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Maternity and perinatal care in the Covid-19 pandemic: experiences and perceptions in the post-pandemic narratives of women in transition to motherhood in Italy

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Abstract

This paper explores how the Covid-19 restrictive policies and organizational changes in maternal and perinatal (health) care services affected the perceptions and subjective experiences of women in transition to motherhood in Italy. It does so on the basis of 20 interviews with first-time mothers who gave birth in 2020-2021 in Northern Italy. Contrary to WHO recommendations promoting physiological childbirth and a humanized birth model, pandemic measures increased the medicalization of perinatal care and hindered fathers' involvement in childbirth and early childcare (Zanini and Quagliariello 2023). Most studies have been carried out during the emergency phase, rarely from a sociological perspective, and without distinguishing between first-time mothers and women with previous childbirth experience. Our paper analyses, through a sociological lens, women's narratives collected in the current post-pandemic phase, making it possible to retrospectively explore pregnancy, childbirth, and post-partum experiences during the pandemic, and the consequences that this latter had for the experience of transitioning to motherhood. The findings seem to confirm that the pandemic further rationalized and technicalized maternity care services, prioritizing safety and risk management over the need for care (Davis-Floyd and Gutschow 2021) and revealing significant gaps in support for mothers and their families during the period of crisis due to Covid-19.

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Introduction

The WHO (2016) has identified respectful maternity care as a key component of high-quality perinatal care, in which health care must be safe, effective, timely, efficient, equitable and person-centred (Lalor et al. 2023). Contrary to WHO recommendations that promote physiological childbirth and a humanized birth model, the Covid-19 pandemic measures negatively affected antenatal and postnatal care.

(Expectant) parents worldwide experienced changes in the way they gave birth as a result of the Covid-19 pandemic, including restrictions on access to maternity units and the presence of partners during the birth, and changes in birth plans (Jackson et al. 2022). According to a study by Drandić et al. (2022) on 13 European countries, most of them maintained antenatal and postnatal care but restricted psychosocial support, separated mothers and babies and (re-)established non-evidence-based practices in many settings, depriving women and families of many factors which evidence has shown to be essential for a positive birthing experience.

However, there has been limited investigation of maternal healthcare experiences during the Covid-19 pandemic and how restrictions and protocols reshaped women's experiences of pregnancy and birthing in Italy – our research context – especially in the first transition to motherhood. This transition represents a critical turning point in the life course (Elder 1995), marked by profound identity negotiations and the reconfiguration of family roles and responsibilities (Naldini 2016). Parenting is a continuous process that evolves over the life course, implying that parenting experiences, care responsibilities and family dynamics change over time and interact with personal and social trajectories (Elder 1995). It is during this phase that women face a profound change, acquire new status and are subjected to numerous social pressures and gendered expectations, which prescribe their role as primary caregivers and reinforce traditional notions of motherhood (ibidem). Most of the extant studies were carried out in the emergency phase, on the basis of quantitative data deriving from survey or clinical records. They were rarely conducted from a sociological perspective, collecting the direct voices of women for example by means of discursive in-depth interviews, and – apart from a few rare exceptions (Jullien and Jeffery 2022) – they did not distinguish in their samples between women becoming mothers for the first time and women with previous birthing and nurturing experience. Nor was their focus on

the life-course phase of transition to motherhood: that is, the process whereby a woman becomes a mother for the first time.

Our paper retrospectively explores, through a gender sociological lens and from a life-course perspective (Elder 1995), how the Covid-19 restriction policies and organizational changes in maternal and perinatal (health) care services affected the perceptions, subjective experiences and meanings of women in transition to motherhood in Italy. It does so on the basis of 20 interviews conducted in the current post-pandemic period with first-time mothers who gave birth in 2020-2021[1] in Northern Italy. The pregnancy, childbirth and postpartum phases were experienced in a condition of double uncertainty since they were embedded in a macro-critical historical event – the Covid-19 global pandemic – and in the interviewees' micro-biographical transition to motherhood, a life event that can itself be fraught with criticality and change in many respects (Grunow and Evertsson 2019). The paper seeks to understand how health protocols enacted to stem the spread of Covid-19 infection impacted on women's experiences of becoming mothers, their experiences of pregnancy, childbirth and breastfeeding, the interactions between experts/professionals and parents, medicalisation vs. de-medicalisation, the role of expert knowledge, interviewees' practices/strategies of 'resistance' to the challenges posed by the anti-Covid and social-distancing measures and restrictions, and how hegemonic intensive parenting cultures (Hays 1996) impacted reproductive experiences during Covid-19 in the transition to the parenthood life-course phase within the context of intensified anxiety and concerns linked to the pandemic.

Research and theoretical background: the worldwide impact of the Covid-19 pandemic on maternal and perinatal health and care

The impact of Covid-19 on the (physical and mental) health of pregnant and child-birthing women and on maternity care and experience has been the subject of a substantial body of international literature, especially in the clinical, psychological, and (to a lesser extent) (medical) anthropological fields (Arendt et al. 2022; Davis-Floyd and Gutschow 2021; Jackson et al. 2022; Zanini and Quagliarello 2023).

The pandemic revealed structural weaknesses in the formulation of public health policies and in the organisation of hospital services (Davis-Floyd and Gutschow 2021). In many places around the world, the pandemic induced drastic changes in the care of women and children, such as the

[1] From the first 'wave' of the pandemic and when the WHO declared pandemic status (March 2020) to the third 'wave' (rise in infections) of the pandemic. In Italy the state of emergency ended in March 2022.

separation of Covid-19 suspected/confirmed women from their babies and the avoidance of breastfeeding, which was contrary to both WHO standards and most Covid-19 guidelines, and even though intrauterine, vertical, and breastmilk transmission were unlikely (Kotlar et al. 2021).

Furthermore, the need to postpone many non-essential health services to prevent transmission within clinics led to significant reductions in the provision of antenatal and postnatal care (Davis-Floyd and Gutschow 2021). At the same time, there arose a number of critical issues relating to health inequalities and the ways in which maternity was accompanied and supported (Benaglia and Canzini 2021; Davis-Floyd and Gutschow 2021). During childbirth and the early stages of parenthood, separation and physical distancing represented two guiding principles of health protocols which ignored women's agency and subjectivity (Benaglia and Canzini 2021). The health crisis also led to an over-medicalisation of hospital care[2], and potentially harmful policies were implemented with little evidence (Kotlar et al. 2021), so that trust and compliance between pregnant women and the nursing and midwifery staff was compromised (Gentile et al. 2022; Davis-Floyd and Gutschow 2021).

Another important aspect is that the global health emergency of the Coronavirus greatly intensified the anxieties and worries of (future) parents in a cultural context characterised by intensified parenting (Hays 1996; Furedi 2002). Due to the Covid-19 pandemic, parents – and especially mothers – navigated a terrain characterised by uncertainty, anxiety, difficulties in managing the work-family balance at a time of school closures, home working, and social isolation (Bernhardt et al. 2023; Derndorfer et al. 2021; Rinaldo and Whalen 2023).

