – this was particularly important considering this was a single case study. With the intention of 'being led' by the participant, the researcher did not rigidly adhere to the interview schedule to promote a natural flow of conversation (Pietkiewicz & Smith, 2012).

Possible prompts were created as part of the interview guide to assist the participant should she not be able to respond to the questions. However, follow-up questions were not prepared for the first interview; rather the researcher relied on the client's responses to determine if a follow-up questioned was deemed necessary in order to allow the natural flow of conversation.

The researcher also employed the interpersonal skills she frequently uses as a trainee clinical psychologist with clients; these skills were particularly useful to ensure that the participant felt comfortable (Smith & Shinebourne, 2012b). The researcher was empathetic and actively listened to the participant (Smith & Shinebourne, 2012b). As a result, the researcher established a good rapport with the participant. The interviews were also conducted in a space that the participant was comfortable and familiar with, which was at her workplace under a tree in the backyard for privacy purposes, given that all rooms of the school were occupied (Pietkiewicz & Smith, 2012; Smith et al., 2022). With the participant's consent (Appendix K), the interviews were audio-recorded, transcribed, and later coded for analysis (Van der Riet, 2009). Smith et al., (2022) argue that IPA requires verbatim recording of the data collected. IPA also requires semantic recording of the interviews; in the case of this study, the transcripts reflected all the words of both the researcher and the participant (Krefting, 1991).

## 3.7 Data analysis

After the data collection phase, the data was analysed for it to become knowledge and make sense (Pietkiewicz and Smith, 2012). This section describes the IPA analytic process. Smith et al., (2022) indicated that while IPA provides an analytical process, it is not prescriptive. However, while there are multiple approaches to data analysis in qualitative research, the IPA analytic process differs because its analytic focus draws our analytic attention towards the participant's attempt to make sense of her experience (Smith et al., 2022).

The following data analysis steps as, suggested by Smith et al., (2022) for an IPA study, were employed:

### *3.7.1 Reading and rereading*

The first step employed in the analytic process involved reading and re-reading the transcripts of the two interviews conducted with the participant while listening to the audio recordings of the interviews (appendix E). Simultaneously, the researcher also attempted to imagine the participant's voice while reading the transcripts as Smith et al., (2022) indicated that the process tends to assist with a more complete analysis. The first step of the analytic process is conducted so as to ensure that the participant is the focus of analysis by slowing down the researcher's usual propensity for a synopsis that is 'quick and dirty'. This step also involved recording emerging powerful recollections from the interview experiences and observations from the transcripts.

### *3.7.2 Exploratory noting*

The second step to the analytic process involved exploratory noting (appendix E). The process involved examining the semantic language and content used on an exploratory level. The researcher analysing the data noted anything of interest and maintained an open mind about the transcript. The exploratory process is well suited for exploring nuanced and complex

phenomena with limited prior research available (Smith et al., 2022). The process allowed the analysts' familiarity to grow and take note of specific ways that the participant spoke, thought about, and understood their experience. Interpretative noting assisted the researcher to understand further why the participant may have had these concerns related to her experience. Through careful analysis of the language used and thinking about the participant's context, the analyst was enabled to identify more abstract concepts, which assisted in making sense of the patterns in the participant's meaning of their account. The process resulted in an additional annotation layer containing more reflective and hermeneutic content. The aim of this step was to produce detailed, comprehensive comments and notes on the data. During this step, the analyst was equally concerned with the outcome and the process of engaging with the transcript.

### *3.7.3 Constructing experiential statements*

According to Smith et al., (2022), the third step is important for crystalising and consolidating the researcher's thoughts. During this stage of the analytic process, the researcher shifted to primarily working with the exploratory notes instead of the transcript (appendix E and F). The process of analysing exploratory comments to identify experiential comments involved focusing on the discrete chunks of the transcript. The process further involved recalling what the researcher had learnt while making exploratory notes. The result was the production of a pithy and concise summary of the important aspects of the notes.

### *3.7.4 Searching for connections across experiential statements*

During this stage, the researcher began mapping or charting how the statements fit together as guided by the research question (appendix G). The researcher found a way of drawing the experiential statements together and producing a structure that points to all the important and interesting aspects the participant's account. The researcher kept a copy of the transcript with the experiential statements and exploratory notes. Another copy of the transcript

was used to sort the set of experiential statements so that the experiential statement appeared on a separate piece of paper. The statements were reordered and randomly distributed to break their initial order and begin searching for a more conceptual, different ordering and forming clusters.

### *3.7.5 Naming the personal experiential themes, consolidating and organising them*

During this stage, the researcher provided a title to each cluster of experiential statements sorted in the previous step according to the research questions (appendix H). These clusters became the participant's personal experiential themes (PETs) and were placed in a table.

**Table 1. Summary of themes**

The table below maps out the various emergent themes that the researcher considered to be most relevant to the research question. The themes that were selected and formed from the PET's were considered the most relevant to the research question.

| Group Experiential Theme | Superordinate theme | Subordinate theme |
|---|---|---|
| A sense of loss and change | The impact of the pandemic on her romantic relationship and immediate family | Separation from partner |
| | | Becoming a single parent |
| | | Unfair treatment and dismissal due to pregnancy |
| | | Being pregnant and seeking employment |

| | | |
|---|---|---|
| | Employment and financial independence | The initial idea of how life will turn out |
| | | Balancing independence and room for assistance |
| | An altered state of emotion and mind | Depressive symptoms |
| Managing COVID-19 and its regulations during the perinatal period | Travelling and using public transport during the pandemic | Travelling and using public transport during the pandemic |
| | Perinatal healthcare visits during the pandemic | Perinatal care visits at the clinics |
| | | Perinatal care visits at the hospital |
| | Mixed feelings towards the vaccine | Hopefulness brought about by the COVID-19 vaccine |
| | | Resistance towards being vaccinated |
| | Exposed to COVID-19, standing ground and taking action | The neglect of COVID-19 regulations, compliance-standing up |
| Glimmers of hope and desirable aftermaths | The return home and reunion with family | Becoming closer to family again |
| | | Pregnancy, the silver lining of the pandemic |

| | | |
|---|---|---|
| | Looking back and recovering from the pandemic | Comparing then and now |

### *3.7.6 Continuing the individual analysis of other cases*

This step usually takes place in a study that involves more than one case. However, Smith et al., (2022) indicated that a write-up of a single case study is possible. As a result, this stage was not employed in this case study.

## 3.8 Reflexivity

Unlike quantitative methods that intend to generalise and achieve objectivity, qualitative methods such as IPA acknowledge the value of the role of the researcher's subjectivity in the research process (Eatough & Smith, 2006). The researcher's subjectivity is seen as a tool to obtain deeper insights into the participant's experience (Eatough & Smith, 2006).

I as the researcher, experienced the perinatal period during the COVID-19 pandemic. Therefore, I needed to be cognisant of my assumptions and experiences throughout the research study. Going into the study, I had several assumptions regarding the perinatal period amid the pandemic from my experience. In relation to the prepartum period, I had hopes to receive the COVID-19 vaccine since I formed part of the health workers population. I was disappointed that I could not get vaccinated even though I understood that I could not receive it as a safety measure. Following this experience, I was under the impression that most pregnant women during the pandemic would appreciate the vaccine as soon as more research was available regarding its safety for women during the perinatal period.

Another assumption I had going into the study was that most women also appreciated some COVID-19 regulations such as the lockdown which allowed us to spend most of our time

at home instead of being at work. For example, considering that I was a student, I appreciated the ability to attend my classes and write exams online at the comfort of my home as opposed to being on campus. I appreciated this experience as a safety measure because it afforded me more time to rest during my pregnancy.

I, similarly to the participant, had to undergo an emergency caesarean. As a result, I could relate to some of her experiences and emotions during the intrapartum period of my experience. These included feeling lonely, as I also did not have loved ones around me; I could also relate to anxieties and stressors during this period as I, like the participant was a first-time mother, and I felt a sense of longing to have someone more patient, supportive and caring than the hospital staff. I wished to have had someone who could explain what was going on as different processes were ongoing. However, I also felt a sense of the hospital staff being less caring, focused on the work and lack communication, but also, I felt a sense that they were tired and overwhelmed. Particularly in the ward I was in, as I could hear a couple of nurses complain of the number of emergency caesarean births that were taking place and the extent to which they were understaffed at the time.

I employed bracketing to minimise the influence of my subjectivity during the data collection and interpretation of the participant. To do this I engaged in self-reflection and kept a journal which highlighted my own assumptions and experiences that I needed to be aware of so that I was open to the participants' experiences.

During the interviews, I had to be continuously mindful that the study was about the participant's own experience and not that of myself. As a result, the employment of the interview schedule and pilot interview was very useful in ensuring that I remained objective. The interview schedule assisted me to remain focused on the questions planned. However, it also allowed the participant to form their narrative of their experience instead of me imposing

my experience onto the participant. It allowed me to actively listen to what was being said by the participant and avoid the immediate connection of their experience to my own. Journaling my assumptions prior to allowed me to remain open-minded and curious to explore the participants experience from their perspective further, instead of assuming that their experience is similar to mine. I also refrained from sharing my own experiences and opinion as these can potentially steer the conversation towards a biased direction. Instead, I used the similarity of experiences between myself and the participant, which allowed me to be more connected to the participant and build rapport with her. The similarities further allowed me to relate with the participant in an informed manner. Lastly, the pilot interview was very useful in ensuring that I remained objective as it granted me a practice round that could later be reviewed and improved during supervision.

During the analysis phase, I was also cognisant of considering of the participant's meaning-making. The reflexivity journal was considered useful during this stage as when I journaled about my own experience, I became increasingly aware of it and thus was able to separate it from the participant's experience.

During the interpretation of the data phase, my self-reflections that I previously noted down were used in the following ways. For example, my assumptions and experiences made it easier for me to empathise and connect with the participant at times when I could relate to her experience. I was able to relate to some of her physical and emotional challenges, together with the fears and uncertainties that she experienced during the period of the pandemic. Lastly, I also used my assumptions and experiences to contextualise my interpretations to understand the participants experiences deeper. For example, I considered contextual and other factors that may have been at play for similarities and differences in experiences.

## 3.9 Ethical considerations

This section discusses the ethical considerations for this study. This section also explores the risks and benefits of this study and the procedures employed to mitigate the risks of the study.

According to Larkin and Thompson (2011), ethics is referred to as the moral principles that guide our actions. Smith et al., (2022) explain that social scientists who engage in the social lives of other human beings have an ethical obligation; therefore, numerous laws, policies and practices need to be followed. Smith et al., (2022) added that ethical practices related to research should be observed throughout the data collection and analysis phases of a study. As such, the researcher applied and was approved for ethical clearance from the Rhodes University Human Research Ethics Committee before the study was conducted (Appendix I).

### *3.9.1 Informed consent*

According to Eatough and Smith (2006), informed consent implies that the participant understands the study's implications. Smith et al., (2022) indicated that informed consent is obtained not only for the data collection phase but also for the data analysis process. A participant can only be fully informed about their participation in a study if they are aware of all potential risks and benefits related to the study (Smith et al., .2022). The researcher obtained informed consent from the participant to ensure that the participant voluntarily agreed to participate in the study and understood that she could withdraw (right to withdraw) from the study at any point (appendix J). This opportunity was also used to explain exactly what the interview will entail, what is expected from the participant and the potential contributions of the study. The researcher was also transparent and provided the participant with adequate information regarding the study relating to the nature of the study, including the aim and purpose of the study, together with the possible risks and consequences of the study. The risks of the study included the participant becoming distressed due to the nature of the interview, as

it required the participant to revisit their experiences. The benefits of the study were also explained to the participant, Eatough and Smith (2006) explain that participating in an IPA study provides the participant with the privilege of being the source of interpretation. Further, in consideration of the aim of IPA, the participant is gaining an opportunity to explore in detail the meaning of experiencing the perinatal period during the COVID-19 pandemic according to them. In response, the researcher disclosed and explained to the participant that she us allowed to pause the interview whenever she felt the need. The participant was also provided with telephone numbers should she seek psychological services after the interviews. Further, the researcher facilitated the referral of the participant for psychotherapy upon her request.

### *3.9.2 Confidentiality and anonymity*

According to Smith et al., (2022), confidentiality relates to the right of the participant to keep their personal information private. Anonymity refers to ensuring that the participant remains nameless (Smith et al., 2009). In the case of the study, the researcher used pseudonyms to protect the participant's identity and removed any specific identifying information for anonymity purposes. Further, only the researcher and the supervisor had access to the raw data. The research also employed a transcriber, who signed a confidentiality document to ensure that the participants' confidential information is protected (appendix M).

## 3.9 Reliability and Validity

Smith et al., (2009) poses the following Yardley's (2000) four principles suitable for IPA to ensure validity and reliability:

### *3.9.1 Sensitivity to context*

Good qualitative research demonstrates sensitivity to the context (Smith et al, 2009). This can be achieved by demonstrating sensitivity in a number of ways such as showing

sensitivity to the cultural context in which the study is established, the existing literature relating to the topic and the material obtained from the participants.

This principle is achieved in this study by ensuring sensitivity to the current existing literature through the literature review section. Smith et al., (2009) argue that adopting IPA as a methodology is centred on the perceived need for sensitivity to context through engaging with idiography. Further, the researcher was considerate of the power dynamics between the researcher and the participant, and the researcher ensured that they employed their therapeutic skills to be empathetic towards the participant and establish rapport. Good rapport was established with the participant. The researcher enquired about the participant's background to obtain a richer description of her context. Lastly, the researcher considered the possible cultural difference between the researcher and herself relating to the perinatal period (Smith et al., 2009). For example, the researcher was aware that the participant was of a different race and culture. As a result, the researcher asked questions regarding the participant's experience from a curious standpoint and not in an offensive manner (Smith et al., 2009).

### *3.9.3 Commitment and rigour*

According to Smith et al., (2009) in IPA, the expectation regarding commitment is demonstrated in the degree of attentiveness to the participants during the process of data collection and the care involved during analysis of each case. During the research study, I ensured that I read extensively about IPA, familiarising myself with the procedures related to data analysis. I was also committed and invested in ensuring that the participant was comfortable and closely attending to what the participant said. Good rapport with the participant was established and evident as the participant could provide open and detailed responses suggesting, that she was comfortable during the interview process. The participant also portrayed active participation in the interviews by showing interest in the research topic and requesting clarity of questions when necessary (Smith et al., 2009). Yardley (2000) in

Smith et al., (2009) describes rigour as the thoroughness of the study. I also ensured the documentation of the data analysis procedures.

A rigorous study also uses the appropriate research tools for the study. I, as the researcher, closely followed the outlined steps for IPA research. Further, ongoing supervision verified the analytic process and the findings of the study; research supervision also ensured that I engaged in an iteration process with the supervisor. For example, multiple themes were discussed and revised during supervision.

### *3.9.4 Transparency and coherence*

According to Smith et al., (2009), this refers to the extent to which the stages of the research process are clear in the write-up of the study. This was achieved and enhanced by describing how participants were selected, describing how the interview was conducted and the analysis procedure. The researcher ensured increased transparency of the analysis process through the use of quotes from the data collected and by describing each stage of the process involved in the data analysis section.

### *3.9.5 Impact and importance*

This refers to the extent to which a study is appropriately and sensitively conducted in order for the study to be useful and interesting to the reader (Smith et al, 2009). This was achieved in the study by discussing the significance of the study broadly, and more specifically, to the profession of Clinical Psychology in the introduction section of the study.

## 3.10 Conclusion

In conclusion, this chapter has described the IPA research methodology employed for the study. The chapter has also discussed the theoretical framework employed and the research design. The method of data analysis has been described together with a discussion of the ethical considerations and reliability and validity of the study.

