The impact of pregnant women's health-seeking behaviour and mode of birth preferences on pregnancy distress during the COVID-19 pandemic

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April 05, 2024

Abstract

Background: The COVID-19 pandemic affects health of pregnant women and their attitudes and behaviours related to pregnancy and birth. Aim: To explore the impact of pregnant women's health-seeking behaviour and mode of birth preferences on pregnancy distress during the COVID-19 pandemic. Material and Method: The type of this study is cross-sectional. It was conducted with 351 pregnant women admitted to the pregnancy outpatient clinic. The data were collected using the "Pregnancy Information Form, the Pregnancy Distress Scale, and the Health Seeking Behaviour Scale". The data were evaluated with Wilcoxon, Binary Logistic, and Linear regression analysis. STROBE checklist guide was followed in the study. Results: The study revealed that the total pregnancy distress score and risky distress levels of pregnant women during the COVID-19 pandemic were higher than before. On average, four out of every five pregnant women (81.2%) stated that they experienced difficulties (decreased social support, finding information suspicious, having to go to the hospital) during the pandemic. During the pandemic, pregnant women mostly wanted to get information about the impacts of COVID-19 on the health of pregnant (59.54%) and foetus (67.81%). Increased health-seeking behaviour in pregnant women decreased the pregnancy distress stemming from inadequate partner involvement. 11.3% of the pregnant women have changed their mode of birth preferences due to the pandemic. The risk of pregnancy distress increased 5.4 times in those who changed their mode of birth due to pandemic compared to those who preferred vaginal birth before and during the pandemic. Conclusion: There is effect of their health-seeking behaviour and mode of birth preference on distress of the pregnant women during pandemic. Health professionals should reduce the distress of the pregnant woman by ensuring the continuity of antenatal care and counseling services during the pandemic. Keywords: COVID-19 pandemic, pregnant women, distress, health-seeking behaviour, mode of birth

TITLE PAGE

Title: The effect of pregnant women's health-seeking behavior and preference for mode of birth on pregnancy distress during the covid-19 pandemic

Running-Short Title: The factors affecting pregnancy distress during the covid-19 pandemic

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Acknowledgements

The authors wish to especially thank women who volunteered to participate in this study. This study was presented as an oral presentation at the the Current Aspects of Reproductive Health was held in Bulgan, Mongolia on May 5-6, 2021.

Conflict of interest

The authors declare that they have no competing interests.

Author contributions:

Study design: SA, RA, DKB Data collection: DKB Data analysis: SA, RA Study supervision: SA, RA, DKB Manuscript writing: SA, RA, DKB Critical revisions for important intellectual content: SA, RA, DKB

Funding Information

There was no funding.

Data Availability Statement

Data available on request due to privacy/ethical restrictions: The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Abstract

Background: The COVID-19 pandemic affects health of pregnant women and their attitudes and behaviours related to pregnancy and birth**.**

Aim: To explore the impact of pregnant women's health-seeking behaviour and mode of birth preferences on pregnancy distress during the COVID-19 pandemic.

Material and Method: The type of this study is cross-sectional. It was conducted with 351 pregnant women admitted to the pregnancy outpatient clinic. The data were collected using the "Pregnancy Information Form, the Pregnancy Distress Scale, and the Health Seeking Behaviour Scale". The data were evaluated with Wilcoxon, Binary Logistic, and Linear regression analysis. STROBE checklist guide was followed in the study.

Results: The study revealed that the total pregnancy distress score and risky distress levels of pregnant women during the COVID-19 pandemic were higher than before. Increased health-seeking behaviour in pregnant women decreased the pregnancy distress stemming from inadequate partner involvement. 11.3% of the pregnant women have changed their mode of birth preferences due to the pandemic. The risk of

pregnancy distress increased 5.4 times in those who changed their mode of birth due to pandemic compared to those who preferred vaginal birth before and during the pandemic.

Conclusion: There is effect of their health-seeking behaviour and mode of birth preference on distress of the pregnant women during pandemic. Health professionals should reduce the distress of the pregnant woman by ensuring the continuity of antenatal care and counseling services during the pandemic.

Keywords: COVID-19 pandemic, pregnant women, distress, health-seeking behaviour, mode of birth

What is already known about this topic?

COVID-19 pandemic elevates the anxiety and stress of pregnant women.

What does this article add?