While most international research has focused on intensive parenting during the pandemic, less is known about how intensive parenting cultures impacted on reproductive experiences during Covid-19, especially in the transition to the parenthood life-course phase, and on perception of assistance in accessing perinatal services and maternity support.

Despite the importance of these studies, some issues have not yet been adequately addressed from a qualitative and sociological perspective, especially in the Italian context. In Italy, as in other European countries, the Covid-19 crisis was driven by the decision-making of policymakers rather than by scientific evidence and international guidelines (Drandić et al. 2022). Like many other countries, Italy was inadequately prepared for the impact of the SARS-CoV-2 pandemic on perinatal health services (Zanini and Quagliarello 2023; Gentile et al. 2022). Italy was the first European country to report cases of Covid-19 in March 2020, and in it the mortality rate was higher than in many other European countries (ibidem). However, the incidence of SARS-CoV-2-positive cases, the spread of the infection and the number of deaths from Covid-19

[2] For example, Cesano et al. (2021) reported that, in one of the six COVID-19 maternity hubs and the largest high-risk maternity unit in the metropolitan area of Milan (Lombardy), during the COVID-19 pandemic and 2020 lockdown the rate of labour inductions was higher than in the same period of 2019 [436 (34.6) vs 378 (31.1), p=0.008].

varied considerably across the country (Cena et al. 2021; Spina 2023). Nevertheless, even though hospitals had become primary sites for Covid-19 transmission (Zanini and Quagliarello 2023), the Ministry of Health maintained that hospitals were still the safest places for antenatal care and delivery (Ministero della Salute 2020).

Some recent studies on the Italian context have highlighted the feelings of fear, loneliness, and anxiety that pregnant women experienced during the Covid-19 pandemic (Nespoli et al. 2022; Zanini and Quagliarello 2023). These studies have also explored the traumatic childbirth experiences of women in Italy who tested positive for Covid-19 and demonstrated that the pandemic did not result in a transformation of medical health practices; rather, it led to an intensification of (over)medicalisation (Gentile et. al 2022) and a shortage of assistance and support for pregnant women.

The regulations enacted to curb the Covid-19 virus meant that women had to go through the entire pregnancy process alone, without the constant presence of a partner. Routine gynaecological visits took place unaccompanied, with the exception of a few cases, and a family member was not allowed to be present for some particularly important examinations (Benaglia and Canzini 2021). Moreover, despite the progressive attenuation of precautionary measures related to childbirth and perinatal care, these restrictions persisted throughout the 2021-2022 period; in some southern regions (Campania, for example), despite the fact that the pandemic emergency was over, at some public hospitals protocols to separate infants from Covid-positive mothers were still in place even in 2023, contrary to WHO guidelines.

Organization, objectives and outcomes of perinatal care in the Italian context: an overview

Given that our case study was conducted in Italy, this section provides contextual information and data on the Italian perinatal healthcare system and outcomes.

Over the past two decades, the organisational model of the perinatal care has undergone a change process aimed to organise care according to the level of obstetric risk, improve continuity of care in the various phases of the pregnancy/delivery/birth pathway by promoting closer integration between obstetric and neonatal care at all levels and between the various professions involved so as to guarantee the highest quality and safety standards, as well as a rational and efficient use of both human and material resources used.

Starting from the so called POMI 'Maternal-Infantile Objective Project' ('Progetto obiettivo materno infantile') adopted in 2000 by the Italian Ministry of Health[3], the obstetric and neonatological-paediatric care, and therefore healthcare facilities, were differentiated and classified into three levels (I, II, III) to allow physiological pregnancies to be treated in low-risk units (level one), while at the same time allowing pathological pregnancies to be treated in the most highly specialised facilities (level three)[4].

Ten years later, the 'Guidelines for the promotion and improvement of the quality, safety and appropriateness of care interventions in the birth process and for the reduction of Caesarean section' ('Linee di indirizzo per la promozione ed il miglioramento della qualità, della sicurezza e dell'appropriatezza degli interventi assistenziali nel percorso nascita e per la riduzione del Taglio Cesareo') elaborated by the Italian Ministry of Health and approved by the State-Regions Conference on 16 December 2010 (Agreement no. 137) have reduced the previous three levels to two levels of assistance. First level: care of pregnant women and babies in the physiological/low obstetrical risk or small/medium pathology; second level: in addition to the care of pregnant women and newborns in the physiological/low obstetrical risk or of small/medium pathology, it assists women and newborns in cases of severe maternal/foetal/high obstetrical and neonatal risk (Zanini 2021). Integration is promoted through the application of the Hub & Spoke model (ibidem).

The 2010 Ministerial Plan was an important step in the organization and regulation of perinatal care in Italy because made explicit a number of inalienable principles, starting from the obvious, but not taken for granted, consideration that pregnancy and childbirth, while representing a significant field of public health intervention, are not precisely – except in certain cases – a pathology to be treated, but rather a pathway to be accompanied, guaranteeing clinical safety and the humanisation of the care approach (Save the Children 2023). However, its implementation has been very discontinuous and controversial, characterised by a profound inhomogeneity among the various Regions of the country[5] and penalised by widespread financial distress in regional healthcare funding. Moreover, the stated objective of the 2010 Ministerial plan to close the small birth units[6] (below 1000 births) because being considered inadequate has

[3] Ministerial Decree (Decreto Ministeriale) 24 April 2000 (G.U. 7.6.2000 n.131).

[4] First-level functional obstetrics and neonatology-pediatrics units (I) were meant, in the absence of established pathologies, to control the pregnancy and to assist the pregnant woman in delivery and normal neonates at gestational age >34 weeks; the second-level functional obstetrics and neonatology-pediatrics units (II) were meant to assist at-risk pregnancies and deliveries, at gestational age ≥32 weeks, in situations that do not presumptively require a high level of technology and care typical of level III, for the mother, the foetus and neonate; finally, third-level functional obstetrics and neonatology-pediatrics units (III) were conceived to assist high-risk pregnancies and deliveries and physiological and pathological infants including those in need of intensive care.

[5] In some cases, even within the same region, different ASLs (local health agencies) have adopted different organisational models and not always fully adhered to the ten lines of action described in the Agreement of 2010 (Zanini 2021).

[6] As a result of the 2010 plan, 107 birthpoints were closed between 2013-2020, of which 36 with a volume of births <500 per year.

caused controversy and discontent among local governments and users. If the monitoring parameters on maternal and neonatal mortality are among the most satisfactory in Europe, the same cannot be said for the so-called humanisation of the birth pathway. The focus on couples, women and babies seems to be on achieving a successful perinatal outcome, with the fewest possible side effects and discomforts in the shortest possible time (ibidem).