# 4. CHAPTER 4: FINDINGS

## 4.1 Introduction

This chapter reports the findings of the analysis using the IPA steps described in detail in the preceding chapter following the two semi-structured interviews with the participant. This study aimed to explore and understand a woman's lived experience of the perinatal period during the COVID-19 pandemic in Makhanda, South Africa. The transcript

analysis identified three main Group Experiential Themes (GET's) from the Personal Experiential Themes (PETs), which relate to the participant's lived experience of the perinatal period during the COVID-19 pandemic. Each GET was further broken down into superordinate and subordinate themes identified using quotes from the participant's transcript. Post the analysis phase, themes related to the research question were selected, and themes less related to the research question and aim were omitted. The findings of the data are explored below.

## 4.2 Description and interpretation of the themes

### *4.2.1 A sense of loss and change*

After reading the interview transcript multiple times, an essential feature of the participant's description of her experience of the perinatal period during the pandemic was her understanding of how the COVID-19 pandemic resulted in the experience of multiple losses which she had to manage alongside her pregnancy and change to various aspects of Sunita's life. The participant's different experiences of loss that occurred as a result of COVID-19 formed a master theme. This master theme, consisting of three superordinate and seven subordinate themes, is explored below.

#### 4.2.1.1.1 The impact of the pandemic on her romantic relationship and immediate family

This superordinate theme focuses on how the COVID-19 pandemic affected the participant's romantic relationship with her partner and their plan to become a family. The subordinate themes are explored below:

##### *4.2.1.1.2 Separation from partner*

In the extract below, Sunita describes how she envisioned her life would be together with her partner and her child had the COVID-19 pandemic not occurred. She also describes the impact of the distance that occurred between her and her partner as he had found employment in the City while she had to move back home with her family in Makhanda due to financial constraints that occurred as a result of her losing her job.

It was noted that it was easier for the participant to believe and accept that her loss of employment was a result of the direct impact of the pandemic, following that the school where she was employed began to experience a decrease in the number of children that were attending due to the pandemic and as a result experienced a loss of income and profit. It was also easier to accept and place the blame on the pandemic as compared to the possibility that she was dismissed as a result of her pregnancy. Whether the participant's partner was employed or not prior to the pandemic is unclear. However, the participant indicated that he was struggling *"he wasn't doing well in his industry…."*. The move from their apartment after her loss of employment to temporarily moving in with the relatives of the participant's partner, before the move to the City for her ex-partner to pursue a possible employment opportunity suggests that she may have been the breadwinner of the family, *"...I had to move in with family, not my family but my partner's family in (City)… So, then he got the job there (Another City)"*.

> **Extract 1:** *Sunita: ok, if I didn't lose my job, I wasn't gonna be living with my partner's family. I would still be with my partner, living together, having our baby, being a loving*

*family together, and me and him we were like the type like, you see those types of relationships where you can't take distance, distance is just not go to… so that's just how we were, we couldn't take the distance, the distance just didn't make us. So, then he got the job there and then I had to come back home and stay with my family, p.5.*

In the extract above, the participant suggests that her loss of employment contributed to the physical distance between the participant and her partner as he had to seek employment elsewhere, thus creating distance. This physical distance significantly impacted their relationship as it led to her realising that their relationship could not stand the physical distance. The statement "we couldn't take the distance…" highlights the negative impact of the physical separation on their relationship and suggests that it was fatal and strained their romantic relationship. The idea of an envisioned future together is supported by her statement: "living together, having our baby, being a loving family together". However, the phrase "me and him we were like the type..." suggests that her relationship with her ex-partner is not one that can withstand distance and that without the pandemic they would not have risked being separated because of the type of relationship they had. These emphasise a lack of choice/agency in her situation. Her tone in the extract suggests a sense of regret and sadness about the status of her romantic relationship. She appears to be mourning the loss of her relationship and the life they could have had together if it were not for the pandemic to have occurred.

While the above extract does not provide direct insight into how the participant understood the role of the pandemic on her romantic relationship, a phrase from an extract below provides her understanding of how the pandemic negatively affected her romantic relationship, "*Because if it hadn't happened, I would be in place with my partner, with my child but ja it happened, p16.* The statement reflects a significant disruption and change in the participant's, life from how she envisioned her future with her partner and to how it turned out because of the pandemic. The shift from indicating that her loss of employment was the

significant event that impacted her romantic relationship with her partner to blaming the pandemic highlights her ambivalence regarding the actual cause of the termination of the relationship. A sense of blame and negative feelings towards the impact of the pandemic on her relationship is noted. The statement further highlights the emotional toll that the pandemic has had on her romantic relationship, such as the logistical challenges of being apart for an extended period, not being able to see each other in person and engage in regular activities together, and further not being able to plan for their future as she had envisioned.

#### *4.2.1.1.2 Becoming a single parent*

This subordinate theme is an extension of the preceding subordinate theme; however, it solely focuses on how the participant experienced the pandemic to have resulted in her becoming a single parent of her child. The subordinate theme is linked to the previous subordinate theme; however, it warranted to become a subordinate theme as per the participant's account of her experience and the different meanings she associated with being in a romantic relationship and being a parent.

In the extract below, Sunita describes a situation that occurred during her stay in the hospital during her intrapartum period. This incident occurred after she had her caesarean and was attempting to stand on her feet. While describing her experience, she shifted to indicating the impact of the pandemic on her parenting experience.

> **Extract 2:** *...I think they were trying to help me and I'm still saying that it's because of COVID-19 that I am a single parent today. Because if it hadn't happened, I would be in place with my partner, with my child but ja it happened, p. 16.*

Numerous times during the interview, the participant was noted to attribute her single-parent status to the pandemic including, in extract two; for example, later on in the interview, she says again *"And also another thing, I would say COVID-19 made me a single parent, I*

*actually blame COVID-19".* In the extract above, the participant's statement, "*…I'm still saying that it's because of COVID-19 that I am a single parent today…*" suggests that she blames and places the responsibility of being a single-parent status on the pandemic. The statement further expresses a belief that if the pandemic had not happened, she would still be in a relationship with her partner and raising their child together.

It was noted that even at times when she was communicating other matters related to her broad experience of the perinatal period, she would continuously resort back to expressing how the pandemic resulted in her becoming a single parent, as noted above, suggesting that this was a continuous recurring thought and one of significance to her. The idea was also supported by her use of the phrase "*I am still saying…*" in the statement above.

In the extract below, Sunita is expresses how being a single parent is a significant stressor for her.

> **Extract 3:** *… ja, what else I would say was stressing me out besides my financial issues. Oh ja, being a single parent, wow because now I grew up without my father and I think just the thought of my baby growing up without a father as well made me stress even more. It felt like ja my baby is going through the same things I went through as a child; I still feel that way actually but ja I'll get over it eventually, p6.*

Extract three provides insight into why being a single parent as a result of the pandemic was a significant experience for Sunita; the experience also highlighted her value for family and the impact of seeing her child relive her childhood experiences. A great source of her experience of fear and distress is a sense of similarity between her childhood experiences and what she perceived her child to be currently going through. For the participant, the desire to not be a single parent is not due to the difficulties of raising a child alone or other reasons but is rather about not wanting her child to grow up without her father. However, her statement,

"*I'll get over it eventually*" indicates a sense of resignation or acceptance towards the situation, but also a determination to overcome the stress in the future. The statement also highlights that she is significantly affected by the experience of being a single parent.

In the extract below, Sunita is describing her desire to have had her partner's support during the perinatal period.

> **Extract 4:** *honestly, I would have liked for my partner, actually my baby daddy to have been there to help me with everything and do everything together. I mean we've been through so many things together and then all of a sudden, I'm going through this pregnancy and having a difficult time and he is over there, that makes me angry, it made me angry at him, p28.*

The fourth extract highlights how she interpreted the absence and lack of support from her child's father as having a significant impact on her experience of being a single parent. The correction of her choice of words from "partner" to "baby daddy" highlights the status of their relationship, that they are no longer together. The correction also points to her own ambivalence about the status of the relationship. The extract also highlights the impact the loss of the romantic relationship has had on her parenting, as she had imagined that they would be parenting together with the father of her child. The statement "…*I would have liked for my partner*…" expresses her hope and desire for support and the presence of the father of her child, which was not satisfied, and as a result, is met with rage. The repetition of the word angry emphasises how disappointed and angry she was at him and his absence. Her indication of the participant being angry at the partner and not COVID-19 may suggest that there may have been other reasons behind the end of the relationship beyond the impact of the COVID-19 pandemic. Therefore, it is interesting that Sunita explicitly blames the pandemic, suggesting perhaps that

blaming the pandemic is easier for her than thinking about other possible causes of the breakdown of their relationship.

Another aspect of the participant's life where the pandemic resulted in an experience of loss was related to employment, the theme was explored below.

#### 4.2.1.1.3 Employment and financial independence

The above superordinate theme focuses on the participants' experience of loss of employment as a pregnant woman during the COVID-19 pandemic.

##### *4.2.1.2.1 Unfair treatment and dismissal due to pregnancy during the COVID-19 pandemic*

> **Extract 5:** *I fell pregnant and then they found out at work and then they had to let me go, apparently, I don't know, I think they weren't registered yet so they didn't want to pay maternity leave, so they had to let me go because of that. So then obviously that's unfair dismissal, I had to take them to CCMA, p.2.*

In extract five, Sunita describes what she believes led to her dismissal by her former employer and how she understood the experience. She indicates that "*they found out at work*", possibly suggesting that it was not her intention that her former employer learns of her pregnancy or that she perhaps had anticipated the implications that her pregnancy might have on her employment status. Sunita associates her loss of employment with her pregnancy. She concludes that the company was not registered and could not pay her for maternity leave. Sunita viewed this as an unfair dismissal and a possible violation of her rights. As a result, she took legal action by bringing her case to the CCMA (Commission for Conciliation, Mediation and Arbitration). The experience highlights her resilience and ability to stand up for herself.

While the extract above does not provide a direct link to how Sunita experienced the COVID-19 pandemic, the extract below provides further insight into how she understood the contribution of COVID-19 to her loss of employment.

> **Extract 6***: I don't know… I don't think parents, not everyone but some of the parents were not comfortable sending their children to school 'cause of the children might get infected. So obviously that would mean that the schools are now making less money, maybe they couldn't afford paying someone on maternity leave and getting someone to stand for me at the same time, p56.*

The extract above provides insight into how the participant understood her dismissal at work. She interpreted her dismissal as being a result of the financial constraints experienced by her employer due to having fewer children attending school as a result of the pandemic. She suspected that the school could not afford a double payment for her maternity leave and for her potential temporary replacement. This interpretation explains how, Sunita's loss of her romantic relationship all began with this dismissal, which she links to the pandemic. It helps explain her meaning making around her losses as being as a result of the pandemic.

#### *4.2.1.2.2 Being pregnant and seeking employment*

In the extract below, Sunita describes some of the difficulties she experienced due to being dismissed by her former employee.

> **Extract 6:** *...I had a lot of stress, I wasn't even sleeping most of the time, I was just lying in bed thinking about, what am I going to do now, where am I going to get that for my baby, where am I going to get a job and I couldn't actually find a job because I am 6 months pregnant, almost 8 months pregnant, it's Covid, and they won't be able to give me a job now and then still need to give me maternity leave in a few months. So, I wasn't actually going to get a job at that time, gosh I don't think I wanna go through that again, no, no never… p.8.*

In the extract above, the participant suggests that her stress was exacerbated by her inability to find a job due to her pregnancy. The extract also highlights the impact of the

financial implications of the pandemic on her as it resulted in her feeling dependent on her family for support. Her use of the phrase “it’s covid” suggests that the pandemic exacerbated the employment difficulties that she was experiencing. Whether she actively sought employment or the narrative was in her mind is unclear; however, the statements “they won’t be able to give me a job now” ... and “So I wasn’t actually going to get a job at that time…” indicate the great extent to which she was adamant and convinced that she was not going to be employed at that time.

Sunita’s use of the interjection “gosh” echoes her strong emotions about the possibility of going through the experience of being unemployed and seeking employment during pregnancy in the context of the COVID-19 pandemic again. As a result, revisiting and thinking about the experience is unpleasant for her.

#### *4.2.1.2.3 The initial idea of how life will turn out*

This subordinate theme explores how the participant experienced the pandemic as causing the loss of her initial idea of having an independent life. In the extract below, the participant is describing her life prior to the pandemic.

> **Extract 7:** *Sunita: uhm before March, I think I was in a very good place because I had just got a new job and things were working out man. I had just got a new job, moved to (City), got an apartment everything was nice ja things were going well for me and I was enjoying it. But then when Covid happened, a lot of things changed, p30.*

In the extract above, Sunita describes her life before the COVID-19 pandemic reached the shores of South Africa. This idea is supported by reporting that “*before March*”, which was the time that the virus was reported in South Africa and the subsequent lockdown. According to the participant, she was "in a very good place", suggesting that she was in a decent state emotionally and including her mental health. Sunita attributes this "good place" to being

employed and having a place to stay. She further supports this by expressing that she "was enjoying it". This experience adds to the idea that stability and financial independence are of great value to her. Sunita also states that "everything was nice and things were going well for me", suggesting satisfaction and contentment about the state of her life and how it unfolded. The phrase "but then COVID-19 happened…" suggests a significant shift in the situation and a cause-and-effect relationship regarding what occurred in her life after that, implying that things changed due to COVID-19. She blames the pandemic for the changes that occurred in her life. The idea is further supported by the abstract below:

> **Extract 8:** *Sunita: …But still, it's because of Covid, I mean if I didn't lose my job, I'm still saying even today that I would still have my partner, I would still have my job and we would be a happy family. But unfortunately, it didn't happen, p.39.*

#### *4.2.1.2.4 Balancing independence and room for assistance*

This next subordinate theme focuses on how Sunita understands being independent and how the pandemic challenged this independence and required her to consider receiving assistance from others.

In the extract below, Sunita is describing her experience of returning home and having to rely on others to assist her in multiple ways. During this time, she was eight to nine months pregnant and had to rely on her family to assist her physically. She also had to rely on them financially as she was unemployed.

> **Extract 9***: Sunita: And I'm a very independent person, I don't like to depend on other people, so that also made me stress a lot because now I had to come home and depend on my brothers and sisters, my family and it was so depressing, p.8.*

In the extract above, Sunita declares that she is an independent woman, suggesting that being able to stand on her feet without the assistance of others is of great value to her and that

it is significant for it to be known about her, "*I'm a very independent person*". She describes how the pandemic's circumstances have challenged her to be less independent and allow room for assistance, particularly from her family. This experience was a huge challenge to her; she indicates that the experience was making her "*stress a lot*" and that it was also "*depressing*", highlighting the strain it was for her to allow room for assistance. Further, the omitted to describe how she was actually dependent on her family, possibly due to feelings of shame and embarrassment. The idea is supported by the extract below, where Sunita describes her reasons for not informing her family about her experience of being unemployed in the City.

> **Extract 10:** *Sunita: I still don't feel like telling them* (family)*, I still just wanna keep it to myself (*her experiences of being in the City pregnant and unemployed)*. I don't want them to look at me different, but I want them to know me as this person that this is how we know her, the strong independent woman; I want them to know me like that and remember me like that. Not as this weak person with all these emotions and stuff, p.25.*

In the above extract, Sunita expresses her desire not to inform her family about the difficulties she experienced during her time in the City that led to her moving back home to Makhanda and the challenges she also experienced in Makhanda. While she does not explicitly disclose the difficulties that she experienced, these may have related to her unemployment and her challenges in her romantic relationship. The repetition of "*I still don't feel like telling them*", suggests that she has thought about this decision before and has not changed her mind. She understands requiring assistance from her family as indicative of weakness or vulnerability. This understanding suggests that she values her self-image and is concerned that sharing certain information might change how her family perceives her and that she is not willing to risk that occurring.

The phrase "t*his person that this is how we know her*" suggests that she is aware of how her family perceives her (possibly independent and robust) and wants to maintain that image. The statement also suggests that she values her family's opinion of her and does not want to jeopardise her relationship by sharing something that could alter their perception of her. The extract also suggests that the participant experienced COVID-19 to have resulted in the loss of her sense of self, or who she knew herself to be and further a sense of not being in control.