Pandemic increases the distress of pregnant women. The increase in health-seeking behaviour in pregnant women reduces the distress of pregnant women stemming from inadequate partner involvement. Some pregnant women changed their mode of birth preferences due to the pandemic. The risk of pregnancy distress increased 5.4 times in pregnant women who changed their mode of birth preferences due to pandemic compared to those who preferred vaginal birth before and during the pandemic.

1 | INTRODUCTION

The coronavirus (COVID-19) spread out from China in December 2019, and the WHO declared this novel disease a global pandemic on 11 March 2020.[1] COVID-19 has caused more than 160 million sickness and 3 million deaths by May 2021 all over the world.[2] In response to the pandemic, governments have implemented social restrictions and lockdowns in many countries to prevent disease transmission.[3] The first confirmed case in Turkey was reported on 11 March 2020, and the Turkish government has taken immediate actions like social restrictions (closures of schools, the transition to online education, lockdown at the weekend).[4] The pandemic and restrictions continue in 2021 in Turkey. The COVID-19 pandemic has negatively affected healthcare system all over the world.[5,6] This situation has deeply affected the pregnant women receiving regular health care and services.[1,7]

Changes in daily life routines during the COVID-19, fear of virus transmission, uncertainty about the impact of the virus on her own and foetus health, and the birth mode preference, and inability to benefit from antenatal services adequately compared to before the pandemic (reduction in the number of pregnant outpatient clinics, giving priority to pregnant women at risk, cancellation/delay of appointments, etc.)[8-11], lack of social support[11], not being aware of reliable and easily accessible information sources or having difficulties in accessing or using these sources elevate the distress of the pregnant women.[6,8,12] Research indicate that the distress of pregnant women has increased more during the pandemic than the pre-pandemic period.[5,13,14]

In such cases, pregnant women may engage in more "health-seeking behaviour" to alleviate their concerns.[7,11] Social isolation and lockdown in the pandemic have increased pregnant women's search for tele counselling and online health.[11,15]However, during the health-seeking process, inadequate access to information sources and using either unsafe, inaccurate, and inconsistent information sources or excessive information overload may lead to distress in pregnant women.[6,11,16] Pregnancy distress causes obstetric complications such as perinatal depression, miscarriage, preterm birth, intrauterine growth retardation, etc.[5,14,17] Therefore, it is pivotal for pregnant women to access correct, timely, and sufficient information.

Insufficient scientific evidence regarding the impacts of COVID-19 infection on pregnancy-foetus and birth mode[1], inadequate knowledge about the unit where the birth will take place and the preventive measures taken by health professionals who assist the birth and fear of virus transmission may influence the pregnant woman's preference of a mode of birth.[1,5,8,10,11,18] The distress of the pregnant woman that cannot be prevented/treated can lead to increased birth fears, decreased birth self-efficacy, optional caesarean section preference, and traumatic births.[14,19] The WHO (2020) emphasizes that even the COVID-19 positive pregnant woman is not necessarily a caesarean indication, and the mode of birth should be determined according to the obstetric condition and preference of the woman.[20]

Some studies in the literature have separately examined the impacts of the COVID-19 pandemic on anxiety, depression, and distress of pregnant women.[7,10,18,19,21] However, no study to our knowledge has investigated the health-seeking behaviour and mode of birth preferences on pregnancy distress during the COVID-19 pandemic. This study aims to explore the effects of health-seeking behaviour and mode of birth preferences on the distress of pregnant women in the COVID-19 pandemic. It is believed that the study will fill the gap in literature and shed light on future studies.

2 | MATERIALS AND METHODS

2.1 | Study design

The design of this study is cross-sectional. STROBE checklist guide was followed in the study.

2.2 | Setting and participant

We conducted this study in the obstetrics policlinic of a state hospital between October and November 2020. The population of the study consisted of all pregnant women who were admitted to antenatal control to the pregnant outpatient clinic. The sample size was calculated by using the sample size formula used in the estimation of the mass ratio from an infinite population. According to this calculation, 351 pregnant women constituted the sample of the study. This formula is described below.