Later (on 31 October 2017), the National Birth Pathway Committee (established in 2011[7] by the Italian Ministry of Health) elaborated a document aimed to promote humanization and physiology – the 'Guidelines for the definition and organisation of self-care by midwives in low-risk pregnancies[8]' ('Linee di indirizzo per la definizione e l'organizzazione dell'assistenza in autonomia da parte delle ostetriche alle gravidanze a basso rischio ostetrico (BRO)' – on the basis of previous Italian legislation (particularly, the 2010 State-Regions Agreement) and indications from the international literature showing that low-risk pregnancies and births managed by midwives are associated with maternal and neonatal health outcomes no different from those of traditional units (Zanini 2021). Despite this, there was no parallel effort to reconsider the positions and operating methods of the professional figures involved in the innovation process, which remained substantially unchanged in terms of responsibilities and competencies. In fact, even in the planned low-risk units, despite the calls of international bodies and their transposition at national level, there was no greater concentration of midwives who are specialised in physiology, nor of gynecologists in facilities dedicated to the care of pathological pregnancies, which would have allowed a greater intensity of care for high-risk pregnancies.

In the pre-pandemic 'local' model of birth care of the two regions where we conducted our interviews, the experience of motherhood is usually managed within a medical framework, albeit within a general trend towards promoting the physiology of birth. In particular, in Piedmont, the Birth Pathway has been revised and reorganised in 2008 by the DGR[9] no. 34-8769 (12/05/2008) 'Piano socio-sanitario regionale' 2007-2010. Area materno-infantile: definizione obiettivi ed indicatori del 'Percorso Nascita'. The following year (2009), the so-called 'Agenda di Gravidanza' ('Pregnancy Diary'), approved by DGR no. 38-11960 on 4 August 2009 and revised in 2013[10], started the implementation of the actions included in the State-Regions Agreement of 16 December 2010. On 28 June 2018 (Resolution No. 268), the Lombardy Region, based on all the scientific evidence, the WHO recommendations and the guidelines of the Ministry of Health and the Italian National Institute of Health[11], defined the 'Regional network for maternal-neonatal care, addresses of appropriateness of the physiological birth pathway with obstetrical

[7] Health Ministerial Decree (Decreto Ministero della Salute) 12 April 2011.
[8] 'Linee di indirizzo per la definizione e l'organizzazione dell'assistenza in autonomia da parte delle ostetriche alle gravidanze a basso rischio ostetrico (BRO)' 31/10/2017 Italian Ministry of Health.
[9] Regional Council Resolution.
[10] DGR 29 January 2013, no. 35-5283.
[11] ISS - Istituto Superiore di Sanità.

management' ('Rete regionale per l'assistenza materno-neonatale, indirizzi di appropriatezza del percorso nascita fisiologico a gestione ostetrica'). The organisational model provides pregnant women with a reference midwife, in a network with the obstetrics and gynaecology specialists and the other professionals involved in the Birth Pathway, such as the general practitioners, the freely chosen paediatrician and other professionals where necessary. The priority objective of these guidelines is to maintain, or activate where not present, the organisational-assistance model of the 'physiological or low-risk birth pathway managed by midwives'. This means that in the case of a pregnancy classified as physiological, it is the midwife who is responsible for the clinical care of the pregnant woman. If indications emerge that the pregnancy is not progressing normally, the midwife promptly schedules a check-up with the obstetrician-gynaecological specialist, in accordance with the booking and/or referral procedures formalised by the hospital.

Overall considered, in Italy, care during pregnancy and childbirth is generally good: the risk of stillbirth has almost halved since the early 1980s, the percentage of women assisted during pregnancy has exceeded 90 per cent, all deliveries are attended by healthcare professionals and the percentage of pre-term births and that of underweight births have decreased significantly. However, the Italian reality is still characterised by an excessive medicalisation of the birth event – of which the inappropriate use of caesarean sections is a manifestation – and by the extreme fragmentation of birth centres (Boldrini et al. 2023). Another issue is obstetric violence. Despite academic studies, such as those coordinated by Patrizia Quattrocchi (2024) funded by the European Union[12], having highlighted the lack of quantitative and qualitative data on obstetric violence in Europe - with Italy standing out due to the lack of official surveys conducted by state institutes and agencies - it is plausible that many women experience disrespectful, abusive or neglectful treatment during childbirth in healthcare facilities. This violates not only their rights to respectful care, but also threatens their rights to health, bodily integrity, and freedom from discrimination. According to a survey with 424 respondents, 21.2% of women in Italy considered themselves victims of obstetric violence (Ravaldi's et al. 2018). A web-based cross-sectional study (Scandurra et al. 2021) conducted with 282 Italian women revealed that three quarters of the sample (78.4%) had experienced at least one type of obstetric violence (55.5% of non-consented care and 66.4% of abuse and violence).

The Covid-19 pandemic broke into a fragmented system searching for a difficult balance on its way towards a more efficient reorganisation of perinatal care and the promotion of the humanisation and physiology of the birth event, revealing – as discussed in section 2. – structural weaknesses in the formulation of public health policies and in the organisation of hospital services.

[12] 'International Platform on Obstetric Violence (IPOV): an innovative tool for a respectful maternity and childbirth care'. Project ID: 101130141.

In 2020, the first year of the Covid-19 pandemic, according to data from the CeDAP (i.e. 'Certificati di assistenza al parto') birth records of the Italian Ministry of Health's statistical office (Ministero della Salute 2021), in Italy in both the public and private sectors the decline in birth rates continued in all areas of the country[13]. The average number of children per woman was 1.24[14] (the same in Piedmont, 1.26 in Lombardy).

In 89.4% of pregnancies the number of obstetrical visits carried out is more than 4, while in 73.9% of pregnancies more than 3 ultrasound scans are carried out. In 2020 the percentage of Italian women who made their first visit after the first trimester of pregnancy is 2.2%; foreign women make their first visit later: indeed 11.3% of them make the first visit after the first trimester of pregnancy. Also, women with a low to middle school education make their first visit later: the percentage of women with an elementary school education or no education at all who made their first visit after the 11th week of gestation is 12.1%, while for women with a high school education, the percentage is 2.2%. Being under 20 years of age is also associated with a higher risk of not attending check-ups (2.5%) or attending them late (first visit after the 11th week of gestation in 13.7% of cases).

The great part of deliveries (88.2 per cent) took place in public and equivalent care institutions. Regarding the two regions involved in our study, in Lombardy the percentage is quite similar (88.9%), while in Piedmont we observe a higher percentage of deliveries (99.8%). About 21% of births were to non-Italian mothers (this figure is higher both in Piedmont and especially in Lombardy where this percentage is over 30%). The most represented geographical areas of origin are Africa (27.9%) and the European Union (21.4%). Foreign mothers of Asian and South American origin were 20.3% and 7.8%, respectively. In 2020 the average age of the mother was 33 years for Italian mothers while 30.8 for foreign mothers. The average age at the first child for Italian women is over 31 years. Foreign women give birth to their first child on average at 28.9 years of age.