#### 4.2.1.3 An altered state of emotion and mind

The next superordinate theme explores how the participant's experience was also accompanied by changes in her emotional and mental health during her pregnancy. The researcher noted that most of these changes and challenges were experienced during the postpartum period of the participant's perinatal period. Throughout this theme, the participant does not provide an explicit link between the pandemic and the experience; rather she attributes the experiences to the pandemic because they occurred within the time frame of the pandemic and her perinatal period. It is also possible that she understands all her difficulties, as starting from the loss of her employment, which she blames the pandemic for.

##### *4.2.1.3.1 Depressive symptoms*

This subordinate theme focuses on the depressive symptoms that Sunita experienced as a result of her pregnancy and the impact of the pandemic upon her life. In the extract below, the participant explains the beginning of the change that she experienced.

> **Extract 11:** *a few months ago, I just felt like everything was just too much, I couldn't take it anymore like, it's all overwhelming like oh a lot of things happening and ja, p20.*

In the above extract, Sunita indicated that she experienced a period of intense emotional distress, characterised by an overwhelming sense of being unable to handle the various challenges and demands in her life. She also seemed to have experienced a significant

emotional burden during this period, characterised by heaviness and exhaustion. The feeling of being overwhelmed suggests an inability to cope with the circumstances and responsibilities at hand. The emotional build-up may have occurred over time, leading to a breaking point where everything felt like "too much. "The word "ja" and its positioning in the phrase may suggest that she recognises the intensity of her emotions and the need to acknowledge and address them. In the extract below, she further explains the emotional changes that occurred.

> **Extract 12:** *I don't know what to say, but I was sad, I was very very sad, I was so so sad, p19.*

> **Extract 13:** *I was feeling very alone, I was feeling alone, depressed, stressing but at the same time I was enjoying spending time with the baby, p15.*

In extract 12, Sunita explains that she felt sad for reasons she did not indicate. She seems to be struggling to articulate the reasons for her sadness, as suggested by the statement, "I don't know what to say." The repetition of "very" and "so" suggests a profound level of sadness that she was experiencing. In the subsequent extract, the participant describes a complex mix of emotions she experienced following the birth, including feeling alone, depressed, and stressed. The statement "at the same time I was enjoying spending time with the baby" suggests that she may have experienced moments of joy and connection with her newborn despite her overall emotional difficulties. In the extract below, Sunita explains the impact of the physiological changes she experienced due to her pregnancy.

> **Extract 14:** *I wasn't comfortable with my body anymore, I really wasn't. Ja that was the only thing I was thinking at the moment, I wasn't comfortable with my body; the way it looked, p18.*

In extract 14, Sunita expresses her concerns about her physical appearance. She uses the word "anymore" to imply that there was a period in her life when she was comfortable with

her body, possibly before her pregnancy. The physical appearance is valued and was of significant concern for her, as suggested by the statement "the only thing I was thinking at the moment", indicating that her concerns were all-consuming. The focus on her appearance implies that she may have experienced body image issues or self-esteem concerns. In the extract below, she shares some of the thoughts and difficulties that resulted in suicidal ideation.

> **Extract 15:** *So now the fact that my child is going to go through the same things that I went through as a child, it just, it's actually not really nice and I actually tried to commit suicide because of that thought, p19.*

In extract 15, Sunita expresses her concerns about her child experiencing similar difficulties she did as a child, and as a result, the matter became a significant source of distress. The extract could also indicate a sense of empathy or desire to protect her child from an experience that is "not really nice". The statement "it's actually not really nice" also suggests that this is an understatement and that the experience of growing up without a father may have been difficult for her to the extent that she cannot bear to witness her child go through the same experience; hence she experienced suicidal ideation. Not only did she experience suicidal ideation, but she further described struggling to sleep.

> **Extract 16:** *I wasn't even sleeping most of the time, I was just laying in bed thinking about, what am I going to do now, where am I going to get that for my baby, where am I going to get a job, p8.*

In extract 16, Sunita explains that she experienced insomnia due to constantly engaging in deep thought and contemplation about her current situation and concerns regarding her baby and seeking employment. Her thoughts revolve around two main themes: her baby's needs and financial instability. Sunita reflects a state of anxiety, uncertainty, and a strong sense of responsibility she has towards her child. This change in Sunita's mental state needs to be

understood in the context of the losses she described, which she understands as being due to the pandemic. For Sunita, her altered emotional state and her loss of self all began with the pandemic. It is possible that this increased her sense of vulnerability and not being in control. A sense of panic as opposed to proactivity.

### Summary

In summary, this master theme explored how the participant experienced the pandemic to have cased multiple losses and changes in multiple areas of her life. She understands the pandemic as destroying how she envisioned her future life. The areas of her life that were affected and explored included her romantic relationship, parenting, employment, financial independence, and mental health. As a whole, Sunita understands the pandemic as threatening her sense of selfhood during what, in her mind could have been a happy stage of her life.

## *4.2.2 Experiences of managing COVID-19 and its regulations during the perinatal period*

The following master theme explores the participant's experiences of being confronted with the COVID-19 pandemic and its regulations. The master theme explores how Sunita navigated the different spaces and scenarios created by the pandemic during her perinatal period. The master theme consists of three superordinate themes and seven subordinate themes.

### *4.2.2.1 Travelling and using public transport during the pandemic*

This superordinate theme explores the participant's experience travelling using public transport during the pandemic.

**Extract 17:** *we had to move to (City), while I'm still pregnant. I think I was 5 months pregnant when I got into a bus and went to (City), p2.*

**Extract 18:** *I was actually 8 months pregnant when I got on another bus and went to Grahmstown, ja it's not nice and while I was sitting on the bus, I was stressed I was crying because I was about to give birth, you know anything could happen at 8 months. What if I gave*

*birth in the bus, just imagine. So ja my trip to Grahamstown wasn't nice, I was thinking of all of that stuff, what if I give birth right here blah blah. And inside the bus they didn't have air conditioner and it was so, so hot, I couldn't take the heat, I had to ask the bus driver if I could sit in front, and my feet were swollen because of sitting for hours ja and the bus was so full even though it was COVID-19, we were packed full, p3.*

In the extracts above, the participant is describing her travelling experiences during the pandemic and her pregnancy. She suggests that she travelled at least twice via bus during the pandemic. However, she is noted to focus on her second time travelling via the bus, possibly due to the second experience being more challenging as she was more heavily pregnant. According to Sunita, the trips were not pleasant. The phrases "not nice" and "blah blah" indicate a sense of frustration and possibly helplessness. The trip is suggested to have been unpleasant due to the stress and worries that Sunita was experiencing about giving birth in transit. She mentions that being eight months pregnant means "anything could happen", highlighting the uncertainty and vulnerability that she was experiencing during that time.

Sunita also highlights the emotional impact of the stress she was experiencing, as she indicates that she was very emotional to the extent that she shed tears. The absence of air conditioning on the bus worsened the situation, as it was uncomfortably hot. The repetition of "so, so hot" highlights the extent of the high temperatures that she was experiencing. In the above extract, the COVID-19 pandemic is noted to be in the background of her experiences on the bus, as though it was not an important concern compared to the other experiences and concerns, she experienced on the bus.

#### 4.2.2.2 Perinatal healthcare service experiences during the pandemic

This superordinate theme focuses on how the participant experienced healthcare services during the pandemic. These experiences include her experience at multiple local clinics, and her stay at the hospital during the birth of her child.

##### *4.2.2.2.1 Perinatal care visits at the clinics*

The subordinate theme focuses on Sunita's experience of her perinatal care visits at the clinics. In the extract below, the participant is describing her experiences of her clinic perinatal care visits.

> **Extract 19:** *So, every time I had to go and get my medication I had to go to a different clinic and I had to open a new file, wherever I go I had to open a new file, a new clinic file and that was too much for me, I couldn't take it. Dealing with the stress of not having a job and also having to go to different places to find medication and stuff so ja, p3.*

Sunita's perinatal care visits to the clinic involved visiting multiple clinics due to her relocating multiple times. The phrase "*that was too much for me, I couldn't take it*" implies a sense of frustration, exhaustion, or emotional strain experienced by Sunita. Constantly opening new files and seeking medication from various locations compounded her existing challenges and overwhelmed her. Further insight into her experiences at the clinics is provided by the extract below.

> **Extract 20:** *so now what happens inside the clinic is that, there is not enough space for everyone and now other people they were supposed to sit outside instead of inside to obey social distancing. And there was this other time it was raining that day, and we had to sit outside because it's full inside. We were about 13 or 12 pregnant women who*

*were sitting outside and we were asking, why is this line not moving and then they said no we are helping the elderly first and stuff and there is no space inside, p37.*

According to Sunita, the clinic had limited capacity due to social distancing. As a result, the line of patients waiting outside the clinic was not moving, leading to confusion and frustration among the pregnant women. Further, the weather was rainy, adding to the discomfort experienced by those waiting outside. The participant may have felt a sense of being less prioritised as a pregnant woman. In a subsequent response to this particular experience, the participant indicated that "*But when I get there, there would be people already, the queue would be this long"* indicating her disappointment and helplessness over the situation. Overall, the experience was unpleasant. It was noted that some of these feelings and experiences the participant experienced were not specific to COVID-19, such as having to open new files or stand in long queues, while others were COVID-19-specific, such as waiting outside in the rain due to social distancing. These experiences highlight that for many women in South Africa, receiving health care during the perinatal period is challenging, even beyond the context of the COVID-19 pandemic.

Despite the above experiences at the clinics, Sunita describes a positive experience that occurred during one of her postnatal care visits in the extract below. This was the participant's first postnatal visit at a clinic in Makhanda.

**Extract 21:** *well actually I wouldn't say it was hectic because when you get there they say, they start with you if you have an appointment for the baby, they literally start with you so it was just in and out for me, it was just in and out it didn't take time, p27.*

Despite multiple challenges Sunita encountered following the COVID-19 regulations at clinics, Sunita had some positive encounters that resulted from COVID-19 regulations. In the above extract, she describes an experience at a clinic in Makhanda during her postnatal care

visit. The statement *"I wouldn't say it was hectic"* highlights the system's efficiency, where women who had a perinatal care visit were prioritised and allowed to book a slot to reduce their time at the clinic. This system resulted in a quick *"in and out"* experience without significant waiting times- *"it didn't take time"*. The extract also highlights her satisfaction with the efficient service provided, a different experience compared to her experiences in the cities. The extracts earlier were predominately related to her experiences in the two cities she initially resided in, whereas extract 21 was an experience she had at a clinic in Makhanda.

#### *4.2.2.2.2 Perinatal care at the hospital*

This subordinate theme explores the participant's perinatal experience at the hospital. In the extract below, the participant is expressing her experience of travelling and being admitted to hospital for the birth of her child.

> **Extract 22:** *You only have to go in if you are there to be treated other than that, you couldn't go in. So, I had to go alone. And there was also a lot of stuff that I forgot to take with me and I was like, ok how am I going to get it now because people are not allowed to come inside, they only stop there by the security guards, that's where they stop. So, I had to come alone and I was so scared, I mean there's no one here to help me or talk me through it, I was all alone, p50.*

In the above extract, Sunita expresses fear and anxiety about being alone in the hospital due to the COVID-19 regulations implemented at health facilities. The statement "*And there was also much stuff that I forgot to take with me …"* may indicate that she may have had to come before the time she was expecting to do so and was thus ill-prepared as per her description. The statement may also highlight her lack of knowledge regarding items required during labour due to her being a first-time mother. The participant is also noted to be describing feeling alone and unable to call on support due to the pandemic and the restrictions imposed.

Sunita's fear and anxiety stemmed from not having anyone present to help or offer emotional support during her labour admission at the hospital. The phrase *"help me or talk me through it"* highlights the extent to which she needed the support as a first-time mother; without the presence of a familiar face or someone to offer guidance, her apprehension about the experience likely intensified. The phrase *"they only stop there by the security guards"* indicates the barrier that security guards formed between the public and the patients at the hospital. Sunita continues to express her experience at the hospital in the extract below.

> **Extract 23:** *oh, ja people couldn't bring you food from home to eat and even when you needed something, you needed to ask the security to go fetch it down there at the gate. I needed slippers, I was wearing boots and I needed slippers and after a c-section, you need something you can just put your feet in so that you don't have to lift up your leg. And I couldn't because who is gonna bring my slippers and how are they gonna get in and oh a lot of stuff man, p14.*

In the extract above, Sunita further explains the limitations placed on her by COVID-19 regulations during her hospital stay following the birth. The need to rely on hospital staff or security to bring them items like slippers highlights her lack of autonomy and control over her care, especially for her as she values independence. This experience of having to rely on the hospital staff adds a layer of complexity and dependency on others to fulfil basic needs. The statement *"oh a lot of stuff man"* suggests that she may have been overwhelmed and frustrated by the various limitations and challenges she faced during her hospital stay due to Covid regulations.

In the extract below Sunita describes how she felt about the treatment she experienced from the nursing staff at the hospital after she had her caesarean surgery.

**Extract 24:** *It didn't feel that way, I felt like they didn't care about me, they just wanna do their jobs and get done with it but at the same time they were helping me to get better. But ja and then I collapsed, as I was telling them I couldn't walk and they were forcing me and I told them I couldn't, as I tried there, I went. P16.*

The extract above explains how Sunita felt a sense of indifference from the staff. She understood the treatment from the nurses and staff as primarily focused on completing their tasks rather than showing personal care for her. Sunita suggests that the staff lacked a personal connection or empathy, perhaps due to the demanding nature of their jobs, especially during the pandemic. Below, Sunita explains how some of the COVID-19 protocols became a secondary priority due to her birth experience.

**Extract 25:** *no, we weren't wearing masks, we didn't wear masks, dude you were so, everything was so sore, you couldn't move anything, how were you going to wear a mask? p,17.*

Sunita mentions that during her hospital experience, they were not wearing masks, possibly indicating that the regulations were not strict at the maternity ward or the hospital. She expresses surprise or disbelief at the idea of wearing a mask, considering the extreme discomfort and pain that she was experiencing. This extreme soreness and immobility are emphasised, suggesting that wearing a mask would have been an additional physical burden or challenge. The rhetorical question *"how were you going to wear a mask?"* and tone further emphasise the practical difficulties of wearing a mask in the state that she was in. Sunita questions the feasibility of wearing a mask given her condition, suggesting that it was simply not feasible or manageable at the time. An absence of fear by Sunita about her or her baby contracting the COVID-19 virus is noted in the extract. Her main focus seemed to be on how COVID-19 resulted in her situation being difficult and lonely and not COVID-19.

#### 4.2.2.3 Mixed feelings about the vaccine

This superordinate theme explores the participant's experiences relating to the COVID-19 vaccines as a pregnant woman and during her postpartum period.

##### *4.2.2.3.1 Hopefulness brought about by the COVID-19 vaccine*

This subordinate theme focuses on how the participant experienced the introduction and announcement of the COVID-19 vaccine. In the extract below, the participant is explaining her response when the vaccine was introduced.

> **Extract 26***: I felt more relieved because at least there is something, something to prevent, ok I don't wanna say prevent but there was something to help me… ja to help with the situation and make people feel more, I don't wanna say safe, ja for people to have hope maybe, p45-46.*

In the extract above, Sunita suggests that she experienced a sense of relief and hopefulness following the announcement of the COVID-19 vaccine. During this time, the participant was about three months pregnant. The phrase *"I felt more relieved"* suggests that she was previously anxious or stressed. Sunita is also hesitant to use the word *"prevent,"* possibly indicating that she is aware that the vaccine does not eliminate COVID-19 but can still be helpful.

> **Extract 27**: *I felt more relived because at least there is something, something to prevent, ok I don't wanna say prevent but there was something to, please help me, p45.*

The phrase *"but there was something to, please help me"* from extract 27 may indicate that she is having difficulty expressing herself or finding the right words to convey her thoughts or feelings, it may also indicate that she believes that she was in a more desperate situation than others."*ja I think"* suggests that she is not entirely confident about the hope she suggests she

felt. The participant is also noted to express a desire for others to feel a similar sense of hope or reassurance.