$n = z^2pq / d^2$

n = Number of individuals to be included in the sample.

p = Frequency/probability of occurrence of the event (0.5).

q = Frequency/probability of non-occurrence of the event (1-p = 0.5).

z = Theoretical value from the table z for a high degree of freedom at a given confidence level (1.96 for 95% confidence interval).

d = Standard error of the ratio to be determined in the study (0.05 for 95% confidence interval). $n = 1.96^2$ x 0.5 x 0.5 / $0.05^2 = 351$

The inclusion criteria of the study were being at least primary school graduates, volunteering to participate in the research, being over 20 years old, being pregnant at least 12 weeks (by USG), having a low-risk pregnancy, and not being diagnosed with COVID-19 during pregnancy. The pregnant women who could not read and write in Turkish, those with hearing and visual impairment, high-risk pregnancy, and a known psychiatric disorder were excluded from the study.

2.3 | Data collection

The data were collected using the *"Pregnancy Information Form* , the "*Tilburg Pregnancy Distress Scale"* (TPDS), and the*"Health Seeking Behaviour Scale"* (HSBS).

The Pregnancy Information Form (PIF): The form was developed by the researcher by scanning the literature and includes socio-demographic (age, education, etc.) and obstetric characteristics (number of pregnancies, etc.).[5,11,22-27]

The Tilburg Pregnancy Distress Scale (TPDS): Pop et al. (2011)[28] developed the scale to determine distress (stress, anxiety, depression) during pregnancy. The Turkish validity and reliability study of the scale was conducted by Çapık and Pasinlioğlu (2015).[23] It is a self-rating scale consisting of 16 items, and each item is rated in a 4-point Likert-type. 11 items are reverse coded (3,5,6,7,9,10,11,12,13,14,16). The lowest and the highest scores to be obtained from the scale is 0 and 48, respectively. It has two sub-scales: "negative affectivity (min:0, max:33 points) and partner involvement" (min:0, max:15). The scale can be applied to those at least 12 weeks pregnant. The cut-off point of the scale is 28 points and above. A total score of 28 and above indicates the pregnant women at risk for distress (stress, anxiety, depression). The Cronbach Alpha coefficient for the total score of the scale is 0.83.

The Health Seeking Behaviour Scale (HSBS): Created by Kıraç (2019),[29] the scale consists of 12 items. It is a 5-point Likert type and includes 3 sub-scales: "online, professional, and traditional". "Online health-seeking behaviour" is to seek help from various health sources and expert opinions via Internet; "Professional health-seeking behaviour" refers to getting help from health institutions and health professionals. "Traditional health-seeking behaviour" includes using complementary and alternative medicine methods and getting information from friends, etc. The scores to be obtained from the scale range from 12 to 60. As the score increases, the participants' health-seeking behaviour increases. Cronbach Alpha is 0.75 for the total score on the scale.

To collect the data, we presented two options to the participants, who were admitted to the outpatient clinic for pregnancy follow up and agreed to participate in the study. The first option was to distribute the scales in paper form, and the second one was to send the data collection forms via the survey online to the WhatsApp's of the participants. 30 pregnant women chose the first option and filled out the data collection forms in an appropriate room of the hospital. The other 331 pregnant women participated in the survey online. The telephone number of the researcher was given to all pregnant women so that they could call if they did not understand any item while filling out the questionnaire. Data collection time takes 15-20 minutes.

2.4 | Ethical consideration

Prior to the study, written permission was received from the XXXX University Research Ethics Committee Approval (Approval No: 30.04.2020/5207) and the XXXX Ministry of Health COVID-19 Scientific Research Commission (Approval No: 2020 / 20T21). We explained the aim of the research and the way it would be conducted to pregnant women before data collection and received their oral and written consents.

2.5 | Data analysis

We performed all statistical analyses using Statistical Package for the Social Sciences (SPSS) 25.0 software. Kolmogorov Smirnov and Shapiro Wilk tests were used for the determination of normal distribution. For pairwise comparisons, we used Wilcoxon signed-rank test for continuous variables for categorical variables. Distress scores of pregnant women before and during the pandemic were compared with Wilcoxon test. Linear regression analysis was performed to determine the effect of the independent variable (birth type, etc) on the dependent variable (28 total distress point). Binary Logistic regression analysis models and Linear regression analysis were used to determine the prenatal distress risk factors. The results were evaluated using a 95% confidence interval, and $p<0.05$ was considered statistically significant.[30]

3 | RESULTS

The study showed that the mean age of the participants was 29.1±4.93, and almost half of them had a bachelor's degree (43%). Most of the pregnant women lived in the city (64.1%) and had a nuclear family structure (87.2%), and more than half did not work (52.7%). More than half of the pregnant women were primigravida (54.1%), the vast majority were in the third trimester (71.5%). The average gestational week of the participants was 30.09±8.32, and the number of pregnancies was 1.76±8.32 (Table 1).