42.6% of women who gave birth in the first year of the pandemic in Italy had a medium-high level of education, 24.8% medium-low and 32.7% had a university degree. Among foreign women, on the other hand, medium-low education prevails (43.3%). The analysis of professional status shows that 56.2% of the mothers are employed, 27.5% are housewives and 14.3% are unemployed or seeking their first job. The professional condition of foreign women who gave birth in 2020 is that of a housewife for 52.2% compared to 63.5% of Italian women who have a job. Where women

[13] In the world and Europe, Italy is a declining demographic context characterised by low fertility and birth rates and an increasing trend towards population ageing. With 6.7 births per 1,000 inhabitants in 2022 – the latest year for which data are available – Italy was the country with the lowest natality rate in the European Union and one of the countries with the lowest rates in the entire world (after Japan, Puerto Rico and the Republic of Korea, among others). Source: The World Bank Data, https://data.worldbank.org/indicator/SP.DYN.CBRT.IN?most_recent_year_desc=true.

[14] Ten years before, in 2010, it had been 1.46.

were allowed to have someone with them at the time of delivery, in 94.1% of cases it is the father of the child, in 4.5% a family member and in 1.5% another trusted person.

Data from CeDAP show that, in 2020, there was a high propensity to perform caesarean sections in both accredited (45.3%) and private (65.8%) nursing homes. In Piedmont and Lombardy, the percentage was lower (respectively 26.7 and 23.0 per cent). In the years of pandemic (2020-2021), there is no evidence of an impact of the SARS-CoV-2 pandemic on the frequency of use of cesarean section (on average, in 2020, 31.12% of deliveries were by caesarean section). A wide variability between regions persists: the recourse to cesarean in the South regions and Islands (Sicily and Sardinia) is higher. This does not seem to be associated with the different incidence of Covid-19 infection: although the virus has circulated more in the North, there was a greater incidence of cesarean section in the South. The differences between national geographical areas are probably more attributable to clinical and organisational factors – indeed, Italy it is characterised by a strong lack of homogeneity of perinatal services (Zanini 2021) – than to real differences in the health status of the population, constituting an unequal offer of care of assistance (Perrone et al. 2023).

The analysis of the use of caesarean section in Robson's classes – recommended by the World Health Organisation as a global standard for the evaluation and monitoring of the (inappropriate) use of caesarean section – shows a wide regional variability in the classes theoretically at lower risk of caesarean section (class 1: first-term mothers with cephalic presentation; 3 multiparous mothers at term, with cephalic presentation and who have not had previous caesarean sections). These classes account for a very high percentage of births in all Italian regions, confirming the possibility of significant improvements in the organisational and clinical practices adopted in the different realities (Ministero della Salute 2021).

Methods and data

The data used in this study are based on the analysis of semi-structured narrative interviews conducted with mothers who experienced their first pregnancy, childbirth, and the postpartum period after the onset of Covid-19 in Italy. The research was conducted in the post-pandemic period; all the women were interviewed between February and June 2024. This study focused on women in heterosexual relationships who experienced their first pregnancy, birth and postpartum period during the Covid-19 pandemic. The decision to include only women in heterosexual relationships was guided by the research aim to explore the specific dynamics of this group, particularly in relation to the role of male partners in pregnancy and postpartum experiences,

within the unique constraints of the pandemic. We recognise that many of the challenges addressed in the study – such as limited access to care, restrictive hospital policies and lack of emotional support from trusted individuals – are likely to be highly relevant to non-heterosexual couples and single women. However, the decision to restrict the participant group was motivated by theoretical considerations to explore gendered expectations and the division of emotional labor and caregiving in heterosexual couples based on the relevant literature (Jullien and Jeffery 2022; Gentile et al. 2022).

Participants were recruited by snowball sampling, which was used until a point of data saturation was reached (Cardano 2019). Potential participants were initially identified by criteria such as having given birth for the first time during 2020-2021 and being in a heterosexual relationship. The recruitment process involved the distribution of a flyer among the researchers' contacts. These contacts were a combination of professional networks, personal connections, and community groups likely to know eligible participants. The flyer outlined the purpose of the study, confidentiality guidelines, and contact information of the research team. It is important to clarify that while some participants were identified through the intermediary of professionals – such as midwives – the majority of participants were reached through a bottom-up process. In particular, women who had already participated in the research played an active role in promoting participation within their own social circles and encouraging other eligible women to participate. This bottom-up approach contributed significantly to the recruitment process, fostering a chain of referrals that enriched the group of participants. The interviews were conducted in a mixed format: some in person, others via video calls depending on the participants' preference and location. In total, 20 interviews were conducted with white middle-class women, all living in northern Italy (precisely 10 in Lombardy and 10 Piedmont regions). They had given birth between 2020-2021 and were aged 26-46 at the time of the interview. 8 were high school graduates, 12 had a university degree; all except one worked, in the majority of the cases full time.

In accordance with the European General Data Protection Regulation (2016/679/EC) and with the participants' informed consent, all interviews were recorded, respecting confidentiality and anonymity. To ensure informed consent, all participants received a detailed explanation of the study objectives, including assurances regarding confidentiality and the voluntary nature of participation. They were also informed of their right to withdraw at any point without providing a reason.

The aim of the interviews was to gain better understanding of the interviewees' subjective experiences and perceptions of maternity and perinatal care practices. The interview explored the experience of pregnancy, birth, and the postnatal period during the pandemic, the stay in hospital during and after the birth, the expectations, perceptions, and experience of becoming a

parent during Covid-19, the subsequent re-organisation of the family, the relationship with the partner and the family network.

Each interview lasted between 45 and 90 minutes. Participants were initially invited to share their experiences of pregnancy, childbirth and postnatal care. For many of the women interviewed, this also meant recalling difficult moments of isolation, fear, and anxiety. Not only joy, but also suffering imbued their memories of motherhood. We decided to focus on certain passages, moments or episodes of their experience, while at the same time leaving the interviewees free to choose the events or passages that they considered to be turning points (Giddens 1992). For most of the interlocutors, the interview was a moment of 'leaving an important testimony'; for many of them, recounting aloud and retracing their often-traumatic experiences were new experiences: for the first time they were 'telling about themselves' and reworking their subjective experience. Finally, at the end of the interview participants were asked if they had any final comments or questions, which often led to further discussion. The duality of participants' experiences during the interviews – described by some as empowering and liberating, while others recalled them as emotionally challenging – required a careful and ethical approach to ensure their well-being throughout the research process. For example, participants were reminded that their participation was entirely voluntary and that they could pause, skip questions, or withdraw from the study at any time without explanation. The interviews were conducted with an emphasis on empathy and active listening. Open-ended questions allowed participants to control the pace and depth of their narratives, and interviewers avoided pressing on topics that appeared to cause distress. Participants were also invited to provide feedback on the research process, which allowed us to adapt our approach as needed to better meet their needs. This iterative process helped ensure that participants felt respected, supported, and valued throughout their involvement.