#### *4.2.2.3.2 Resistance towards being vaccinated*

This subordinate theme explores Sunita's experience of not being vaccinated for COVID-19. In the extract below, the participant is explaining her resistance towards receiving the COVID-19 vaccine.

> **Extract 28***: honestly, I didn't mind not getting the vaccine because I'm pregnant, what if there is something in there that's going to affect my baby. So, I didn't mind when they said OK, health care people only, we're coming to you at a later stage, I didn't mind at all because I knew that I didn't want the vaccine. You can give it to me after birth, but at the moment, no thank you, p46.*

The extract above portrays a drastic shift from the previous extract. The participant is noted to hesitate to receive the COVID-19 vaccine due to concerns about its potential impact on her unborn child and is willing to postpone it until after giving birth. While the hesitancy may reflect an instinct to prioritise the health and safety of her unborn child, the hesitancy may also stem from a lack of information about the vaccine's safety during pregnancy, leading to a cautious approach. The phrase *"I didn't mind"* implies that she was not bothered or concerned about not being prioritised for vaccination. Her willingness to consider vaccination post-birth shows a potential openness to receiving the vaccine, albeit at a different time. Her fear is further explored below.

> **Extract 29:** *no, I'm still a little bit scared of the vaccine, ok that time I was thinking of my baby, this time I was thinking of myself; what if there is something in there that I'm allergic to, p47.*

The extract above highlights further reasons why Sunita did not get vaccinated. She fears potential allergic reactions to the vaccine, highlighting her desire to prioritise her well-being. The fear of an allergic reaction in her or her child stems from an allergic experience that her former partner had when he was younger.

#### 4.2.2.4 Exposed to COVID-19, standing ground and taking action

This superordinate theme explores how the participant navigated being confronted by COVID-19 and its regulations at home with family and friends as her pregnant woman.

##### *4.2.2.4.1 The neglect of COVID-19 regulations compliance-standing up*

In the extract below, Sunita expresses her concerns regarding the safety of her daughter in relation to COVID-19.

> **Extract 30:** *Is my baby going to be fine? Because I remember my cousin gave birth a few months before me and the baby actually got Covid. So, I was so stressed, what if my baby is born and then she gets Covid. Ja even at home they didn't obey the rules of COVID-19 so I was stressed about that as well. These people were coming and going inside the house as they want. So, what if my baby gets COVID-19 but then ja.*

The extract reflects Sunita's deep concerns and anxieties regarding the health and safety of her baby exposed to COVID-19 when she returns home. Her worry stems from a personal experience where her cousin's baby contracted COVID-19 shortly after birth. This experience is a source of stress and fear for her as she contemplates the possibility of her baby's birth and subsequently contracting the virus. The disregard for safety measures intensifies her fears and anxiety. The repeated question, *"Is my baby going to be fine?"* reflects Sunita's central concern and worry. The phrase *"but then ja"* suggests a resignation to the uncertain circumstances and an acknowledgement that the outcome is beyond her control.

**Extract 31:** *But I had to tell a lot of people to go away, they cannot see my baby. So, I was scared and angry at the same time.*

The statement conveys a complex mix of emotions experienced by Sunita. The complex emotional state includes worry, anger, and a sense of responsibility towards her baby. The statement also highlights the challenges of navigating relationships and setting boundaries to safeguard her baby's health, all while managing her emotions in a delicate situation. It lastly suggests that she was proactive in enforcing measures to minimise the risk of exposure to the virus, especially for her vulnerable baby.

## Summary

The master theme explored Sunita's experiences of managing the risks of COVID-19. These experiences included her experiences of travelling via the bus, where the concern about contracting the virus was minimal compared to her concern of the possibility of being in labour while travelling. The master theme also explored her perinatal care visits, which included both her clinic and hospital visits, where her experiences at the clinics predominately involved a sense of not being prioritised and feelings of loneliness and not being cared for by the staff members at the hospital. The themes also highlighted how COVID-19 was not always the participant's main concern and thus, indicating the challenges that many women generally face when pregnant. Nonetheless, the participant's experiences relating to the COVID-19 pandemic suggested an overall feeling of not being in control. The participant also included her experience of the COVID-19 vaccine, which she initially saw as a source of hope. However, she soon felt resistance towards it due to lack of knowledge and previous experiences of vaccines. Lastly, the theme also explored how Sunita navigated her experience of being exposed to the virus through family and friends.

### 4.2.3 Glimmers of hope and desirable aftermaths

Another feature of how the participant experienced the perinatal period during the COVID-19 pandemic was her experience of favourable outcomes that resulted from her pregnancy and the pandemic. This master theme thus focuses on how Sunita experienced the pandemic and her pregnancy to have had positive consequences for her life and family. The master theme also explores how the participant favourably contemplated her experiences and depicts hope for the future. The master theme consists of two superordinate and three subordinate themes that are explored below.

#### 4.2.3.1 The return home and reunion with family

This superordinate theme explores Sunita's experience of how she returned home and reunited with her family as a result of her pregnancy and the pandemic. It also explores how the pregnancy became a perfect distraction from the pandemic for her family.

##### *4.2.3.1.1 Becoming closer to family again*

This superordinate theme focuses on Sunita's reunion with her family and how they became closer because of the pandemic. In the extract below, the participant reflects on the impact the pandemic has had on her and her family.

> **Extract 32:** *thinking of it now and everything wasn't like this, if it wasn't for my pregnancy I wouldn't be as close with my family as I am now, like I'm more close than I used to be before, I am more close w1`ith them so that's one good thing, p9.*

In the above extract, Sunita describes how her pregnancy made her closer to her family than before. The statement *"thinking of it now and everything wasn't like this"* reflects on her past experiences. The statement also provides a sense of confirmation that there may have been a shift in her relationship with her family compared to how it was before the pregnancy. The statement is supported by the phrase *"closer"* which highlights her dynamics with her family

and suggests that there may have been distance or disconnection prior to her current increased closeness with her family because of the pandemic and her pregnancy. Sunita notes the increased closeness with her family as *"one good thing"* resulting from her pregnancy, highlighting the challenges of the pregnancy in the context of the pandemic. The phrase *"one good thing"* was also noted to be a positive contradiction to her initial perspective of her pregnancy, as noted in the first master theme.

#### *4.2.3.1.2 Pregnancy, the silver lining of the pandemic*

The next superordinate expands on the closeness of the family; however, it focuses on how the participant experienced the pregnancy as a silver lining and a perfect distraction from the pandemic for her family. She explains below, how her pregnancy had favourable outcomes despite being unplanned.

> **Extract 33:** *Yes, it was unplanned but I was kind of excited at the same time, it actually made everyone, my pregnancy actually made people, how can I say, comfortable, I don't know the word, feel at ease, p36.*

> **Extract 34:** *about the whole thing going on, like it actually took their mind off from Covid for a while, so they just focused on my pregnancy; being excited blah blah blah. So ja I would say my pregnancy like, took away my mind from Covid for a while…p40.*

In the extracts above, Sunita describes how her pregnancy became a good distraction from the pandemic for her family. She explains that despite the initial surprise of the pregnancy, she did experience some excitement. Additionally, her pregnancy positively impacted others, making them feel more comfortable and at ease. The positive impact may have been evident to her through her family's reactions and behavioural change in response to the news, thus creating an atmosphere of ease amid the pandemic. Sunita struggles to find the right word to describe the specific feeling experienced by others, which may suggest that she recognises the

impact her pregnancy has had on people's emotions but finds it challenging to articulate the exact sensation.

In the subsequent extract, she further explains that she experienced the pregnancy to have consumed her family's thoughts and attention away from the other stressors and concerns resulting from the pandemic. The extract might also suggest that the family focused on the positive aspects of the pregnancy, such as the excitement and anticipation, thus providing a welcome respite from the constant news and updates about the pandemic.

#### 4.2.3.2 Looking back and recovering from the pandemic

The next superordinate theme explores how Sunita makes meaning of her experience of the perinatal period during the COVID-19 pandemic and is hopeful for the future post the pandemic.

##### *4.2.3.2.1 Comparing then and now*

This subordinate theme explores how Sunita makes sense of her experiences of the perinatal period and predominately the postnatal period. In the extracts below, Sunita explains her life after having her daughter and post the pandemic even though she does not make a direct reference to the pandemic.

> **Extract 35:** *exactly, so ja but I'm actually in a better place now than I was that time, I got a job again and ja my baby is growing, she's healthy ja and I'm still a single parent, p19.*

> **Extract 36:** *I think that things are turned out, ok what can I say, I'm actually glad things turned out the way they did because what if I had to move with my baby to (City), back to (City). I mean life in (City) is very busy, it is very busy. I think being in Grahamstown was actually the better decision because my baby now can grow up around family and ja have that environment, you see that environment where there's*

*lots of love showered at you. People just shower you with love whereas in (City), it would have just been me, her and her dad and obviously her dad's brother. Which is not enough because they don't know about babies, they don't know anything about babies. So being at home is actually, it turned out good because they taught me a lot about how to be with a baby and ja. Now actually I know how to deal with the baby, ok I do deal with kids everyday but they are not babies so ja, p23.*

In the extract above, Sunita reflects on her move to Makhanda and expresses her contentment with how things turned out. The statement *"I'm actually glad things turned out the way they did…."* suggests that she was able to find positives to her stay in Makhanda despite her initial reluctance. She believes being around family in Makhanda benefits her baby, as there is lots of love and support, suggesting that she may have experienced less love and support in the cities she resided. Her statement supports the idea: *"Which is not enough because they don't know about babies, they don't know anything about babies"*. Sunita also believes that her return to Makhanda was beneficial as it allowed her to learn a lot about caring for her baby, which may suggest that she had less experience caring for babies despite her working with children in her former workplace and further less support compared to the other places that she resided in during the pandemic and prior to moving to Makhanda. Sunita's repetition of the phrase "…life in (City) is very busy" highlights the extent to which life in the city is fast-paced and busy and her realisation that the City might not have been a conducive environment for her to raise her child.

While these beneficial reasons for her residing in Makhanda may be valid, they were noted to contradict her initial view of residing in the City *"everything was nice"* as opposed to Makhanda, as highlighted in the first master theme. These reasons may have served to console her and help her become content with her residing in Makhanda as it was not her initial desire to do so. Hence, she now considers being in Makhanda as a better decision. The participant is

also noted to have moved from a sense of self as fiercely independent to a sense of self as socially connected.

## Summary

Overall, this master theme explored how Sunita's pregnancy served as a unifying factor in bringing her closer to her family, the good outcomes that resulted from her pregnancy and pandemic and her reflections on the past and her current life.

The findings of the study highlighted the ways in which the participant experienced COVID-19 as significantly impacting her life. The pandemic took away her independence, which was a big part of how she viewed herself. The findings also highlighted her management of COVID-19 as a pregnant woman and new mother a how these experiences had challenges. These challenges were noted to be more in the background compared to the mental and emotional challenges of becoming a single mother and moving back, which she feels were prompted by the pandemic. The third main theme highlights the emergence of new experiences which were possibly facilitated by greater stability due to renewed employment. The participant feels socially connected and is ultimately happy with how COVID-19 impacted her plans. However, it is also clear that she sometimes still feels ambivalent about this. Lastly, the findings highlighted how COVID-19 increased the vulnerability of women like Sunita, particularly because of the way it impacted employment arrangements.

# 5. CHAPTER 5: DISCUSSION OF THE FINDINGS

## 5.1 Introduction

The aim of the current IPA study was to explore the research question: how did the participant experience the perinatal period during the COVID-19 pandemic? This chapter provides an overview of the key findings related to this question, describing how the participant made sense of her experience and comparing this to current research in the field. As such, this chapter will discuss how the current research findings relate to, extend, replicate and contradict the literature.

## 5.2 Overview of key findings

The analysis of the participant's experience of the perinatal period during the pandemic identified three main themes: A sense of loss and change; managing COVID-19 and its regulations; and glimmers of hope and desirable aftermaths. These main themes represent the participant's experience of the perinatal period during the COVID-19 pandemic and provide rich insights into the complexities of her experience.

## 5.3 Interpretation and discussion of the main findings

### *5.3.1 A sense of loss and change*

This master theme illustrated the overarching concept that emerged from the findings of the study, highlighting the participant's experience of a profound sense of loss and change that occurred in her life during her perinatal period, which she attributed to the COVID-19 pandemic. The participant's sense of loss was characterised by various subordinate themes. including her separation from her partner, single parenting and unemployment and a change in her mental state. The participant was also noted to have also lost her sense of self and control due to the pandemic. The analysis showed that the participant placed the blame on the pandemic for the multiple significant changes and losses that occurred in her life during her pregnancy, even when there was not a direct link of the experience to the pandemic.

While the pandemic significantly contribution to these losses and changes, it may have also been easier for the participant to bear and accept these losses and changes by attributing them to the pandemic. This sense of loss and change was not a unique experience to the participant as studies by Huang et al., (2022) and Maison et al., (2021) revealed similar themes of a sense of loss. Maison et al., (2021) explain that the attribution of challenges and difficulties experienced in life to an external event such as the pandemic may serve as a psychological coping mechanism (Maison et al., 2021). According to Maison et al., (2021), when people encounter multiple uncertainties and stressors, finding a tangible and single explanation reduces the feelings of hopelessness, confusion, and self-blame.

The pandemic's economic (loss of employment) impact was a major direct and indirect contributor to the participant's experience of a sense of loss and change. Her employment seemed to have been the anchor of her relationship with her child's father as it allowed them to live together in the apartment and thus be close to each other. This closeness also allowed the participant and her ex-partner an opportunity to parent together. It further granted her financial independence, which she understood as something that decreases her stressors and assists with her mental health.

The themes related to her separation from partner and becoming a single parent were derived from the participant's narrative of how she experienced the pandemic to have resulted in the end of her romantic relationship and her becoming a single parent; following that her partner moved to one South African city to another for employment reasons. The sense of loss and change in relation to the above themes likely stemmed from the physical distance, increased stress and uncertainty following the pregnancy and her loss of employment amid the pandemic. This was a reality for many South African families as the COVID-19 pandemic had a greater impact on middle-income countries. Employment in the country decreased by 2.16

million by the second quarter of 2020, resulting in changes in lifestyle, increased stress and uncertainty for many households (Hübner et al., 2022).

A study by Mollard and Wittmaack (2021), which explored the impact of the pandemic on romantic relationships, indicated that COVID-19-related stress was accompanied by greater negative conflict and miscommunication, especially among couples. Previous scholars also observed that times of crisis can strain romantic relationships and further exacerbate underlying issues that may have existed within a relationship before the actual crisis (Mizrak Sahin & Nur Kabakci, 2021). This may have been the case for the participant as she had indicated that they (herself and her ex-partner) do not do well with distance, suggesting that distance may have been a pre-existing issue for reasons unknown. Puertas-Gonzalez et al., (2021) explain that it is worth noting that the context of the COVID-19 pandemic added a distinct layer of fear and uncertainty that intensified relationship challenges.

Whether the COVID-19 pandemic had an impact on romantic relationships as an external stressor might be better understood with the conceptual framework of the vulnerability-stress-adaptation model (Pietromonaco & Overall, 2020). According to this model, the COVID-19 crisis generated several stressors and contextual factors (such as confinement, financial strain, and job loss) that had the potential to damage a couple's relationship by escalating negative existing processes that may have already existed in the relationship such as hostility, estrangement, and less responsive support. As a result, the impact of stressors related to the pandemic was exacerbated by the presence of greater pre-existing contextual vulnerabilities that affect the relationship combined with individual vulnerabilities of one or both partners. However, despite these contextual factors, the participant still attributed the separation to the pandemic.

The findings of the current study also correlate with earlier research by Tavares et al., (2021) who explored the effects of the pandemic on relationships during pregnancy and postpartum. While the study by Tavares et al., (2021) provided insights into the impact of the pandemic on couples working from home together and the impact of social distancing and quarantining on romantic relationships, the findings of the current study provide insights into the impact of long-term physical distance that resulted from the pandemic on romantic relationships. Further, the current study provides insight into the impact of the pandemic on romantic relationships in the South African context.