"Table 1 in here"

84.6% of pregnant women adhered to the COVID-19 regulations, and 39.6% of them needed professional support during the pandemic. Most of them benefitted from the internet as an information source (69.52%), and 42.5% found the information sources regarding the pandemic "sufficient". During the pandemic, pregnant women mostly wanted to get information about the impacts of COVID-19 on the health of pregnant (59.54%) and foetus (67.81%). On average, four out of every five pregnant women (81.2%) stated that they experienced difficulties (decreased social support, finding information suspicious, having to go to the hospital) during the pandemic (Table 2). Two out of every three pregnant women (66.5%) benefited from the "online" source for the COVID-19 pandemic. Before and during the pandemic, 53.3% and 23.4% of the pregnant women reported that they would have a vaginal birth and caesarean section, respectively. 11.3% of them changed their decision on the mode of birth due to the pandemic, and 12% have not yet decided about it (Table 2).

TPDS total score perceived by pregnant women was found to be 17.1±5.87 before the COVID-19 pandemic and 18.71±8.53 during the pandemic, which shows a statistically significant difference (Graphic 1). According to the cut-off point of TPDS, the rate of distress score being at risk (28 points and above) was 4.8% (n=17) before the COVID-19 pandemic, while it was 16.5% (n=58) during the pandemic, and the difference was statistically significant ($p<0.05$) (Table 2). During the COVID-19 pandemic, the total mean score was 42.86±7.39 for the HSBS; 19.58±5.25 for the online health-seeking subscale; 13.51±1.85 for the professional health-seeking subscale, and 9.77±2.61 for the traditional health-seeking subscale (Table 2).

"Table 2 in here"

The comparison of the pre-pandemic and during pandemic TPDS total and subscale mean scores of the pregnant women revealed that during pandemic the "TPDS total and negative affectivity" sub-scale scores increased, and the distress score decreased due to "inadequate partner involvement". The difference between the mean scores was found to be statistically significant (Graphic 1).

Figure 1 in here

It was detected that the increase in the HSBS total score in pregnant women decreased the distress caused by the inadequate "partner involvement" ($p<0.001$ for each). The increase in professional health-seeking behaviour of pregnant women and finding information sources sufficient decreased the "TPDS total score" ($p<0.001$ for each). Not needing professional support was found to reduce the distress of pregnant women caused by "TPDS and negative affectivity" ($p<0.001$ for each). Not adhering to the COVID-19 regulations during pregnancy increased the TPDS total score, that is, the distress of the pregnant woman ($p=0.009$, $p=0.045$, $p=0.034$, respectively). As the age of the pregnant and the number of pregnancies increases, "distress due to inadequate partner involvement" decreased ($p=0.011$, $p<0.001$, respectively). Also, the increase in the education level of the pregnant woman increased the distress due to "negative affectivity" ($p=0.009$).

"Table 3 in here"

The risk of pregnancy distress (28 points and above) in women with a change in the mode of birth during the pandemic was 5.4 times higher than those who preferred vaginal birth before and during the pandemic ($p<0.001$, OR: 5.4 CI: 2.112 - 13.809).

The risk of distress was lower (28 points and above) in pregnant women who did not have a change in their mode of birth preference and in those who did not decide on their mode of birth yet before and during the COVID-19 pandemic ($p=0.001$, OR: 0.241 CI: 0.104-0.558; $p=0.027$, OR: 2.83 CI: 0.093-0.863 respectively). Additionally, in the COVID-19 pandemic, pregnant women who do not need professional support, and those who find information sources sufficient have a lower risk of pregnancy distress (28 points and above) compared to those who do not ($p=0.004$ OR: 0.429 CI: 0.242 - 0.761; $p=0.02$ OR: 0.355, CI: 0.147-0.857, respectively).

"Table 4 in here"

4 | DISCUSSION

This study has revealed that while the COVID-19 pandemic has elevated the distress of pregnant women, the increased health-seeking behaviour (online, professional, and traditional) has reduced their distress due to "inadequate partner involvement". Besides, pregnancy distress risk was found 5.4 times higher in pregnant women who made a change in their mode of birth preferences due to the pandemic than those who preferred vaginal mode of birth before and during the pandemic.