Interviews were transcribed verbatim using word processing software, and their content was analysed thematically using the relevant literature on the subject and a grounded theory approach (Strauss and Corbin 1998) to facilitate understanding of sensitive issues. The interviewers included a senior researcher, a research fellow with a PhD in Sociology and a senior undergraduate student, all women, trained in qualitative research and analysis. Both the authors reviewed transcripts and independently evaluated emergent themes. The adoption of thematic analysis, as outlined by Clarke and Braun (2017), facilitated the identification, analysis, and interpretation of emergent themes. Given the exploratory nature of the research and the complexity of the experiences discussed, this method was chosen for its flexibility to highlight implicit aspects in the findings. The interview transcripts were read several times to fully understand their content and to identify their main themes. Both inductive and deductive approaches were used to develop themes and sub-themes representing key concepts or ideas.

Each theme was clearly defined, highlighting its relevance to the research questions and objectives (ibidem).

Finally, as qualitative researchers, our positionality played a significant role in shaping the research process, from designing the study to interpreting the findings. We approached this study aware of our position as women, and feminists with varying degrees of familiarity with the experiences of motherhood. Our relationships with participants were largely mediated through the recruitment process. While some participants were recruited through professional networks, most were referred by other women who had previously participated in the study. This bottom-up recruitment process fostered a sense of shared connection and trust, but it also required reflexivity during the research process. We critically examine how our identities and theoretical frameworks shaped the questions, the data analysed and the conclusions, remaining attention to power dynamics.

Findings

The analysis of the qualitative interviews carried out with mothers who had given birth during the Covid-19 pandemic (2020-2021) enabled us to explore more fully the perceptions, experiences and meanings of the care and treatment paths in a condition of deep double uncertainty. This we can describe as a micro-social uncertain condition – linked to the novelty and change in becoming mothers for the first time – embedded in another macro-social one – that due to the Covid crisis. Analysis yielded various key themes: 1) a lack of support and isolation in the maternity pathway; 2) discontent with the limitations imposed on sharing the birth event with the partner; 3) strategies with which to resist and cope with the anti-Covid measures; 4) the 'best for the child' and the coronial intensive parenthood challenged by Covid.

'Like a fish thrown into the open sea': lack of support and isolation in the coronial maternity pathway

The assistance maternity path never came to a halt during the pandemic. However, one of the main themes in the interview responses was the perceived loneliness and lack of (both emotional and practical) support in all phases of pandemic motherhood. In order to ensure maximum safety for both the mother and the newborn child, following the health authorities' instructions, during certain critical periods of the pandemic, no accompanying persons were allowed to enter the hospital during specialist visits and pre-hospitalisation. Therefore, almost all the interviewees

underwent the period of pregnancy and birth with a strong sense of loneliness. They experienced a high level of stress, discomfort and suffering due especially to being alone in hospital and facing childbirth without the support of a partner or other significant family members.

The words most frequently used by the interviewees to describe their experiences, especially in the period before and immediately after birth, were 'loneliness' and 'lack of socialization'. The social distancing imposed by the circumstances led to a real and concrete absence of social support.

Starting from the antenatal period, the possibility of attending pre-birth classes differed among hospitals and varied according to the period of the pandemic. Respondents whose pregnancies were in progress during the first 'wave' of the pandemic were unable to attend the pre-birth classes because these had been suspended in order to comply with the regulations to curb the infection. Over time, hospitals took steps to ensure that expectant mothers were not left alone at such a delicate time by offering antenatal classes conducted by telephone, where a midwife answered pregnant women's questions, and online. These classes provided essential information on how to access the birth pathway, how to recognise the onset of labour, how to manage labour, and how to breastfeed.

Several interviewees expressed regret at not having been able to attend antenatal preparation classes in person. They did not like the quality of the antenatal classes offered online, considering them to be rigid and focused on providing only theoretical information, with no practical activities or two-way dialogue. This was especially the case when the midwives organised the class using only slides and did no more than read them aloud, and when the group of participants was large. In contrast, when the group was smaller, there was more active and engaged participation.

What they reported illustrates how the absence of antenatal classes – especially for interviewees without prior experiential knowledge because they were first-birth mothers[15] – left them unprepared, unsure and uninformed for the birth of their babies. This added to the anxiety and uncertainty of an already delicate and complex time and event. One interviewee used the metaphor 'like a fish thrown into the open sea' to describe the feeling of not knowing what she was getting into, including simply how to regulate her breathing when she had to push. She said:

> *It was a continual search on the Internet, phoning anywhere to get a minimum of feedback, and then in the end I scheduled my own caesarean section with the availability at *** (name of the public hospital); so, it wasn't a path where someone would follow you […]. I found myself looking for telephone numbers […]. So, it*

[15] For example, an interviewee, aged 38, who gave birth in May 2020, said 'It was my first child. I'd never had children or grandchildren. I didn't even know how to handle a child, put it like that'. (2E birth 2020)

became a bit more complicated.
Interviewer: So, there wasn't support from the hospital in directing the mothers a bit? preparing them?
Interviewee: No, zero. I think the antenatal class prepares you for that as well. (14T birth 2020)

The moment of childbirth is an emotional and stressful event in itself. Finding oneself in a hospital, a strange and potentially life-threatening place because of Covid, without the support of a trusted person, made the experience even more difficult. The expectant mothers had to rely entirely on a team of professionals – doctors, midwives and nurses – who, however competent and dedicated they might be, could not replace the comfort and emotional support provided by the presence of a family member.

Almost all the women interviewed went through labour alone. Medical personnel were present, but 'at a distance'. In the mothers' perception, the doctors were 'not very human' in their treatment of them. Often cold, detached, without a word of comfort or support, also due to restrictions (e.g. face masks, uniforms, etc.). Only a few mothers reported that midwives made any effort to ask them how they were feeling, although for them every small action, such as going to the toilet, was a real challenge. A 36-year-old interviewee complained about the lack of emotional support from health professionals during the birth she experienced in full lockdown (April 2020): she reported that none of the doctors and midwives had asked how she was after the birth, also expressing a sense of disappointment about expectations that were not met in relation to what had been announced during the antenatal class:

How are you doing? How are you? What hurt me, really left me speechless, is that, I mean, after the birth [...] beyond the normal general condition, but at that time, so with a Covid experience behind anyway [...] no one ever came to me and asked (with emphasis) 'Are you OK?' i.e. 'How are you feeling? How are you experiencing it?'. During that famous antenatal class, the midwife had said... she said: 'There will be the birth. Then different members of the medical staff will come and ask you if you have problems...' I mean, nobody came to ask me: 'Are you OK? Is everything OK? Is anything wrong? How are you feeling? Do you need me to explain something to you?' (12T birth 2020)

A 34-year-old woman, who gave birth in March 2021, reported barriers to health care and low levels of social support when she discovered that she was Covid-19 positive at the time of delivery. Despite the scientific evidence that the child was not at high risk of infection and transmission, care practices often moved in a different direction. This interviewee, who was positive at the time of delivery, recounted how she had experienced a differential and

disqualifying pathway during delivery and postpartum. For example, she explained that, despite her plans to give birth at home, the reality was that she had to give birth in hospital. In fact, after the first few hours of difficulty, the midwives decided to take her to hospital, where she discovered that she was Covid-19 positive:

> *They took me to my room in this makeshift Covid ward... I couldn't leave the room. [...] It was quite calm, although I was pissed off. I always thought I could get out (a few days after the birth). Then in the morning I realised it wasn't going to be that easy. I didn't know who was coming into the room, whether it was a midwife, an OSS, or a doctor, because nobody identified themselves. [...] They only came to our rooms twice a day for the minimum amount of time. You can imagine a woman who has just given birth wearing the postpartum pad, with her tits out and in that state, with cameras and instructions not to ring the bell... because they won't come anyway. That was one of the indications. (4E birth 2021)*

The perceived and experienced lack of support was not confined to the prenatal period and during childbirth; it was challenging during the postnatal phase as well. In these short extracts, the interviewee talks about the difficulty of getting support from medical staff. It is interesting to note that – like the above interviewee – she gave birth in March 2021, when the pandemic had lasted more than a year and was in a phase of 'chronic emergency' with the vaccination campaign against Covid-19[16]:

> *So, I only received support during the delivery, from the doctors and nurses who were there [...] It would definitely have been better if there had been something more. I remember that I was in pain, I was losing too much blood, etc. [...] There weren't many examinations, there weren't many checks at the time. I remember that they had given me stitches. Then at a certain point I went upstairs, they made me sit on a chair and I fell down, my stitches ripped, I mean... everything was a bit messed up and psychological counselling was entirely lacking. At that very delicate moment, I had to look for it externally for a fee. (5E birth 2021)*

Keeping fathers out: discontent with the limitations imposed on sharing the birth event with the partner

As already highlighted (Gentile et al. 2022), in a hospital setting in Italy during the pandemic, the woman's right to be accompanied by her partner (or a trusted person) for the entire duration of labour and delivery was temporarily suspended. Partners/fathers were only permitted to attend the birth at the moment of expulsion. Moreover, many fathers could not be present during

[16] 27 December 2020 is the date that marked the official start of the vaccination campaign against COVID-19 across Europe.

antenatal procedures like the morphological ultrasound scan, an important examination that analyses in detail the anatomical development and health of the foetus and makes it possible to discover the child's sex as well.

This is a crucial issue that was consistently emphasized by all the interviewees. One interviewee, aged 39, who gave birth in October 2020, described the feeling of isolation that she experienced during her pregnancy. Although she had chosen to be cared for by a private gynaecologist precisely to avoid the infection risks then present in public hospitals, she recounted that all the examinations, even the important ones such as translucency, were carried out alone, without the presence of her partner:

> *She (the gynaecologist) had the office all to herself all the time. So he (the partner) couldn't attend any ultrasounds. He accompanied me to do the blood-glucose curve, but he still couldn't go in. So he accompanied me, but he stayed outside the office. (9E birth 2020)*

The thought of facing childbirth without the partner's presence was a source of great anxiety for the interviewees, sometimes even greater than the fear of childbirth itself. However, it was not only a sense of isolation and inability to be supported by their partner that was experienced. Many interviewees illustrated how these rules and procedures failed to take into account not only the needs of mothers, such as the desire to have their partner present during the examinations and hospitalisation, but also the father's right to be involved and participate.

> *It seemed excessive to me not to let the baby's father be present at the examinations, also because if we had Covid in the family, if he had it... I had it too. I can understand the thoughtfulness, but it's still the father, it's not a cousin or a neighbour. And so, I suffered that, the lack of dad during the antenatal examinations. (9E birth 2020)*

This generated a sense of exclusion in some interviewees and made the experience less participatory. Another interviewee declared:

> *I couldn't even say to him (the partner) that the baby had been born. No one warned? him and no one called him. Because he had to stay away from the hospital. [...] He was Covid positive and had to stay at home, in isolation. (4E birth 2021)*

In many cases we found regret that the father had not been able to share and experience important moments in the maternity care pathway, in their first child's entry into the (chaotic

and critical coronial) world, and in the biographical transition from couple to parental family, to mother and father. An interviewee said:

> *One of the worst things about the pregnancy was that the daddy couldn't be there, couldn't see, couldn't hear the things that were said, which were always the same things. You go to the gynaecologist and everything is always fine. She (the gynaecologist) tells you that the baby is growing, it's fine, see you in a month. But I'm sorry he missed it. (9E birth 2020)*

Resistance to and strategies to cope with the anti-Covid measures

In addition to the limitations mentioned in the previous sections, another issue that emerged from the interviews was the use of the face mask during labour and childbirth. The interviews revealed significant tension between women's expectations of childbirth and the restrictive measures imposed during the Covid-19 pandemic. The requirement to wear a face mask during labour was a contentious issue. For a significant number of women, this measure was perceived as a symbol of dehumanising detachment. Women often had to give birth wearing a mask, which made everything difficult and cold, and they could not see the faces and expressions of the medical staff. Some women reported that they refused to wear one as a form of resistance:

> *Another thing I discovered is that, theoretically, we should have given birth wearing a mask. I accept everything. I've always walked around with the mask on […] But to give birth wearing a mask, no! because we did 500 tests, all the staff around me were wearing masks. I took mine off. (6E birth 2020)*

> *They had told us that we would have to wear the mask during labour [...]. But the idea that they would tell us to keep the mask on all the time, I was worried about that. (3E birth 2021)*

> *I gave birth without a mask. I had no intention of wearing one.*
> *Interviewer: Because the instruction was to keep the mask on?*
> *Yes, yes. (4E birth 2021)*

Moreover, there were also very strict restrictions in hospitals on leaving the room. Before the health emergency, patients were allowed to take walks along the corridors to stretch their legs or even just to get some fresh air. However, with the advent of Covid-19, these simple activities (such as leaving one's room to get a bottle of water from the vending machine) were banned.

In addition to resistance, women employed various coping strategies[17] to mitigate the emotional and physical toll of these restrictive measures. In order to have a better experience of pregnancy and childbirth, many respondents preferred to be cared for by a gynaecologist in a private setting. This choice was motivated by the different nature of the care compared to that provided in a hospital setting. In a private setting, women in labour could enjoy longer and more detailed examinations. In addition, in many cases (but not always) they were offered the opportunity to have their partner or husband attend the visits.