The study also highlights the impact of financial independence and loss of employment on the participant. Financial freedom was significant to the participant as she interpreted it as a form of independence, which is of great value to her. The participant saw this financial independence being lost as she was dismissed from her job. his financial strain impacted the participant's initial idea of how her life would turn out and further forced her to return home. Johnson (2021) reported that the financial strain of COVID-19 on pregnant women has been a topic of increased interest in the literature however none of the studies thus far have the primary purpose of studying the factors associated with the financial strain. In response, this current study was able to shed some light on the impact of the financial strain that the pandemic contributed on the life of a woman during her perinatal period (Mortazavi & Ghardashi, 2021).

In line with the findings of the current study, where the participant was unfairly dismissed, a study by Johnson, (2021) conducted in the USA found that while some pregnant women voluntarily stopped working during the pandemic as a safety measure, others were penalised for being pregnant or having a newborn by their employers, and as a result lost employment or a promotion. Correll et al., (2007 as cited in Zanhour & Sumpter,2022) explained that norms within the working space often betray pregnant women and mothers even prior to the pandemic. Although policies such as maternity and family leave exist, informal

norms within the workspaces usually discourage pregnant and working mothers from taking advantage of them, especially during times of crisis such as pandemics. This may have been applicable to the participant who would have been due for maternity leave at work. According to Zanhour and Sumpter (2022), the work culture tends to idealise workers whose lives centre on their full-time work, predominantly men, as they can afford to prioritise work and be available consistently. Motherhood is often seen as misaligned with the ideal worker image (Mortazavi & Ghardashi, 2021).

Her mental health was another aspect of the participant's life that experienced a change. According to Lebel et al., (2020), increased research studies suggest that the symptomology of perinatal depression and anxiety was increasingly common during the pandemic and linked to factors such as the loss of income. While the pandemic created emotional, logistical and financial stress for everyone, for the participant, the occurrence of the difficulties that she experienced during her perinatal period heightened the stress. It resulted in her experiencing great uncertainty and fear for herself and her baby regarding their future and safety. A study by Sherin et al., (2021), found that a sense of low control over triggers such as lower or no income and stressful life events have a high likelihood of contributing to perinatal depression. As a result, Sherin et al., (2021) suggest that it is expected that loss of employment or unplanned alterations to work plans because of COVID-19 elevated the mental illness risk amongst pregnant individuals. Another contributor to the participant's mental health was quarantining.

According to Burke et al., (2020), prior studies indicated that prolonged quarantine and isolation are associated with increased psychological distress. This is because women during the perinatal period tend to experience a sense of loneliness, as the participant also described. This sense of loneliness during the pandemic was further exacerbated by the fact that women during the perinatal period formed part of the vulnerable populations and, as a result were required to socially isolated as a safety measure (Burke et al., 2020). As a result, a higher

prevalence of depression, stress, emotional disturbance, insomnia, low mood and irritability was experienced by women during the perinatal period (Burke et al., 2020).

### *5.3.2 Managing COVID-19 and its regulations during the perinatal period*

The findings of this master theme were derived from the participant's narrative of her experiences managing COVID-19 regulations during her perinatal period. The findings revealed that the participant experienced negative and positive experiences related to the theme. While the participants management of COVID-19 had its own challenges, these challenges were noted to be in the background, and the emotional impact of the pandemic and pregnancy were at the forefront. This was also evident during her intrapartum period, where the participant's sense of loneliness and the lack of support was at the forefront compared to the risk of contracting the virus-she was not concerned about wearing a mask. A thematic analysis by Gamberini et al., (2022) revealed mixed results regarding women during the intrapartum period complying with the safety regulations of the hospitals in response to the pandemic. Some women wore masks, sanitised, and complied with other regulations while others felt a sense that the pandemic was not a major concern at that moment, thus highlighting the importance of emotional support and care during the intrapartum period (Gamberini et al., 2022).

To the best knowledge of the researcher, no studies provided insight into the actual experiences of women travelling and using public transport for other reasons that exclude perinatal care visits amidst the pandemic. Most studies focused on women's experiences of accessing perinatal health services via public transport services. Nonetheless, a study by Mortazavi and Ghardashi (2021) conducted in Hong Kong, China highlighted that pregnant woman avoided using public transport for perinatal care visits due to the increased fear of contracting the virus as a result of a lack of guaranteed social distancing or personal hygiene. These findings contradicted the findings of this current study as the participant feared the possibility of giving birth while using public transport instead of the lack of adherence to the

COVID-19 regulations that occurred during her travelling. Possible reasons for the discrepancy may include contextual factors as South Africa is a low- and middle-income country, and as a result, public transport is common as compared to well-resourced countries that may have a larger population owning private cars (Burke et al., 2020).

According to Gamberini et al., (2023), the COVID-19 pandemic was reported to have had an indirect negative impact on perinatal care services in the Netherlands and worldwide. The pandemic resulted in unprecedented levels of strain and stress on healthcare services across the world. The impact of the COVID-19 regulations was also evident in the health facilities that the participant visited for her prepartum and intrapartum care visits. However, the findings also suggested that the participant had positive experiences during her postnatal care visits, suggesting that during that time, the health systems had significantly improved and adapted to the COVID-19 pandemic from the time of her prepartum care visits to the time of her postnatal care visits.

Gamberini et al., (2023) also reported that the pandemic led to the restructuring of perinatal care consultations, leading to increased remote prepartum consultations in many countries so as to limit potential exposure to the virus (Gamberini et al., 2023). This was found to be contrary to the findings of the current study, which suggested that prepartum visits were still conducted physically and pregnant women were not considered vulnerable and thus not prioritised for their consultations. Most studies highlighted that pregnant women were considered to be part of the clinically vulnerable population, and as a result, had limited perinatal care follow-up visits or alternatives such as online consultations, (Gamberini et al., 2023; Ryan et al., 2020). However, other studies also highlighted that the changes that occurred in perinatal health facilities resulted in clinic visits being an unpleasant experience for some women. The participant's experience of efficient services during her postpartum care visits at

the clinic contradicts the literature. The current study provides insight into some of the positive experiences that women experienced in the global South due to the pandemic.

The study found that the participant experienced mixed reactions towards the COVID-19 vaccine. The participant initially experienced the vaccine as providing a sense of hope; the vaccine was seen as a source of help. This suggests that the participant considered the vaccine a source of health and safety for her and her unborn baby at the time, considering that pregnancy is a vulnerable time for both their immune systems. The findings suggest that the vaccine was seen as an additional layer of protection against complications resulting from contracting the virus or severe illness. However, while the vaccine became a source of hope for her, she also felt resistance towards receiving it due to past experiences and a lack of knowledge regarding the vaccine. Blakeway et al., (2020) explain that vaccine safety scares reduce coverage and erode confidence whether they are fabricated or factual. The findings of the study were similar to the results of a study by Maison et al., (2021), which found that some women refused to be vaccinated due to the fear of experiencing side effects. This fear was found to be greater than the fear of contracting the virus. The findings provided insight into the impact of insufficient knowledge regarding the vaccine on pregnant women at the time (Maison et al., 2021).

A mixed-method survey conducted in the USA by Huang et al., (2022) similarly revealed that some of the participants perceived the vaccine as providing a sense of hope, while others expressed concern regarding its safety of the vaccine. This was a common thread in the findings of multiple studies, where a division amongst the participants was noted regarding the vaccine. However, this current study provided insight into the evolution of an individual's perspective regarding the vaccine.

The findings of the current study relating to the participant's birth experience were similar to the findings of a study in Germany by Miani et al., (2023), where the participants

were not primarily concerned about COVID-19 precautions (wearing masks) during birth but rather about being ill-treated by hospital staff and denied supportive care from their loved ones. According to Miani et al., (2023), deficiencies in maternity care that women experienced during the intrapartum period were not unique to the pandemic, however these deficiencies were noted to be increasingly common during the COVID-19 pandemic. The increase across many countries was a result of several reasons, including staff shortage and as a result, the available staff was overworked and overwhelmed, communication challenges between staff members and patients, and increased focus on medicalisation where health professionals focused on managing and preventing infection and most frequently at the cost of patient preferences and care (Dasupta et al., (2021).

Gamberini et al., (2023) explain that the intrapartum period is a vulnerable time for expecting women; having to face unpredictable circumstances in the absence of loved ones is a threat to birth integrity. The presence of a loved one during the intrapartum period provides vulnerable patients with emotional, practical and informational support, which contributes to them having positive experiences (Huang et al., (2022).

### *5.3.3. Glimmers of hope and desirable aftermaths*

The findings of the study revealed that the peripartum during the pandemic underscored the participant's capacity to find positive aspects amidst challenging circumstances. The superordinate themes highlight the resilience and adaptability of the participant.

The subordinate theme of returning home and reuniting with family suggested that the participant found hope and solace in her return to her family during this difficult time. The findings suggest that a reconnection occurred between the participant and her family, which indicated that the context of the pandemic prompted her and her family to repair and strengthen their bond. The findings of the current study contradict most findings of other studies, which

found that the pandemic diminished the sense of closeness with family (Gamberini et al., (2022). While a small number of studies do explore the experiences of women with family during the perinatal period amidst the pandemic, most of these studies provide insight into the immediate family of the participants however, this study provides insight into the extended family of the participant, which is a reality for many families in the South African context (Tavares et al., 2021).

The findings also revealed the reflective aspect of the participant's experience. The theme also provides insight into how the participant's perspective of her experience evolved during the pandemic and pregnancy to the time of the study. The findings also suggested a sense of appreciation for normalcy where the participant indicated a newfound appreciation of the new 'normal', her new life and circumstances.

## 5.4 Conclusion

The findings of the study confirmed the findings of other studies that COVID-19 was experienced as a source of loss and change by women during the perinatal period as a coping mechanism. The study further confirmed that the changes in perinatal care services in response to the pandemic were a significant stressor to women during the perinatal period; the impact of these changes was of greater concern than the possibility of contracting the virus. Mixed reactions relating to the COVID-19 vaccine by pregnant women, as highlighted in other studies were also confirmed in this study.

The findings of the study extend on literature relating to the sources of psychological distress during the pandemic, where many studies highlighted the impact of isolation and quarantining on the psychological well-being of women during the perinatal period. The study highlighted another source of psychological distress, which was found to be the financial impact of the pandemic. The study also added on literature related to the dynamics of romantic

relationships of expecting couples or new parents during the COVID-19 pandemic, most studies highlighted the impact of the pandemic on couples having to spend more time together such as times of quarantining, this study highlighted the impact of separation of couples as a result of the pandemic. The current research study also extended literature regarding the impact of the pandemic on families, where most studies focused on the impact of the pandemic on immediate families; the current study provided insight into the impact of the pandemic on extended families, which is a definition of a family for most South Africans.

The current study contradicted literature which indicated that the pandemic led to the restructuring of perinatal care consultations, leading to increased remote prepartum consultations in many countries to limit potential exposure to the virus as the study revealed that in the South African context, perinatal care visits were predominately in person and pregnant women were not considered as vulnerable and thus not prioritised. However, the study also revealed positive perinatal care experiences, thus contradicting literature which indicated the global South lacks the reporting of positive experiences.

# CHAPTER 6: CONCLUSION

## 6.1 Introduction

This single case study explored an individual's experience of the perinatal period during the COVID-19 pandemic in Makhanda, South Africa. This chapter highlights the implications of the current study for practice and policy. It also discusses the limitations of the current study and provides recommendations for future research.

## 6.2 Implications of the research findings

In light of the findings of the current study, a number of implications that relate to practice and policy are considered.

*Practice*

Below are practical implications that may be considered for future pandemics as currently the risk of COVID-19 has rapidly decreased:

Firstly, the participant's perinatal care visit experiences highlight the need to consider virtual consultations. Integrating telemedicine and psychology into perinatal care routines will offer clients flexibility and serve as backup in times of crisis, such as the COVID-19 pandemic. Secondly, the impact of the pandemic and pregnancy on the participant's mental health suggests an increased need to prioritise and increase mental health support as part of the perinatal health care services. Thirdly, the findings related to the mixed emotions regarding the COVID-19 vaccine suggest the need for effective communication and information dissemination. The findings emphasized the need for accurate, clear, and empathetic communication regarding COVID-19 risks, vaccination and prevention measures.

Fourthly, the research findings of the study regarding the participant's intrapartum experiences of ill-treatment by the nursing staff and the lack of support highlight the need for continuous programmes, training and education of healthcare staff focusing on improving

patient-centred care, communication, and empathy, especially during times of crisis such as the COVID-19 pandemic. The findings also highlight the lack of and need for psychological support during the intrapartum period. Healthcare facilities can also consider transparent communication where patients are fully informed in advance about changes in policies and procedures and the reasons behind them so that patients are aware and prepared prior to their admission to the health facilities. Healthcare facilities can also receive continuous feedback from patients and engage them in decision making where possible to improve current policies but also prepare for future situations like the COVID-19 pandemic.

Lastly, there is a need for psychoeducation and social awareness for families living with people who form part of the vulnerable population, such as pregnant women, regarding their safety and protection. The participant's experience of the neglect of COVID-19 regulations around her and her baby highlights the need for educational campaigns that intend to raise awareness among families and others around women during the perinatal period. The government could also provide sanitizers and masks to women during the perinatal period together with their families so that they feel less vulnerable about contracting the virus.

Additionally, the findings of the study also highlighted the financial stressors that women faced during the perinatal period during but also beyond the pandemic. Healthcare facilities can collaborate with relevant stakeholders to educate women during the perinatal period regarding their employment rights and implement other related financial literacy programmes.

*Policy*

The findings also advocate for policy changes that prioritise the needs of pregnant women at times of public health crises; this includes ensuring that they can access essential health care and support but also that they are prioritised. In relation to the findings about the

participant's unfair dismissal at work and challenges of seeking employment during the pandemic as a pregnant woman, the participant's experience underscores the need to strengthen anti-discrimination policies and maternity leave benefits in the workplace to ensure that pregnant women are protected from injustices of such nature and receive comprehensive maternity leave that reduces the risk of being unfairly dismissed.

Further, to address the difficulties or anticipated difficulties of seeking employment as a pregnant woman, policy initiatives could implement job placement services tailored for pregnant women precisely so that pregnant women receive guidance for navigating the job market space during pregnancy, especially in times of crisis such as the pandemic. Government and agencies could also consider financial support programmes such as maternity grants or unemployment benefits tailored particularly for pregnant women to mitigate the financial challenges experienced by unemployed, pregnant women during times such as the COVID-19 pandemic, but also more generally. Policies related to public transportation could consider pregnant women's safety and needs, such as providing guidelines catered for pregnant women travelling using public transport during challenging times such as the pandemic. Lastly, health facilities can collaborate with other relevant stakeholders to ensure that policies relating to maternity leave, family-paid leave, and government support programmes such as social support grants are improved.

### 6.3 Limitations and strengths of the study

I, as the researcher, acknowledge that the study has several limitations. Firstly, I am a novice researcher of IPA. However, I engaged in extensive supervision and reading regarding the IPA methodology. Secondly, the interview was conducted in English, which is a second language for the participant as she is an Afrikaans-speaking female. The nature of the study consisted of a single participant, which suggests that the findings of the study are not generalisable to a larger population. A single woman's experience may not accurately represent

the diverse range of women's experience during the perinatal period during the pandemic. A single case study may also not accurately capture broader contextual factors that may influence other women's experiences in other contexts. These factors include contextual factors and socio-economic amongst other factors. However, the findings of the study may be transferrable. Another limitation of the study was that at times, the participant spoke in abstract terms instead of always expressing her detailed personal experiences.

However, despite the above constraints, the study provided an in-depth exploration of a specific woman's experience, thus allowing for a detailed and rich understanding of her unique journey of her perinatal period during the pandemic. Using IPA allowed the researcher to capture the complexities of the participants' experience, perceptions, and emotions. This allowed the study to cover a range of the participant's experience, including the social, economic and health-related aspects of her experience and thus providing a holistic view of the participant's journey. Further, in consideration that IPA involves a thorough analysis of the research data, such as multiple stages of analysis and interpretation, the method ensured that the participant's experience was examined systematically and rigorously.