It was seen in the study that the "TPDS total score" and "negative affectivity sub-scale" mean score of the pregnant women were found to be higher during the COVID-19 pandemic than pre-pandemic, and the mean distress score caused by "inadequate partner involvement" decreased ($p<0.001$) (Graphic 1). According to the cut-off point of TPDS, the risky (28 points and above) level of distress of pregnant women increased 4 times during the pandemic compared to the pre-pandemic (Table 2). These two findings of the study support each other and indicate that the pandemic elevates pregnancy distress. TPDS evaluates the anxiety, stress, and depression of pregnant women. Research has shown that the levels of anxiety and depression experienced by

pregnant women during the pandemic are significantly higher than before the pandemic.[13,21,31] The results of the study are consistent with the literature.

In the pandemic, the distress of the pregnant woman varies depending on factors such as the status of adherence to the COVID-19 regulations, the state of accessing and benefiting from the information source, the duration and frequency of lockdown, the socio-demographic, obstetric, and cultural characteristics of the pregnant women, the week of gestation, risk status of pregnancy, the quality of antenatal service in the country, number of children,[6,18,32] pregnant women's coping methods, social support perception, economic status and spousal support.[5,6,9,25,33] The unprevented/untreated trauma of the pregnant woman may lead to the deterioration of the mental health of the pregnant woman and the epigenetic transfer of the trauma to the next generations.[34] Therefore, in the pandemic, it is necessary for healthcare professionals to evaluate the distress level of each pregnant and the associating factors and to provide psychosocial support to those with high distress, and monitor them afterward.[21,24,25,33]

In this study, TPDS "distress due to inadequate partner involvement" sub-scale score was found lower during the pandemic than pre-pandemic period. It is believed that due to the national policies against ongoing pandemic, the pregnant women's partners "working home office" and "flexible working hours" made it possible for couples to "spend more time together at home" and since more than "half of the pregnant women in the study are nulliparous, they do not have to take care of another child at home", which may have contributed to the "reduction of distress" caused by inadequate partner involvement and "positive partner relationship". Evidence suggests that unlike women who have financial difficulties, whose husbands have been laid off during the pandemic process or who have many children,[35,36]partner relationships of those without financial and domestic problems have been positively affected,[7,18,37] noted that pregnant women with poor partner support in the COVID-19 pandemic experienced more anxiety and depression symptoms.

Situations that alarming the society, such as pandemics and disasters, may increase the pregnant woman's desire to be informed about her own and foetus health and the need for professional support, as they cause more distress in the pregnant woman.[8,11,33] In this study, some pregnant women expressed that they wanted to be "informed" about the impacts of COVID-19 on the health of pregnant (59.54%) and foetus (67.81%), that they found the source of information "insufficient" and "needed the support of health professionals (40%)". This finding of the study reveals the unmet "education and care needs and expectations" of pregnant women during the pandemic period. Similarly, in some studies, pregnant women found the counselling of healthcare professionals insufficient about COVID 19,[11] they were not sufficiently informed,[5] so felt neglected by health professionals, and wanted to be given information.[8]

During the pandemic, the concerns of the pregnant about pregnancy-birth-breastfeeding, difficulties in accessing antenatal-innatal-postnatal services can increase the health-seeking behaviour of the pregnant woman.[15,18,31,38] In this study, the health-seeking behaviour of pregnant women in the pandemic was evaluated considering the maximum values of the scale, and it was concluded that pregnant women have above the average "health-seeking behaviour" with the following scores; 42.86±7.39 (max:60) from the total score of HSBS, 19.58±5.25 (max:30) from the online health-seeking subscale, 13.51±1.85 (max:15) from professional health-seeking subscale and 9.77±2.61 (max:15) from traditional health-seeking subscale. A relevant study suggested that the health-seeking behaviour (especially online) in the obstetrics of pregnant women in the second and third trimesters during the pandemic increased.[39] The reason for the pregnant women in this study to have more health-seeking behaviours towards birth and the baby may be because most of them are in the third trimester and their due date approaches. The fact that the traditional health-seeking behaviour of pregnant women is lower than the others suggests that pregnant women may receive more online and professional support and may have remained away from traditional health-seeking behaviours such as "friend support" due to social isolation. It should be kept in mind that exposure of pregnant women to unconfirmed and distorted information about birth may cause them more distress by creating fear.