Others chose to give birth at home, both to avoid going to hospital in an emergency and to have their partner and relatives present during the birth. However, many of them were transferred to hospital due to complications during labour at home, which contradicted their expectations and ideals of childbirth as a 'natural' and 'intimate' moment involving mother, partner and child:

> *At a certain point, however, we realised that it wasn't going well and they (the midwives) were a bit scared. So they said to my husband [...], get the car and take her straight to the hospital. [...] and there (at the hospital) [...] I couldn't stand on my feet, I just couldn't. At one point I threw myself on the floor […], and I was sitting on the floor and there was nobody there. And I was in this room in the hospital... a nurse came in and swabbed my nose, but she couldn't do the Covid-19 text. Then I was always there on the floor... and she came back and did it again. [...]I felt very... My partner wasn't there, the midwives who had looked after me weren't there, my mother was at home [...] There was nobody I knew in there. (5E birth 2021)*

One of the interviewees (12C), who gave birth during lockdown (April 2020), a sufferer of panic attacks at such a sensitive time and alone, would have needed more attention and support from health staff to adequately manage her emotional state. During her stay in the hospital, she suffered greatly from the pain of the caesarean section and the absence of her husband. She reported that, despite her repeated requests to the nurses and midwives to intervene, she did not receive adequate help. In a state of extreme desperation, she decided to call her husband and said: 'Either you come here (at the hospital ward) and get someone to come here to me or I swear I will get out of bed and throw myself off the balcony'. The husband, realising the seriousness of the situation, rushed to the hospital and insisted that the hospital staff let him in. Thanks to intervention by the wife's gynaecologist, who was at the hospital at the time of the husband's arrival, it was possible to obtain exceptional leave to visit for one hour a day. The

[17] Following Lazarus and Folkman's (1984) definition, coping strategies are cognitive and behavioural efforts that people use to face external and/or internal stressing demands, and they can be distinguished as being either problem-focused (aimed at addressing the problem directly) or emotion-focused (aimed at dealing with feelings associated with the stressor).

husband's presence was a relief for the wife, in terms of both emotional comfort and practical help in coping with the post-caesarean pain.

These narratives illustrate how women navigated the dual pressures of institutional constraints and the personal need for emotional security during childbirth. Resistance practices, such as defying mask mandates, and coping strategies, like seeking private care or opting for home births, reflect women's strategies to assert control during the experience of pregnancy and childbirth.

The 'best for the child' and coronial intensive parenting challenged by Covid: between vaccine hesitancy and uncertainty and overanxious parenting

The findings indicate that the challenges and pressures experienced by mothers during the period of the Coronavirus pandemic (Covid-19) have resulted in significant consequences to their experiences of pregnancy, childbirth and early parenting. These experiences can be conceptualised within the framework of an intensive parenting culture (Furedi 2022; Lee et al. 2023). This model emphasises an increased sense of responsibility on the part of parents for their children's physical and emotional well-being, with parents often striving to protect their children from any potential risk. The pandemic has served to exacerbate these concerns, engendering a pervasive sense of uncertainty and the necessity for risk management.

One of the crucial aspects of the pandemic was the issue of anti-Covid vaccination for pregnant and breastfeeding mothers. Our analysis suggests that this issue is representative of intensive parenting (Lee et al. 2023; Furedi 2022).

The anti-Covid vaccine was available in Italy after 14 December 2020, when the first vaccine was approved. In general, the mothers interviewed showed great confidence in the knowledge of experts, which means that they chose to listen to and follow the advice of health professionals, such as gynaecologists and general practitioners, before making any decisions regarding the vaccine.

The hesitation of some mothers to be vaccinated was a state of indecision rather than rejection, in a context of uncertainty and crisis (Giddens 1992; Lee et al. 2023). Many women experienced confusion due to conflicting information (Waker et al. 2021) about Covid-19 vaccine safety and efficacy and reported that their gynaecologists and general practitioner suggested waiting until after giving birth to vaccinate. One interviewee – a pharmacist by profession – thus expressed this sense of uncertainty and confusion, where even health professionals were not sure and certain:

> *I went to my general practitioner and asked him 'Doctor, what do you think? Because if you tell me it's important... I'll do it.' 'No, no, don't bother, because for other people there haven't been many studies, you're breastfeeding, wait'. So he was holding me back because I had already started with the idea of doing it... (…) And a month later I got a letter from the local health authority saying that if I didn't vaccinate, they'd disbar me... [...] anyway on the paper it was clearly written? that in any case in the case of pregnancy or breast-feeding it was the mother's responsibility, etc. This was not a beautiful chapter? because, I mean, I repeat, I gave my son all the vaccines, I believe a lot in the advancement of science and everything, but if I'm told one thing, I'm told another… (6E birth 2020)*

Similarly, another respondent said:

> *Yes, I did it (the vaccine) at the beginning. What I remember is that even the doctors didn't have a clear idea whether it should be done. My gynaecologist told me at the beginning: 'No, absolutely', because there was little information about the impact the vaccine would have on my pregnancy. So, at first, 'No, never mind, let's not, let's wait, let's wait...'. Then afterwards, however, the indications changed completely. Vaccination was absolutely necessary (…) So even my gynaecologist told me: 'But yes, let's do it'. He also changed and so I followed him and got vaccinated. (13E birth 2021)*

Interestingly, two mothers, who were sisters, expressed particular appreciation for the non-pushy approach of the gynaecologists. The doctors respected their need for time to reflect and make informed decisions, without exerting pressure. This attitude helped to create a relationship of trust and collaboration between the mothers and their gynaecologists, facilitating open and respectful communication.

There were also those who saw the vaccine as an opportunity in the workplace, as in the case of this interviewee, a psychologist who was able to benefit from the vaccine in advance as a health professional:

> *I have always had great confidence in science, even in pharmacology. I have never been afraid to take a certain drug [...] I experienced the vaccine as an opportunity, not so much as an imposition, a defeat. In fact, I was absolutely convinced that I should be vaccinated. (E11 birth 2020)*

The set of doubts and concerns related not only to the uncertainty of a vaccine being produced in a short time, but also to the sense of responsibility for the well-being of one's own child:

> *I believe in science. I believe and I want to hope that if there is a vaccine it has been tested [...]. But if [...] it is a vaccine that was produced in a very short time, so that the tests done were certainly probably only the necessary ones… It probably caused problems for some people. Unfortunately, science is not infallible [...] But if for me I can say 'ok I do' [...] but I would never have felt like saying 'OK, I'll be vaccinated in pregnancy'. For the same reason, I didn't leave the house for all the months of pregnancy; because my responsibility at that moment was also for another human being, and if something had ever happened to her (to her daughter) […] I would never have forgiven myself. So in pregnancy I would never have done it. (7E birth 2020)*

In this regard, it may be of interest to recall the concerns of one interviewee, who recounted the 'guilt' of those who refused to be vaccinated:

> *I get angry because they have not protected pregnant and breastfeeding women... by self-blaming… you are making others sick. And if something happens to your baby? (12E birth 2021)*

Regarding parents' experiences, the emergence of the SARS-CoV-2 virus increased anxiety and worry in a cultural context already characterised by a cultural model of intensive parenting (Lee et al. 2023). Several interviewees described how Covid-19 had complicated their perceptions of risk and safety in relation to their children's wellbeing. They monitored and protected their children not only against the 'risks' of pregnancy but also against the unknown effects of Covid-19.