Considering that the study was conducted in a specific context, the study was able to offer insights into how the global pandemic crisis affected the perinatal period in South Africa, which is a significant and unique contribution. The study gave a voice to a woman who is part of a population that is rarely heard and often marginalised. Despite the findings of the study not being generalisable to a larger population due to the design of the study, the findings provide valuable insights into understanding the experiences of other individuals who are in the similar context to the participant.

## 6.5 Future research recommendations

The researcher recommends expanding the study as it provides valuable baseline data for future research related to the topic. The researcher suggests replicating the research study with a diverse sample of other individuals who experienced the perinatal period during the COVID-19 pandemic. This will result in a broader spectrum of experience to be generated and thus allow meaningful comparisons to be made. Further, conducting the study from a quantitative lens and on a larger scale in the South African context will contribute to a sense of the prevalence of the findings of the study. A retrospective study would assist in capturing the understanding of the perinatal period prior to the COVID-19 pandemic, during and post the pandemic. It will also provide insight into how women's emotions and experiences evolve. A comparative analysis of women's experiences of the perinatal period during the pandemic with women's experiences during other pandemics (influenza, cholera, smallpox) may also reveal specific changes and challenges that are common and underlying factors that influence the women's experiences.

Extending the research study to include the experiences of the support system members such the family, partner and health care providers in the South African context may also be valuable.

## 6.7 Conclusion

This IPA single case research study's primary aim was to obtain an in-depth understanding of how the participant experienced the perinatal period during the COVID-19 pandemic. The study found three main themes: *a sense of loss and change, managing COVID-19 and its regulations during the perinatal period* and *glimmers of hope and desirable aftermaths.* The study highlighted the need for further research, support systems and policy adaptation that prioritise the well-being of women during the perinatal period during times of unforeseen crisis.

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# APPENDICES

## APPENDIX A: ADVERSITEMENT POSTER (ENGLISH)

**DID YOU HAVE A BABY DURING THE RECENT THIRD-WAVE OF COVID-19 (June/July/August)?**

**RESEARCH PARTICIPANTS WANTED TO PARTICIPATE IN A STUDY ABOUT THEIR LIVED EXPERIENCES OF BEING BIRTH AND/OR HAVING A BABY DURING THE COVID-19 (third wave)**

***Looking for participants who are women, currently residing in Makhanda, non-first-time mothers, were pregnant and/or had a baby during the third wave COVID-19 pandemic in Makhanda. The baby must be 4-6 months. Participants Must be 18 years of age or above***

**Research Project Title:** The experiences of women's perinatal period during the COVID-19 pandemic in Makhanda.

**Nature of participation:** Individual interview

**Duration:** Approximately an hour of two sessions

**Place:** Rhodes Psychology clinic

**Purpose of the study:**

Understand the experiences of motherhood during the COVID-19 pandemic.

Your participation is entirely voluntary and should you at any stage wish to withdraw from participating further, you may do so without any negative consequences.

confidentiality and anonymity of records will be maintained- your name and identity will not be revealed to anyone who has not been involved in the conducting of the research

***For further details contact Asanda Hadebe (Researcher)***

***Cell: 0732347153 email: asandahadebe05@gmail.com***

**-The advertisement has been approved by the Department of Psychology's Research Project and Ethics**

**-The research is in fulfilment of my Masters in Clinical Psychology at the department of Psychology under the supervision of Prof Lisa Saville Young.**

**APPENDIX B: ADVERSITEMENT (XHOSA)**

**NGABA UBENOMNANA NGEXESHA LAMVA LESITHATHU AMAZA AMA-COVID-19 (June,/July/August 2021)?**

**ABATHATHI-NXAXHEXHE BOPHANDO Bafuna UKUTHATHA INXAXHEBA KWISIFUNDO ESimalunga namava abo okuphila okukhulelwa, UKUZALWA KUNYE NOKUBA NOMNTWANA NGEXESHA LOMTSHATO WESITHATHU WOKUGQIBELA-19 (ngoJuni / Julayi / Agasti 2021)**

**Ukujonga abathathi-nxaxheba:**

- **Ngabafazi**
- **Bahlala eMakhanda**
- **Abangaqali ukuba ngomama**
- **wayenomntwana kwisibhedlele sikawonkewonke ngethuba lesithathu lomkhuhlane weCOVID-19 eMakhanda**
- **baneminyaka eli-18 ubudala okanye ngaphezulu**

**Yintoni efunekayo kum?**

**Uya kuthatha inxaxheba kudliwanondlebe lweyure enye apho umphandi aya kuvavanya amava akho**

**Indawo**: Iklinikhi yaseYunivesithi iRhodes Psychology

Ukuthatha inxaxheba kwakho kungokuzithandela ngokupheleleyo kwaye ukuba nanini na unqwenela ukurhoxa ekuthatheni inxaxheba, ungenza njalo ngaphandle kweziphumo ezibi.

Ukugcinwa kwemfihlo kunye nokungaziwa kweerekhodi kuya kugcinwa - igama lakho kunye nesazisi asizukutyhilwa kuye nabani na ongakhange abandakanyeke ekuqhubeni uphando

**Ukuba unomdla nceda unxibelelane noAsanda Hadebe (Umphandi)**

**Iseli: 0732347153 imeyile:** asandahadebe05@gmail.com

## APPENDIX C: LETTER REQUESTING PERMISSION FROM GATEKEEPERS


***REQUEST FOR PERMISSION TO POST ADVERTISEMENT TO RECRUIT WOMEN WHO HAD A BABY DURING THE THIRD-WAVE OF COVID-19 (June/July/August).***

To whom it may concern

My name is Asanda Hadebe and I am currently completing a master's degree in Clinical Psychology at Rhodes University under the supervision of Professor Lisa Saville Young. The research I wish to conduct for my master's thesis involves exploring the lived experiences of women who had a baby during the third-wave of the COVID-19 pandemic in Makhanda.

I am hereby seeking your consent to place advertisement to recruit individuals who are women, currently residing in Makhanda, non-first-time mothers, who had a baby at a public hospital during the third wave COVID-19 pandemic in Makhanda and are eighteen years of age or above.

I have received ethical approval to conduct this research from the Department of Psychology at Rhodes University and the ethics committee.

If you require any further information, please do not hesitate to contact me on 073 234 7153 or via email asandahadebe05@gmail.com. Thank you for your time and consideration. Your permission to place the advertisement on your premises and encouragement of women fitting the criteria to participate will be highly appreciated.

Yours faithfully

Asanda Hadebe Trainee Clinical Psychologist

**APPENDIX D: Interview Schedule**

THE EXPERIENCES OF WOMEN'S PERINATAL PERIOD DURING THE COVID-19 PANDEMIC IN MAKHANDA.

Semi-structured interview schedule

-Could you tell me about yourself?

**A. Pregnancy**

1. Can you tell me a bit about your pregnancy and how did you find out about it?

**Possible prompts:** How did you feel about it, how did you cope?

2. What were some of your thoughts/anxieties/distresses/wishes about the pregnancy?
1. Could you tell me a little bit about your pregnancy experiences during the pandemic compared to your previous pregnancy experience(s)

**Possible prompts:** How was it different/the same compared to before?

2. Would you say that the pandemic affected your mental health during the pregnancy?
3. If so, how?

**Possible prompts:** what are some of the distresses and anxiety caused by the pandemic during the pregnancy?

4. What are some of the positive experiences brought about by the pandemic?
5. What are some of the emotions that you experienced during this time due to these positive experiences?
6. What are some of the negative experiences?
7. What are some of the emotions that you experienced in relation to these negative experiences?

**B. Birth**

1. How would you describe your birth experience compared to previous experiences?

**Possible prompts:** what were some of the emotions and feelings you experienced during the time?

**Possible prompts:** How did you feel about the changes brought about by the changes brought about by the pandemic to the birth experience?

2. How were these experiences positive, how were they negative?
3. Did you have any loved ones with you during the birth process?
4. How did this affect you? / How was that for you?
5. How would you describe the treatment of the health workers during the birth?
6. How did that make you feel?
7. How would you compare these two previous experiences of birth?
8. What were some of your worries during the birth process in relation to the pandemic?

**C. Post birth**

1. How would you describe your post birth experience?
2. What are some of the positive experiences brought about by the pandemic in relation to your post birth experiences?
3. How did these positive experiences make you feel?
4. What are some of the negative experiences brought about by the pandemic in relation to your post birth experiences?
5. What emotions and feelings did these negative experiences evoke?
6. Were you able to receive support and help from loved one(s)?
7. How did this make you feel?
8. **Possible prompts:** Were there any differences from previous experiences to your current experience?

9. What other changes that had to be implemented due to the pandemic?

# APPENDIX E: ANALYSIS OF DATA-ORIGINAL TRANSCRIPT, EXPLORATORY NOTES AND EXPERIENTIAL STATEMENT

Descriptive-Linguistic-Conceptual

Exploratory noting and development of experiential statements

| **Experiential Statements** | **Original Transcript** | **Exploratory Notes** |
|---|---|---|
| Identity and personality marked by positive relationship values | Asanda: ok hi Sunita, once again I'm Asanda, I'm currently conducting research about experiences of women of the perinatal period pregnancy, birth, post birth during COVID-19, whatever is said here stays between us, I'm mainly here to explore your experience about being pregnant and being a mom during COVID-19. Maybe we could start with you telling me a bit about yourself<br>Sunita: ok so uhm like I said, I'm a loving person, I love kids as you can see I am working with children here as well. And I'm a first time mom, single parent and *ja* that's it<br>Asanda: and can you tell me a little bit more about your pregnancy, how was it like for you being pregnant during COVID-19? | 'ok' and 'uhm'-hesitant or unsure what to say or where to begin?<br>loving person-values warmth, affection, and emotional connection in relationships.<br>a nurturing, caring personality and is drawn to roles that involve helping and supporting others, particularly young people.<br>"first time mom" and a "single parent,"-she is navigating |

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| Navigating the ups and the downs of pregnancy and employment that were as a result of COVID-19<br><br>Moving in with partners family and challenging financial times as a result of COVID-19, p2 | Sunita: alright, my experience of being pregnant during COVID-19, I won't say, ok it had its bad times and its good times like uhm, bad part is when I lost my job because of my pregnancy. At that time, I was staying in(City), I was renting a flat in (City) with my partner at the time and then I fell pregnant and then they found out at work and then they had to let me go, apparently, I don't know, I think they weren't registered yet so they didn't want to pay maternity leave, so they had to let me go because of that. So then obviously that's unfair dismissal, I had to take them to CCM<br>And of which I won the case. So *ja* I lost my job, I had to move in with family, not my family but my | significant life changes and challenges related to parenthood and raising a child on her own-resilience, adaptability, and a willingness to take on new responsibilities and roles?<br>Ja-culture and identity-Afrikaans; coloured<br>mix of good and bad times. On the one hand, they were excited to be starting a family, but on the other hand, they faced challenges related to their pregnancy and employment.<br>Uhm: False start, finds it difficult to express her mixed experience. Why?<br>Associates her loss of her work to the pregnancy-as a result had to take employer to CCMA<br>then they found out at work and then they had to let me go: Did she not inform them?<br>speculates that the reason for their dismissal may have been that their employer was not yet registered and did not want to pay for maternity leave (uncertainty).<br>Despite winning the case, still lost her job-why |

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| Moving and travelling during pregnancy in a bus during COVID-19<br><br>Navigating a new place and health care facilities | partner's family in (City). But even there like, they needed something like, we needed to contribute monthly and he wasn't doing well at the same time, he wasn't doing well in his industry.<br>So it was a tough time, we were having a tough time financially and I was so stressed, I was so stressed because I had a baby coming and I didn't have a job and my partner isn't doing well financially and all of that, I didn't know how I was going to take care of my baby, I didn't know but *ja*.<br>So we were staying with his family, actually it was his brother, we were staying with him for about 6 to 5 months.<br><br>I'm not sure and then they eventually got tired of us and we had to move to (City), while I'm | Blames COVID-19 for becoming a single parent<br>'Even there'- suggests that this is just one of the many situations they were facing. suggests that this financial strain added to the difficulties of being pregnant during COVID-19 and losing her job.<br>Unclear which industry/profession she is referring to<br>Describe feeling stressed due to financial challenges and impending parenthood. Expresses uncertainty about how they will provide for their child, given their current financial situation.<br>colloquial phrase "but ja" at the end of the sentence, which suggests a sense of resignation or acceptance of their circumstances. This could imply that she has come to terms with their situation and is trying to find a way forward, even in the face of adversity.<br>It is unclear why the family got tired of her and her partner, but the statement suggests that this may have been due to their financial situation or there may have been |

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| Unpleasant trip to Grahamstown during a crucial time of the pregnancy | still pregnant. I think I was 5 months pregnant when I got into a bus and went to (City). | some tension or issues between them. moved to (City) while pregnant, (5 months pregnant)- This indicates that the move may have been challenging and potentially stressful, given the physical demands of pregnancy and the need to adapt to a new environment.<br>Mode of transport-uncomfortable?<br>Describes the difficulties of accessing health care services in CPT. She found the process overwhelming, especially since they were already dealing with the stress of being unemployed.<br>Open a new file every time-no centralized system for managing patient records.<br>find medication and stuff-suggests that accessing medication was not always straightforward-additional stress. |

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| | Ok even there in (City) things, ok even then when I was in between those two places I had to go to different clinics. So every time I had to go and get my medication I had to go to a different clinic and I had to open a new file, wherever I go<br>I had to open a new file, a new clinic file and that was too much for me, I couldn't take it. Dealing with the stress of not having a job and also having to go to places, different places to find medication and stuff so *ja*.<br>Even in (City) I didn't stay for long, I was actually 8 months pregnant when I got on another bus and went to Grahamstown, *ja* it's not nice and while I was sitting on the bus I was stressed I was crying because I was about to give birth, you know anything could happen at 8 months. What if I gave birth in the bus, just imagine. So *ja* my trip to Grahamstown wasn't nice, I was thinking of all of that stuff, what if I give birth right her blah blah. And inside the bus they didn't have air | 'even'-suggests that she experienced a similar experience to JHB in CPT-didn't stay for long. Why did she had to leave?<br>Thoughts: Suggests that she was preoccupied with thoughts of what could happen if she gave birth on the bus. Uncertainty and vulnerability: suggest that she was uncertain about what might happen during the trip, given that she was 8 months pregnant.<br>use of phrases like "not nice" and "blah blah" indicates a sense of frustration and possibly helplessness-unpleasant/difficult journey,<br>Difficulties of travelling in a bus while pregnant during the pandemic- social distancing guidelines may not have been followed on the bus, which would have added to her concerns about contracting the virus.<br>so so hot-emphasise the extent of the heat experienced<br>we were packed full-suggesting there was no vacant seat available |

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| | conditioner and it was so so hot, I couldn't take the heat, I had to ask the bus driver if I could sit in front, and my feet were swollen because of sitting for hours *ja* and the bus was so full even though it was COVID-19, we were packed full. | |

## APPENDIX F: EXPERIENTIAL STATEMENTS

### Experiential Statements

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| Identity and personality marked by positive relationship values, p1 |
| Navigating the ups and the downs of pregnancy and employment that were as a result of COVID-19, p1 |
| Moving in with partners family and challenging financial times as a result of COVID-19, p2 |
| Moving and travelling during pregnancy in a bus during COVID-19, p2 |
| Navigating a new place and health care facilities, p3 |
| Arriving home and going through health care administration challenges again, p4 |
| Dealing with scrutiny and judgement about the pregnancy, p4 |
| Becoming a single parent as a result of COVID-19, p4 |
| The relationship not being able to withstand distance, p5 |
| The green book that caused confusion and being different, p5 |
| Home threatened by COVID-19 due to family members dismissing the regulations, p6 |
| COVID-19 failed, she won despite foreseeing similar past experiences occurring to her child, p6 |
| Strong emotions towards COVID-19 for ensnaring her dream of a family, p7 |
| Reliving City Clinic experiences in Grahamstown, p7 |
| The ups and downs of navigating the public health system, p7 |
| The pregnancy experience that is different from the norm, p8 |
| A shift from independency to allowing room for assistance, p9 |
| Pregnancy, the turning point to becoming closer to the family than before, p9 |
| The uncomfortable and faulty bus, p10 |