In the study, it was determined that the increase in health-seeking behaviour (online, professional, and traditional) in pregnant women during the pandemic reduced the distress of pregnant due to inadequate partner involvement ($p<0.001$) (Table 3). This finding of the study suggests that the increase in health-

seeking behaviour in pregnant women may have contributed to the reduction of the distress that would occur as a result of inadequate partner involvement by meeting the needs of pregnant women for the COVID-19 period and pregnancy. In addition, this finding shows that during the lockdown, pregnant women may engage in health-seeking behaviour at home with their partners, which may influence reducing their anxiety. Meeting the information needs of the pregnant woman reduces her distress.[18,35]Parra-Saavedra et al. (2020)[26] observed more anxiety, depression, and fear in pregnant women who were insufficiently informed about COVID 19 than those who were well informed. The first three sources of information in the study were found to be the obstetrician (44.44%), family physician (24.22%), and midwife (20.51%) (Table 2). This finding of our study overlaps with the finding that pregnant women have a mean score of 13 for "professional health-seeking behaviour", which is close to the maximum value 15. This finding indicates that pregnant women see healthcare professionals as their primary source of information during the pandemic. Research has indicated that those with high professional health-seeking behaviour had lower online health-seeking behaviour.[40] In the study, two out of every three pregnant women (69.52%) stated that they benefited from an "online" resource for the COVID-19 outbreak. Similarly, the literature reports that pregnant women have an increased rate of access to information, online, e-health, m-health health-seeking behaviour due to social distance rules.[26,39] An important point to consider is that pregnant women may also be in the behaviour of seeking professional health care to interpret and discuss the information they obtain online.[13]

The pandemic can lead to an increase in anxiety about childbirth and health-seeking behaviour of pregnant women.[8,9,11] In this study, more than half of the pregnant women (54.99%) stated that giving birth during the pandemic would create difficulties for them (Table 2), and they would like to be informed about which mode of birth (vaginal/caesarean section) is beneficial for the health of the "foetus/new-born" (%24.7) and "pregnant women" (33%) (Table 2). Wu et al. (2020) explained that some pregnant women wanted to be informed about birth by health professionals and they preferred home birthing due to fear of virus transmission. In this study, 11.3% of the pregnant had a change in their preference of a mode of birth due to pandemic (from vaginal to caesarean or from caesarean to vaginal), and 12% of them have not yet decided on the mode of birth. In the study by Yassa et al. (2020) in which they examined the birth mode preferences of pregnant women in the COVID-19 pandemic, it was seen that 55.2% did not have a change in their preference, 18% of them thought to change, 26.7% "did not decide yet". In Yassa et al. (2020)[11] 's study, the reason why the thought of changing the birth mode and the indecisive percentage of pregnant women is different from our study may be that the study was conducted when the pandemic was first declared in the world, and there were more uncertainties and concerns about the virus in pregnant women in that period. For pregnant women have not decided on the mode of birth yet, their are and counselling needs should be met, distress should be eliminated, and they supported to make autonomic and conscious decisions about the mode of birth.[33]

If the distress of the pregnant woman cannot be eliminated/prevented in the ongoing pandemic, the birth self-efficacy of the pregnant woman decreases,[5,41] the mode of birth and the place of birth preference may change.[8,10] In our study, the pregnant women who had a change in the mode of birth preference (from vaginal birth to caesarean or from caesarean to vaginal birth)" before and during the COVID-19 pandemic, had a 5.4 times higher risk of gestational distress than those who preferred only vaginal birth before and during the epidemic ($p<0.05$) (Table 4).

The fact that most of the pregnant women in this study were nulliparous in their third trimester may also increase the risk of distress and anxiety about the mode of birth in the pandemic. Moreover, the fact that more than half of the pregnant women prefer vaginal birth (53.3%) and are nulliparous (54.1%), one out of five pregnant women benefit from the midwife as a source of information reveals the importance of antenatal midwifery care services for women to maintain and realize their mode of birth preferences. In Turkey, Cesarean- Section (CS) rate is very high (52%) (TNSA, 2018). Midwives should maintain the midwife-woman relationship and antenatal services (online, tele counselling, etc.), provide the pregnant women with information about pregnancy and child birthing, and promote their self-efficacy and decision-making skills for childbirth.[5,25,41] It is predicted that all these regulations can substantially contribute to the promotion of quality of antenatal care recommended by WHO during the pandemic period and thus increase the positive

pregnancy and childbirth experience.