For example, some mothers shared their concerns about touch and explained how the pandemic had changed sociality. Two explained how touching, getting one's hands dirty and hugging had been denied to so-called 'Covid-19 children':

> *You told a child [...] not to touch other children, not to touch people. This scared me so much because I saw that anyway (son's name) [...] wouldn't let himself be touched and he didn't want to touch anyone... either for exploration or as a gesture of affection. [...] I never took a train, a bus, for fear of being too long in a closed environment, in shops, in shopping centres, that is, a bubble within a bubble. (3E birth 2021)*

> *My son is Covid's son [...]he doesn't like to be touched by someone he doesn't know and he doesn't like to be hugged, he doesn't want to be kissed. He wipes his cheek, if a boy or a girl comes up to give him a kiss... Now, I hope it's a character trait that maybe he would have had anyway. But I can't deny that it could also be due to the whole Covid thing. (2E birth 2020)*

Another mother told of her partner's anxieties:

> *The first few months were tough. […] Anyone who came into the house had to follow strict rules of hygiene, take the test to find out if she/he had Covid. The first Christmas we all spent together, and (name of the daughter) was born in May. Everyone who came was made to take the test, but not by me. […] Let's say my partner has only recently got over this fear, when we caught it [Covid] last Christmas. (7E birth 2020)*

These excerpts reflect the pandemic's long-term impact on social behaviours and parental anxieties towards childhood and echo what Lee et al. (2023) say about the context of 'no-touch' and child protection. The narratives also reveal how the pandemic intensified the cultural pressures of intensive parenting, particularly regarding risk management and child protection. Mothers described an increase in their vigilance, extending from their own health during pregnancy to their children's early years. For instance, some mothers reported a reduction in social interactions, avoidance of public transport, and the enforcement of strict hygiene rules for visitors. These behaviours reflect the interplay between pandemic-driven risk anxiety and the broader cultural imperative of protecting children at all costs (Lee et al. 2023).

Discussion and conclusion

This study has explored the experiences of pregnancy, childbirth, and postnatal care of Italian women during the pandemic. It has highlighted how the changes of assistance imposed by Covid-19 and inadequate health care services impacted their emotional lives and wellbeing.

To improve the quality of maternal and newborn care in health facilities, the WHO has developed eight standards of quality care, which include: (1) implementation of evidence-based practices for routine care and management of complications, (2) having actionable information systems, (3) having functional referral systems, (4) ensuring effective communication, (5) showing respect for and preservation of dignity, (6) providing emotional support (Lalor et al 2023). Despite these guidelines, our findings seem to confirm that the pandemic further rationalized and technicalized maternity care services, prioritizing safety and risk management over the quality of care and assistance for mothers (Davis-Floyd and Gutschow 2021).

Our research indicates significant gaps in supporting mothers and their families during the period of the Covid-19 crisis (Zanini and Quagliarello 2023). Compared with the existing literature, the data reveal an intensification of over-medicalisation compared with the

pre-pandemic period and, on the other hand, a lack of care with respect to some changes in the assistance model that had taken place previously (e.g. humanisation of care, presence of midwives, listening, etc.) (Spina 2023; Zanini and Quagliarello 2023). As also Gentile et al. (2022) and Benaglia and Canzini (2021) report, the pandemic has had a negative impact as a factor of retrogression, increasing the risk of normalising reactionary forms of medicalisation and health paternalism, as well as forms of obstetric abuse or violence against mothers and couples. In our research, participants expressed a sense of isolation, a lack of support, an anxious climate of separation between mother and child, but also exclusion from, or restricted participation in, the birth event by the partner/father. Our findings also reflect the expectations and disillusionments of mothers in regard to not only the hospital experience but also to the overall experience of motherhood (Jullien and Jeffery 2022). Moreover, our results, which concern the two-year period 2020-2021, compared to those of the many studies that have focused on the peak year – 2020 – reveal that the restrictions continued for a long time (2021) in a context of depersonalisation of care, contributing to an increased sense of uncertainty and insecurity among mothers. These changes have inevitably affected the quality of the experience of women and couples.

Furthermore, the analysis of the data revealed two central themes: resistance and coping strategies in response to restrictive measures, and the intensification of societal pressures tied to intensive motherhood. A significant finding was the variety of resistance practices employed by women against restrictive measures, particularly the use of face masks during labour. Such actions, including the removal of face masks and the challenging of hospital protocols, can be interpreted as forms of everyday resistance. In this context, women sought to reclaim a sense of autonomy within a health system that was otherwise characterised by rigidity and a perceived lack of personalised care. Beyond resistance, many women adopted coping strategies to navigate the challenges posed by the pandemic. Choosing private care or home births were attempts to create more supportive and personalised environments. The absence of partners and support networks during hospital stays emerged as a profound source of distress, especially for women recovering from caesarean sections or managing complications.

The societal pressures associated with the role of the mother were exacerbated by the pandemic, with many women feeling a heightened sense of responsibility for managing risk and ensuring their children's safety (Lee et al. 2023; Jullien and Jeffery 2023). The expectation to protect children from both the virus and potential vaccine side effects placed mothers in a double bind, intensifying feelings of guilt and anxiety. The present study revealed that vaccine hesitancy among women was not rooted in a lack of knowledge or misinformation, but rather stemmed from their dedication to fulfilling the role of a ‘good mother’.

Covid-19 further increased the sense of guilt among mothers who, alone and without support, had to meet society’s expectations of intensive motherhood. The other related aspect is the issue

of vaccine hesitancy. Managing the fear of Covid-19 helped many mothers to engage in activities such as seeking information and understanding the impact of vaccines on the development and well-being of the child. In this scenario, medical experts often gave conflicting opinions and did not support mothers in their choices. Mothers who were hesitant or undecided about the vaccine were not the ignoramuses often portrayed in the media and by common sense. On the contrary, they were often women who, in order to be good mothers, read, informed and documented themselves, questioning the truth of medical knowledge (Schuster et al. 2023).

Finally, our findings suggest that Covid-19 has highlighted structural weaknesses in the Italian healthcare system. Despite recommendations from the Ministry of Health that hospitals be safe places to give birth, many services were suspended or reduced, often to the detriment of the well-being of women and their children (Loghi et al. 2021). The crisis has highlighted the limitations of the traditional biomedical approach, often overly medicalized and technocratic, which has ignored women's subjectivity (Davis-Floyd and Gutschow 2021). The measures of separation and physical distance imposed to limit the transmission of the virus further complicated the birth experience, undermining trust between patients and medical personnel. Future research should focus on different ways to improve health policies and perinatal services in emergency situations. In particular, it should analyze the extent to which political decisions respect scientific evidence and international guidelines, identify any discrepancies and their consequences, and involve women in decision-making processes, and in the planning and evaluation of perinatal services (WHO, 2016).

Our study has some potential limitations. Given the structure and functioning of the Italian National Health Service, our findings focused exclusively on two northern regions of Italy (Lombardy and Piedmont) are likely to reflect region-specific contexts. Therefore, they may not represent the experiences of women in other regions of Italy. Future research should investigate how women from other regions of the country navigated the same phase by exploring regional disparities in access to care and perinatal support.

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