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| A fear of being rejected by family that did not come to fruition, p10 |
| Challenges of travelling in a bus during pregnancy, 10 |
| Grahamstown starting to feel like home again, 11 |
| No complications prior the intrapartum phase, p11 |
| A sudden and unforeseen change to the birth plan, p11 |
| Being in labour and having a Caesarean on Friday the 13th, p12 |
| Expectation vs reality-a lack of physical and emotional support during a time of need, p12 |
| A tough time of being powerless and dependent, p13 |
| Surprised by a portion of support, p13 |
| Desolate childbirth, a fear becoming a reality, p14 |
| Inability to access essentials from home as a result COVID-19 regulations in health care facilities, p14 |
| Experiencing mixed emotions, moments of joy in the midst of loneliness and depression, p15 |
| First impressions of the baby and having to choose between the self and baby, 15 |
| Having a voice and navigating the dynamics of appreciating assistance and maintaining her preferences, p15 |
| Breakdown of communication as a result task-orientation care, p16 |
| A single parent as a result of the COVID-19 pandemic, p16 |
| Postpartum distress and the anxiety of being incapable to care and protect the new born, p17 |
| Compliance to COVID-19 regulations during labour, p17 |
| The trauma of recovering from a caesarean as opposed to natural birth, p17 |
| Adjusting to the bodily changes during postpartum, p18 |

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| Shortened and abrupt postpartum recovery and limited social access due to the pandemic, p18 |
| The emotional impact of altered postpartum plans as a result of COVID-19, p19 |
| Reflections of the pregnancy, acknowledges achievements and shortfalls, p19 |
| Considering suicide and facing multiple postpartum stressors, p20 |
| An emotional dip and experiencing regret, p20 |
| A dream and desire for stability and experiencing disappointment, p20 |
| Walking towards healing from a caesarean, p21 |
| Too young to have undergone her past experiences during pregnancy, p21 |
| Longing to be home, a more understanding and empathic environment as opposed to the hospital, p21 |
| Realising that being a first time mother comes with limited experience and knowledge regarding pregnancy, p22 |
| Mixed resignation, assuming a secondary position to the baby's needs, p22 |
| Comparing how life turned out in Grahamstown opposed to a life in the City, p23 |
| Valuing privacy and personal space, p24 |
| Trusting a stranger over family members, 24 |
| Hesitation to open up to family members in order to maintain her self-image and due to the fear of being judged, p25 |
| Attempting to open up to a family member and being disappointed, p25 |
| Depression as a result of unemployment and lack of financial support, p26 |
| Reflecting on the past causes anger, healing and grateful for the positive outcomes, p26 |
| A quick and efficient postnatal care visit, p27 |
| Longing for the father of her child to have been present and supportive, p28 |

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| Living a comfortable life prior the COVID-19 pandemic, p30 |
| A prolonged national state of disaster response to the pandemic, p31 |
| A longer than expected break, p31 |
| Being indoors and restricted movement as a result of the pandemic, p32 |
| A new reality of being inactive and unproductive, p32 |
| Grief and loss, and behavioural change in response, p33 |
| Grief and loss, and behavioural change in response, p33 |
| The difficulties of being alone in a city far from home, during a pandemic, p33 |
| Sinking into a black hole in the absence of loved ones, p33 |
| Anxiety and distress of hopping from one hot spot to another, p34 |
| Contemplating worst case scenarios of being pregnant during the COVID-19, p35 |
| Learning of the unplanned pregnancy, p35 |
| The pregnancy became a silver lining of the family from the pandemic, 36 |
| The pregnancy became something to take the family's minds off the pandemic, 36 |
| Navigating public health care facilities during the pandemic, p36 |
| The relationship not being able to withstand distance, p38 |
| Fear and anxiety of being exposed to the COVID-19 during perinatal care visits, p40 |
| Navigating spaces where people do not follow COVID-19 regulations, p41 |
| Conflicting information and uncertainty surrounding the virus causing anxiety and confusion, p42 |
| COVID-19 vaccine bringing about hope and relief, p45 |
| Lack of concern and urgency towards being vaccinated during pregnancy due to the anticipated impact of the vaccine on the baby, p46 |
| Vaccination not considered as part of ensuring her babies safety, p47 |

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| Finding reasons not to be vaccinated, 47 |
| Being in labour and not being aware, p48 |
| Lack of communication regarding her pregnancy complications, p49 |
| Having a C-section and taking care of it during the pandemic, p50 |
| Traveling to the hospital alone as due to COVID-19 restrictions, p50 |
| No compliance to the COVID-19 regulation of wearing masks in the maternity ward, p51 |
| Lack of COVID-19 restrictions compliance at home, p52 |
| Conflicted with having confronting family members and pleasing them, p52 |
| Standing up to friends and neighbours to protect herself and baby from COVID-19, p53 |
| Returning from the hospital to home where there is less adherence to COVID-19 regulations, p53 |
| Making tough decision, choosing between isolation or receiving assistance, p53 |
| Suspecting stress to be a possible cause to having pregnancy complications and a C-section, p54 |
| The frustrations of losing her job while being pregnant and unable to seek further employment due to being heavily pregnant, p55 |
| Choosing to be home to avoid contracting the virus and experiencing complications, p55 |
| Loss of employment as a result of the financial impact of COVID-19 on employees, p56 |
| Learning to be comfortable to reflect on a period of being unemployed, 57 |
| Decrease in revenue as an explanation of not being granted a paid maternity leave, 57 |
| Navigating the physical demands of work and pregnancy, 57 |
| COVID-19 risks at work, p58 |
| Having no alternative but to perform work duties, p58 |

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| Identity marked by the ability to persevere through difficult situations and emotional resilience, p59 |
| Possible dismissal as a result of attempting following COVID-19 guidelines at work, p59 |

## APPENDIX G: SEARCHING FOR CONNECTIONS ACROSS EXPERIENTIAL STATEMENTS

**Searching for connections across experiential statements-grouping of experiential statements according to connections**

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| Identity and personality marked by positive relationship values, p1<br>Valuing privacy and personal space, p24<br>Identity marked by the ability to persevere through difficult situations and emotional resilience, p59 | Navigating the ups and the downs of pregnancy and employment that were as a result of COVID-19, p1<br>Decrease in revenue as an explanation of not being granted a paid maternity leave, 57<br>Navigating the physical demands of work and pregnancy, 57<br><br>The frustrations of losing her job while being pregnant and unable to seek further employment due to being heavily pregnant, p55<br>Loss of employment as a result of the financial impact of COVID-19 on employees, p56<br>Learning to be comfortable to reflect on a period of being unemployed, 57<br>COVID-19 risks at work, p58<br>Having no alternative but to perform work duties, p58 |

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| | Depression as a result of unemployment and lack of financial support, p26 |
| Moving in with partners family and challenging financial times as a result of COVID-19, p2<br>A shift from independency to allowing room for assistance, p9<br>A tough time of being powerless and helpless, p13<br>Surprised by a portion of support, p13<br>Making tough decision, choosing between isolation or receiving assistance, p53<br>Having a voice and navigating the dynamics of appreciating assistance and maintaining her preferences, p15<br>Postpartum distress and the anxiety of being incapable to care and protect the new born, p17 | Moving and travelling during pregnancy in a bus during COVID-19, p2<br>The uncomfortable and faulty bus, p10<br>Challenges of travelling in a bus during pregnancy, 10<br>Anxiety and distress of hopping from one hot spot to another, p34 |
| Navigating a new place and health care facilities, p3<br>Arriving home and going through health care administration challenges again, p4<br>The green book that caused confusion and being different, p5 | Becoming a single parent as a result of COVID-19, p4<br>The relationship not being able to withstand distance, p5<br>Strong emotions towards COVID-19 for ensnaring her dream of a family, p7 |

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| Reliving City Clinic experiences in Grahamstown, p7<br>The ups and downs of navigating the public health system, p7<br>Breakdown of communication as a result task-orientation care, p16<br><br>A quick and efficient postnatal care visit, p27<br>Navigating public health care facilities during the pandemic, p36<br>No compliance to the COVID-19 regulation of wearing masks in the maternity ward, p51<br>Inability to access essentials from home as a result COVID-19 regulations in health care facilities, p14<br>Traveling to the hospital alone as due to COVID-19 restrictions, p50<br>Compliance to COVID-19 regulations during labour, p17 | Expectation vs reality-a lack of physical and emotional support during a time of need, p12<br>Desolate childbirth, a fear becoming a reality, p14<br>A single parent as a result of the COVID-19 pandemic, p16<br>A dream and desire for stability and experiencing disappointment, p20<br>Longing for the father of her child to have been present and supportive, p28<br>The relationship not being able to withstand distance, p38 |
| Dealing with scrutiny and judgement about the pregnancy, p4<br>Trusting a stranger over family members, 24<br>Hesitation to open up to family members in order to maintain her self-image and due to the fear of being judged, p25 | Home threatened by COVID-19 due to family members dismissing the regulations, p6<br>Grahamstown starting to feel like home again, 11 |

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| Attempting to open up to a family member and being disappointed, p25 | Lack of COVID-19 restrictions compliance at home, p52<br>Conflicted with having confronting family members and pleasing them, p52<br>Standing up to friends and neighbours to protect herself and baby from COVID-19, p53<br>Returning from the hospital to home where there is less adherence to COVID-19 regulations, p53<br>Choosing to be home to avoid contracting the virus and experiencing complications, p55<br>Grief and loss, and behavioural change in response, p33 |
| COVID-19 failed, she won despite foreseeing similar past experiences occurring to her child, p6<br>Experiencing mixed emotions, moments of joy in the midst of loneliness and depression, p15 | The pregnancy experience that is different from the norm, p8<br>Too young to have undergone her past experiences during pregnancy, p21 |
| Pregnancy, the turning point to becoming closer to the family than before, p9<br>A fear of being rejected by family that did not come to fruition, p10 | No complications prior the intrapartum phase, p11<br>A sudden and unforeseen change to the birth plan, p11 |

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| Longing to be home, a more understanding and empathic environment as opposed to the hospital, p21<br>The pregnancy became a silver lining of the family from the pandemic, 36<br>The pregnancy became something to take the family's minds off the pandemic, 36 | Suspecting stress to be a possible cause to having pregnancy complications and a C-section, p54<br>Being in labour and having a Caesarean on Friday the 13th, p12<br>First impressions of the baby and having to choose between the self and baby, 15<br>The trauma of recovering from a caesarean as opposed to natural birth, p17<br>Mixed resignation, assuming a secondary position to the baby's needs, p22<br>Lack of communication regarding her pregnancy complications, p49 |
| Realising that being a first time mother comes with limited experience and knowledge regarding pregnancy, p22 | Adjusting to the bodily changes during postpartum, p18<br>Shortened and abrupt postpartum recovery and limited social access due to the pandemic, p18<br>The emotional impact of altered postpartum plans as a result of COVID-19, p19<br>Considering suicide and facing multiple postpartum stressors, p20<br>An emotional dip and experiencing regret, p20 |

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| | Walking towards healing from a caesarean, p21<br>Sinking into a black hole in the absence of loved ones, p33<br>Having a C-section and taking care of it during the pandemic, p50 |
| Living a comfortable life prior the COVID-19 pandemic, p30<br>COVID-19 ruining a comfortable life, p39 | Reflecting on the past causes anger, healing and grateful for the positive outcomes, p26<br>Reflections of the pregnancy, acknowledges achievements and shortfalls, p19<br>Comparing how life turned out in Grahamstown opposed to a life in the City, p23 |
| A prolonged national state of disaster response to the pandemic, p31<br>A longer than expected break, p31 | The difficulties of being alone in a city far from home, during a pandemic, p33 |
| A prolonged national state of disaster response to the pandemic, p31<br>A longer than expected break, p31<br>Being indoors and restricted movement as a result of the pandemic, p32<br>A new reality of being inactive and unproductive, p32 | |

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| Contemplating worst case scenarios of being pregnant during the COVID-19, p35<br>Learning of the unplanned pregnancy, p35<br>Fear and anxiety of being exposed to the COVID-19 during perinatal care visits, p40<br>Navigating spaces where people do not follow COVID-19 regulations, p41 | Conflicting information and uncertainty surrounding the virus causing anxiety and confusion, p42 |
| COVID-19 vaccine bringing about hope and relief, p45<br>Lack of concern and urgency towards being vaccinated during pregnancy due to the anticipated impact of the vaccine on the baby, p46<br>Vaccination not considered as part of ensuring her babies safety, p47<br>Finding reasons not to be vaccinated, 47 | Being in labour and not being aware, p48 |

**APPENDIX H: NAMING PERSONAL EXPERIENTIAL THEMES-**

**FORMATION OF THEMES**

| **THE IMPACT OF THE PANDEMIC ON HER ROMANTIC RELATIONSHIP** |
|---|
| **Separated from her partner as result of COVID-19**<br>*The relationship not being able to withstand distance, p5*<br>'we couldn't take the distance...'<br>'I would still be with my partner, living together, having our baby, being a loving family together and me and him we were like the type…' |
| **Being a lone parent because of the pandemic**<br>*Longing for the father of her child to have been present and supportive, p28*<br>And also another thing, I would say COVID-19 made me a single parent, I actually blame COVID-19. |

| **THE REUINION OF THE FAMILY** |
|---|
| **A desire to be home** |
| *Pregnancy, the turning point to becoming closer to the family than before, p9*<br>if it wasn't for my pregnancy I wouldn't be as close with my family as I am now<br>I'm more close than I used to be before, I am more close with them so that's one good thing |
| **An unanticipated closeness of the family**<br>*The pregnancy became something to take the family's minds off the pandemic, 36*<br>so they just focused on my pregnancy; being excited blah blah blah.<br>So *ja* I would say my pregnancy like, took away my mind from Covid |

| **PREGNANCY AND EMPLOYMENT DURING COVID-19** |
|---|
| **Unfairly treatment due to pregnancy**<br>*Decrease in revenue as an explanation of not being granted a paid maternity leave, 57*<br>"it wasn't fair because also when we reopened, there were less children coming, so obviously they were making less money so *ja* I think they couldn't afford paying me for my maternity leave"<br>*Having no alternative but to perform work duties, p59*<br>"at the end of the day I have to be strong because this is my job" |
| **Loss of employment**<br>*Navigating the ups and the downs of pregnancy and employment that were as a result of COVID-19, p1*<br>"I lost my job because of my pregnancy."<br>*Loss of employment as a result of the financial impact of COVID-19 on employees, p56*<br>"…maybe they couldn't afford paying someone on maternity leave and getting someone to stand for me at the same time …"<br>*The frustrations of losing her job while being pregnant and unable to seek further employment due to being heavily pregnant, p55*<br>"now I've lost my job and I can't go and look for another job because I mean I'm pregnant" |

| **EXPOSED TO COVID-19 AND STANDING GROUND AND TAKING ACTION** |
|---|
| **Confronted neglect of COVID-19 regulation compliance-standing up**<br>*Home threatened by COVID-19 due to family members dismissing the regulations, p6* |

| |
|---|
| '…I was so stressed, what if my baby is born and then she gets Covid. Ja even at home they didn't obey the rules of COVID-19…' |
| *Conflicted with having confronting family members and pleasing them, p52* |
| '…I didn't wanna hurt her feelings by saying do not touch my baby or stay away from us…' |
| But I had to tell a lot of people to go away, they cannot see my baby |
| *Returning from the hospital to home where there is less adherence to COVID-19 regulations, p53* |
| *Standing up to friends and neighbours to protect herself and baby from COVID-19, p53* |
| But I had to tell a lot of people to go away, they cannot see my baby |
| **Behavioural response** |
| *Choosing to be home to avoid contracting the virus and experiencing complications* |
| 'I actually wanted to be at home all the time because I knew that there's Covid out there' |
| *Possible dismissal as a result of attempting following COVID-19 guidelines at work, p59* |
| 'And I also think that they didn't like what I was telling them because I just kept on picking on them about these children's temperatures and stuff' |
| *Grief and loss, and behavioural change in response, p33* |
| "I had to take it seriously…" |
| " I couldn't even go to the funeral…" |

| **NEGOTIATING BEING INDEPENDENT AND RECEIVING ASSISTANCE** |
|---|
| **Learning to be taken care of** |
| *A tough time of being powerless and helpless, p13* |
| '…no it's just them doing their job and you're also there, letting them do their jobs…' |
| *A shift from independency to allowing room for assistance, p9* |

| |
|---|
| '…I didn't like to depend on people…'<br>'…they were so caring and they were showering me with lots of baby stuff…' |
| **Balancing appreciating those that offer help and having a voice**<br>*Having a voice and navigating the dynamics of appreciating assistance and maintaining her preferences, p15*<br>After breastfeeding, they said they are going to take the baby back and I was like, no no no my baby is gonna sleep with me<br>*Postpartum distress and the anxiety of being incapable to care and protect the new born, p17*<br>I don't want that, this is my baby leave my baby with me so I can have an eye on her 24/7 |

| |
|---|
| **UNFAIR TREATMENT AND DISMISAL DUE TO PREGNANCY** |
| **Changes in treatment as a result of pregnancy and COVID-19**<br>*Decrease in revenue as an explanation of not being granted a paid maternity leave, 57*<br>'it wasn't fair because also when we reopened, there were less children coming, so obviously they were making less money so *ja* I think they couldn't afford paying me for my maternity leave'<br>*The frustrations of losing her job while being pregnant and unable to seek further employment due to being heavily pregnant, p55*<br>*'ja* I mean now I've lost my job and I can't go and look for another job because I mean I'm pregnant' |

| |
|---|
| **PERINATAL HEALTH CARE VISITS DURING THE PANDEMIC** |

**Living with the frustrations of health care services during the pandemic**

*Inability to access essentials from home as a result COVID-19 regulations in health care facilities, p14*