4.1 | Limitations of the Study

The limited aspect of this study is that the study includes pregnant women who were admitted to only one hospital and low-risk pregnant women over 12 weeks. Furthermore, the majority of the participants were in the third trimester.

5 | CONCLUSION

The pandemic elevates the distress (anxiety, stress, depression) of pregnant women. They would like to be informed about their own and foetal health and birth modes. Increased health-seeking behaviour in pregnant women decreases the distress associated with partner involvement. 11.3% of the pregnant had a change in their preference of a mode of birth due to pandemic.

6 | IMPLICATION FOR PRACTICES

No studies to our knowledge have been conducted so far for this purpose, so it is believed that it will contribute to filling the gap in the literature and shedding light on future studies. During the pandemic period, pregnant women should continue to be given birth preparation training through methods such as tele consultancy and online, and the distress of pregnant women should be reduced by adding modules on "COVID-19 pregnancy and birth" to the content of the birth preparation training. Through the training to be held during the pandemic period, the health literacy skills and the ability to access and use accurate and reliable information sources of pregnant women should be promoted. The internet and web-based obtained information by the pregnant should be discussed by health professionals to ensure that the pregnant woman uses the correct information.

In the midst of the pandemic, health centres should have free "online/tele-counselling lines" and "online/tele psychological support lines" for pregnant women. To protect and promote the bio-psychosocial health and birth self-efficacy of pregnant women, as before the pandemic, uninterrupted healthcare should be provided through both face-to-face and telehealth, e-health, m-health methods, thus midwife / health professional-woman relationship should be maintained. Healthcare service should be 24/7 and free. It is predicted that all these regulations can substantially contribute to the promotion of quality of antenatal care recommended by WHO during the pandemic period and thus increase the positive pregnancy and childbirth experience. It is recommended to conduct this study with a larger population, high-risk pregnant women, mixed research method and follow-up study including birth and the postpartum period.

ACKNOWLEDGEMENTS

The authors wish to especially thank pregnant women who volunteered to participate to study. This study was presented as an oral presentation at the the Current Aspects of Reproductive Health was held in Bulgan, Mongolia on May 5-6, 2021.

CONFLICT OF INTEREST

None of the authors has any conflicts of interest to declare.

FUNDING

No competing financial interests exist

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TABLES

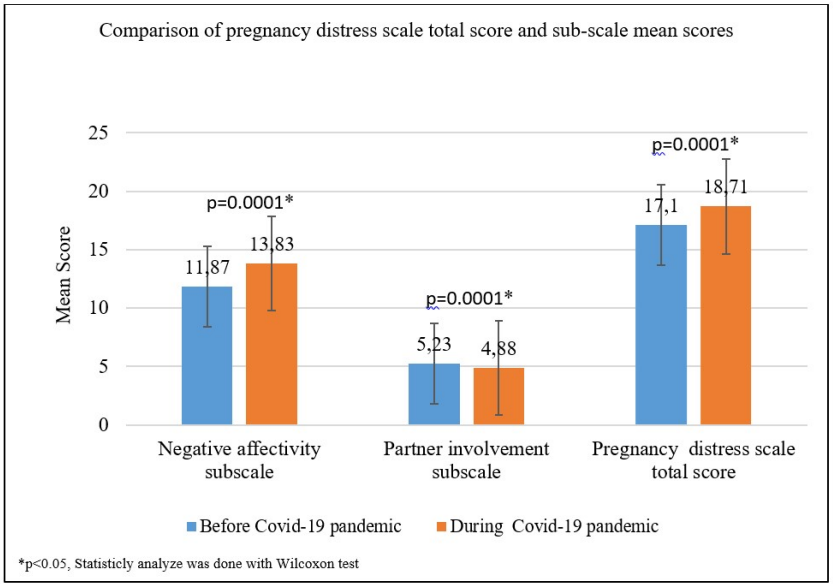
TABLE 1 Distribution of the socio-demographic and obstetric characteristics of pregnant women

TABLE 2 Distribution of attitudes, information sources and needs, Pregnancy Distress Scale (PDS) and Health Seeking Behaviour Scale (HSBS) Mean Scores of pregnant women against COVID-19 pandemic

TABLE 3 Investigation of the effects of health seeking behaviour and some variables on pregnancy distress of pregnant women

TABLE 4 Investigation of the effect of mode of birth preference and some variables on the distress of pregnant women

FİGURE 1 Comparison of pregnancy distress scale total score and sub-scale mean scores according to before and during pandemic period



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