"couldn't bring you food from home to eat and even when you needed something"

*Traveling to the hospital alone as due to COVID-19 restrictions, p50*

"they didn't allow people to go inside if you are not here to be treated or anything"

"So I had to go alone"

*Navigating a new place and health care facilities, p3*

"I had to open a new file, a new clinic file and that was too much for me, I couldn't take it"

*Arriving home and going through health care administration challenges again, p4*

"I then had to go to another clinic and open another file…"

"… so I don't know, I had about 4 files, 4 different clinics…"

*The green book that caused confusion and being different, p5*

"I got there at the hospital the nurses were so confused because they had never seen this green book"

*Breakdown of communication as a result task-orientation care, p16*

"they just wanna do their jobs and get done with it…"

**Positive experiences**

*A quick and efficient postnatal care visit, p27*

"actually I wouldn't say it was hectic"

"it was just in and out for me, it was just in and out it didn't take time"

**USING PUBLIC TRANSPORT DURING THE PANDEMIC**

| **Unpleasant bus travels** |
| --- |
| *Moving and travelling during pregnancy in a bus during COVID-19, p2* |
| I think I was 5 months pregnant when I got into a bus and went to (City). |
| *The uncomfortable and faulty bus, p10* |
| "…it was so packed, it was so packed, packed, packed…" |
| "…I think there was also something wrong with the bus…" |
| "…what if something happens and I'm pregnant…" |
| *Challenges of travelling in a bus during pregnancy, 10* |
| "You know when you're pregnant right, let's say when you are almost about to give birth, you go to the toilet a lot" |
| *Anxiety and distress of hopping from one hot spot to another, p34* |
| "And just knowing the fact that Eastern Cape is one of the hotspots and you are going there…" |
| "I'm going to a hotspot a place where gosh" |

| **POSTPARTUM DEPRESSIVE SYPTOMS** |
| --- |
| **An altered state of emotion and mind** |
| *The emotional impact of altered postpartum plans as a result of COVID-19, p19* |
| "I don't know what to say, but I was sad, I was very very sad, I was so so sad" |
| "I had to deal with a lot of things at the same time. And I couldn't put my focus in one place because there are a lot of things happening" |
| "I actually tried to commit suicide because of that thought…" |
| Adjusting to the bodily changes during postpartum |

"*Ja* that was the only thing I was thinking at the moment, I wasn't comfortable with my body; the way it looked"

**NEGOTIATING WITH TRUST AND JUDGEMENT**

**The different responses from friends and family**

*"Dealing with scrutiny and judgement about the pregnancy, p4*

"uhm you know people had a lot of questions…"

"why did you come home while you're pregnant..."

"you're 8 months pregnant, where did you get the guts to get on the bus"

"and judge me"

*Trusting a stranger over family members, 24*

"you know like talking to you won't be the same as talking to a family member"

"family member obviously knows me so there's a 100% chance that she's going to take the information that I tell her and give it to someone else"

*Hesitation to open up to family members in order to maintain her self-image and due to the fear of being judged, p25*

"I don't want them to look at me different"

"but I want them to know me as this person that this is how we know her, the strong independent woman"

*"ja* cause even now at home they still don't know half, like a lot of things I went through during my pregnancy"

*Attempting to open up to a family member and being disappointed, p25*

"I tried to open up with my cousin,,, the response she gave me wasn't what I expected…"

| **MIXED FEELINGS ABOUT THE VACCINE** |
| --- |
| **Hopeful brought about by the pandemic**<br>*COVID-19 vaccine bringing about hope and relief, p45*<br>"I felt more relived because at least there is something, something to prevent…"<br>"there was something to, please help me…"<br>*Lack of concern and urgency towards being vaccinated during pregnancy due to the anticipated impact of the vaccine on the baby, p46*<br>"honestly I didn't mind not getting the vaccine because I'm pregnant" |
| **Resistance towards being vaccinated**<br>*Vaccination not considered as part of ensuring her babies safety, p47*<br>"well at that time I was almost about to give birth so, the vaccination was the last thing on my mind."<br>"The only thing I had on my mind was my baby's safety, the safety of my baby."<br>*Finding reasons not to be vaccinated, 47*<br>" no, I'm still a little bit scared of the vaccine…" |

| **A PERFECT LIFE RUINED BY THE PANDEMIC** |
| --- |
| **The initial idea of how life will turn out**<br>*Living a comfortable life prior the COVID-19 pandemic, p30*<br>"I had just got a new job, moved to (City), got an apartment everything was nice *ja* things were going well for me and I was enjoying it"<br>"But then when Covid happened, a lot of things changed…"<br>*COVID-19 ruining a comfortable life, p39* |

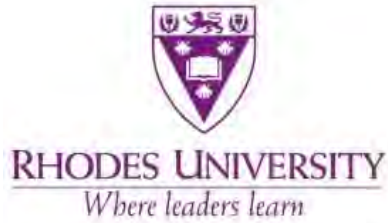
| |
|---|
| "we would still be in our own apartment in (City), we would still be in our apartment in (City), with our baby, because then we, I would have been able to help him financially" |

| **THE IMPACT OF THE PANDEMIC ON THE PREGNANCY** |
|---|
| **The stress caused by the pandemic causing pregnancy complications** |
| *Suspecting stress to be a possible cause to having pregnancy complications and a C-section, p54* |
| "I mean I had a lot of stuff going on during my pregnancy" |
| "*ja* so I think all the stress, COVID-19 stress had an impact in my, of getting a c-section" |
| *No complications prior the intrapartum phase, p11* |
| "I didn't have any complications until the day I was supposed to give birth " |
| *A sudden and unforeseen change to the birth plan, p11* |
| "I was supposed to give normal birth" |

| **LOOKING BACK AND RECOVERING FROM THE PANDEMIC** |
|---|
| **Comparing then and now** |
| *Reflecting on the past causes anger, healing and grateful for the positive outcomes, p26* |
| "well, like I said earlier, when I think back about everything that happened, I really still feel angry but then I feel more positive than I was before" |
| *Reflections of the pregnancy, acknowledges achievements and shortfalls, p19* |
| "so *ja* but I'm actually in a better place now than I was that time" |
| *Comparing how life turned out in Grahamstown opposed to a life in (City), p23* |

| |
|---|
| “ think that things are turned out, ok what can I say, I’m actually glad things turned out the way they did…” |
| “…being in Grahamstown was actually the better decision because my baby now can grow up around family…” |

# APPENDIX I: HUMAN RESEARCH ETHICS COMMITTEE APPROVAL LETTER




**Rhodes University Human Research Ethics Committee**
PO Box 94, Makhanda, 6140, South Africa
t: +27 (0) 46 603 7727
f: +27 (0) 46 603 8822
e: ethics-committee@ru.ac.za

**https://www.ru.ac.za/researchgateway/ethics/**

10 October 2023

Miss Asanda Hadebe

Email: g21h5778@campus.ru.ac.za

Review Reference: 2023-5133-8106

Dear Miss Asanda Hadebe

**Re: Human ethics renewal application:** THE EXPERIENCES OF WOMEN'S PERINATAL PERIOD DURING THE COVID-19 PANDEMIC IN MAKHANDA.

Researcher: Miss Asanda Hadebe

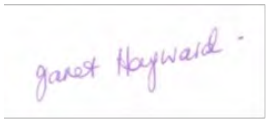
Supervisors: Professor Lisa Saville Young

This letter confirms that the above Annual Report has been reviewed and **APPROVED** by the Rhodes University Human Research Ethics Committee (RUHREC). Your Approval number is: 2023-5133-8106

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period.

Please ensure that the Human Research Ethics Committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the

completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the Human Research Ethics Committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated. Sincerely,



**Dr Janet Hayward**

**Chair: Rhodes University Human Research Ethics Committee, RU-HREC**

cc: Ethics Coordinator

## APPENDIX J: PARTICIPANT INFORMED CONSENT


### INFORMED CONSENT DECLERATION

### THE EXPERIENCES OF WOMEN'S PERINATAL PERIOD DURING THE COVID-19 PANDEMIC IN MAKHANDA.

Asanda Hadebe, from the department of Psychology at Rhodes University has requested my permission to participate in the above-mentioned research project.

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a Clinical Psychology Master's degree at Rhodes University.
2. The purpose of the research project is to explore the experiences of non-first time women who were pregnant and/or women had a baby during the COVID-19 third wave in Makhanda.
3. The Rhodes University has given ethical clearance to this research project and I have seen/may request to see the clearance certificate by contacting Mr Siyanda Manqele (s.manqele@ru.ac.za)
4. My participation will involve a one-on-one interview with the researcher in which I will be asked to answer open ended questions in relation to my experiences on the above topic.

5. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life that I am not willing to disclose.
6. My participation is voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences-however I commit myself to full participation unless unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.
7. I understand that the risk of participating in the study include the possibility of being distressed as I explore my experiences and that the researcher will facilitate psychological assistance should the distress prolong.
8. I understand that the benefits participating in the study include my contribution to the body of literature regarding the topic and a reimbursement of R150 Checkers voucher in respect of my time and contribution to the research study.
9. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. The Rhodes Psychology Clinic (046 603 8502) or Fort England Hospital (046 602 2300) may be contacted for further support on telephone.
10. I agree/disagree to the Principal Investigator's use of voice recording of my comments and opinions during interviews.
11. I understand that the interviews will be transcribed by professionals who will ensure confidentiality of the interview and anonymity of my identity.
12. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

13. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader.
14. The researcher may be contacted on 0732347153 (cell number) or asandahadebe05@gmail.com (email) for any questions or enquiries.
15. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.

I_____, have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

Signed on (date): _____ Participant: _____

Rhodes University, Research Office, Ethics

Ethics Coordinator: ethics-commitee@ru.ac.za

t: +27 (0) 46 603 7727 f: +27 (0) 86 616 7707

Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139

# APPENDIX K: USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RESLEASE FORM

APPENDIX E: RECORDINGS-PERMISSION AND RELEASE FORM

**Rhodes University — Department of Psychology**

## USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

| | | | |
|---|---|---|---|
| Name of participant | | | |
| Participant's contacts details | Email address:<br>Phone number: | | |
| Name of researcher | Asanda Hadebe | | |
| Level of research | Honours | Masters ✕ | PhD |
| Brief title of project | The Experiences of Women's Antenatal Period During the Covid-19 Pandemic in Makhanda | | |
| Name of supervisor | PROF. LISA SAVILLE YOUNG | | |

**DECLARATION**

*(Please initial/tick blocks next to the relevant statements)*

| | | | |
|---|---|---|---|
| 1. | The nature of the research and the nature of my participation have been explained to me. | verbally | |
| | | in writing | |
| 2. | I agree to be interviewed and to allow recordings to be made of the interview. | audiotape | |
| | | videotape | |
| 3. | I agree to _____ and to allow recordings to be made. | audiotape | |
| | | videotape | |
| 4. | The tape recordings may be transcribed | without conditions | |
| | | only by the researcher | |
| | | by one or more nominated third parties | |
| 5. | I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written. | | |
| | OR<br>I give permission for the tape recordings to be retained after the study and for them to utilised for the following purposes and under the following conditions | | |

Signature of participant: _____ Date: _____

Witnessed by researcher: _____ Date: _____

# APPENDIX L: RESEARCH PUBLICATION AGREEMENT

Rhodes University – Department of Psychology

## RESEARCH PUBLICATION AGREEMENT

A signed copy of this agreement must be submitted with all research proposals submitted to the Research Projects & Ethics Review Committee (RPERC). This document must also be signed by: (i) students undertaking Honours level projects and (ii) students and others acting as research assistants for staff members.

| | |
|---|---|
| **Name of student** | |
| **Name of supervisor/project leader** | |
| **Provisional title of thesis/report** | |

A major task of a University is to provide the infrastructure necessary for the conduct of research and for the dissemination of findings through publication in academic journals or edited books. Those who enrol for a postgraduate degree (which includes any form of research) or act as research assistants become participants in this task. With regard to the former, this means that the University has the responsibility and right to take whatever steps may be appropriate to turn student's research work into one or more publications. In light of this, postgraduate students and those acting as research assistants in the Department of Psychology must sign the following agreement as a condition for undertaking supervised research or acting as research assistants.

1. I, _____ (name), undertake to plan and execute the research project referred to above under the supervision of the supervisor / project leader (named above) and to remain in regular consultation with the supervisor / project leader on all aspects of the research.

2. With regard to supervised research, I understand that I have the right to publish the research, that I must reach agreement with the supervisor regarding the nature of the publication and the publication medium (e.g., specific journal or book chapter), and that I should take active steps towards publishing it within six months of being informed by the University that the degree has been awarded.

3. With regard to supervised research, I understand that my supervisor has the right to prepare and submit the research for publication if either: i) I indicate that I do not wish to work on the publication of the research myself, or, ii) I do not provide

# APPENDIX M: TRANSLATION/TRANSCRIPTION CONFIDENTIALITY FORM

Translation/transcription Confidentiality Fom

RHODES UNIVERSITY

Grahamstou'M • 6 40 • South Africa

PSYCHOLOGY DEPARTMENT • Tel: (046) 603 8500/ 85001 • Fax: (046) 622 4032 e-mail: psychology@ru.ac.za

CONFIDENTIALITY AGREEMENT: Transcription/Trans1ation Services

I, Kayakazi Nfkosana , (name of transcriber) agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from Asanda Hadebe related to her research study on The experiences of women of the perinatal period during the Covid- 19 pandemic.

Furthermore, I agee:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Asanda Hadebe.

3. To store all study-related audio recordings and materials in a safe, secure location as long as they are in my possession;

4. To retum all audio recordings and study-related documents to Asanda Hadebe in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality ageement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio recordings and/or files to which I will have access.

Translation/transcription Confidentiality Fonn

Transcriber's name (printed) Mkosana Kayakazi

Transcriber's signature: 

Date 09/05/2022