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Pregnant Women's Experiences of Social Isolation and Diminished Social Support During the COVID-19 Pandemic: A Qualitative Study

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Abstract

Objectives: Public health crises can disrupt maternity care and weaken social support networks during pregnancy. This study aimed to explore pregnant women's lived experiences of social isolation and diminished social support during the early phase of the COVID-19 pandemic in Istanbul, Turkey.

Materials and Methods: A qualitative phenomenological study was conducted within an interpretivist framework. Twelve pregnant women residing in Istanbul were recruited using purposive and snowball sampling during April–May 2020. Data were collected through semi-structured, audio-recorded online interviews conducted in Turkish. Interviews were transcribed verbatim and analyzed using reflexive thematic analysis. Coding was performed on the original Turkish transcripts, and selected quotations were translated into English and checked against the source transcripts.

Results: Three main themes and nine subthemes were identified. Concerns about physical health reflected media-related anxiety, perceptions of hospitals as high-risk environments, and disrupted continuity of care. Reconfigured social support described changes in partner support, loss of embodied contact with family and friends, and partial reliance on online support. Coping with isolation and uncertainty included spirituality, home-based activities, and the perception of home as a safe space. Participants experienced isolation not merely as physical separation, but as a disruption of relational security, professional reassurance, and culturally embedded support practices.

Conclusions: Social isolation during pregnancy was shaped by healthcare uncertainty, altered interpersonal relationships, and culturally meaningful coping resources. Crisis-responsive maternity care should preserve continuity with trusted providers, support safe family involvement, and integrate culturally responsive psychosocial resources alongside telehealth services.

Keywords: Pregnancy, Social isolation, Social support, COVID-19, Maternal health services, Qualitative research, Turkey

Introduction

Public health crises profoundly disrupt social networks, with particularly significant consequences for vulnerable populations such as pregnant women (1–3). During pandemics, pregnant women may face compounded challenges, including heightened health-related anxiety, restricted access to antenatal care, and enforced social isolation that weakens family- and community-based support systems. The COVID-19 pandemic exemplified these dynamics on a global scale, as lockdown measures and overburdened healthcare systems created substantial barriers to both maternity care and social connection (4,5).

Social support during pregnancy, including emotional, informational, and instrumental assistance, is critical for maternal well-being and positive birth outcomes. When these support systems are disrupted, pregnant women may experience increased anxiety, depression, loneliness, and uncertainty, with potential consequences for both maternal and child health (5,6). International research conducted during the COVID-19 pandemic has documented elevated levels of depression and anxiety among pregnant women, while consistently identifying social support as a protective factor (7,8). Qualitative studies have similarly reported fear, uncertainty, disrupted maternity care, reduced interpersonal contact, and pervasive emotional distress during the pandemic (9–11).

In the Turkish context, previous studies have shown that pregnant women experienced fear of the unknown, disruptions in routine prenatal care, changes in daily and social life, sadness, stress, and fear during the COVID-19 pandemic. At the same time, support from partners, family members, and friends was perceived as an important coping resource (12,13). Quantitative studies have also reported high levels of anxiety and depression among Turkish pregnant women, particularly in relation to limited partner support, reduced antenatal follow-up, and difficulties accessing healthcare facilities (14,15).

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Key Messages

- This study extends previous COVID-19 pregnancy research by showing that social isolation was experienced not merely as physical separation, but as the loss of familiar family support, intergenerational guidance, and culturally expected forms of care.
- Pregnant women experienced diminished support not only through disrupted social relationships but also through reduced continuity with trusted maternity care providers, perceived hospital risk, and uncertainty within the antenatal care pathway.
- Virtual communication helped maintain contact but was experienced as insufficient; future crisis-responsive maternity care should combine accessible midwife support, trusted provider continuity, safe family involvement, and culturally meaningful psychosocial resources.

Further qualitative findings suggest that mandatory social isolation intensified feelings of loneliness during pregnancy, childbirth, and the early postpartum period, which are normally periods requiring intensive emotional and practical support (16). Studies focusing on the postpartum period similarly indicate that reduced social support, visitation restrictions, economic difficulties, and barriers to healthcare access negatively affected maternal mental health (17,18). In addition, qualitative studies involving pregnant women diagnosed with COVID-19 have shown that women's expectations for support were often unmet because of disruptions in follow-up care, difficulties accessing reliable information, and reduced social interaction (19).

Despite this growing body of evidence, existing studies in Turkey have primarily focused on general pandemic experiences, psychological distress, and access to healthcare services. Social isolation and diminished social support have mostly been addressed as components of broader pandemic experiences rather than as central phenomena of inquiry. Accordingly, relatively few studies have examined in detail how pregnant women experienced, interpreted, and actively managed the weakening of informal support networks within their everyday relationships (12,13,16,19). More broadly, qualitative reviews and quantitative studies indicate that much of the literature on maternal mental health during the COVID-19 pandemic has concentrated on anxiety, depression, and general pandemic-related experiences. In contrast, the lived experience of social isolation and the disruption of informal support networks have received more limited attention (20–22).

This gap is particularly important because reduced social support during pregnancy and the postpartum period has been associated with loneliness, sadness, anxiety, depressive symptoms, and an overall deterioration in maternal mental health (20–23). However, existing studies have more often measured changes in support levels and mental health symptoms than examined how women interpret the loss of support and negotiate this loss within their social relationships (2,5,24). As a result, the relational and social dimensions of pregnancy during public health crises remain insufficiently understood, particularly in the Turkish context.

Social support during pregnancy should be understood not merely as an individual psychological resource, but as a multidimensional and culturally embedded set of practices. These may include emotional reassurance, practical care, family involvement, partner and peer support, guidance from healthcare professionals, traditional rituals, and spiritual coping. Qualitative studies show that emotional, instrumental, and informational support from extended family members, friends, partners, midwives, nurses, and culturally meaningful practices shapes women's pregnancy experiences and facilitates coping with stress (24–27). Therefore, understanding how the loss or weakening of these multilayered support structures was experienced during the pandemic, and how pregnant women attempted to compensate for this loss, is critical for developing culturally sensitive and relationship-centred maternal care strategies in future public health emergencies.

This study explores pregnant women's lived experiences of social isolation and diminished social support during the COVID-19 pandemic in Istanbul, Turkey. Three research questions guided the inquiry: (1) How did pregnant women experience social isolation during a public health crisis? (2) How did they perceive changes in their social support networks during the pandemic? and (3) What coping strategies did they employ when traditional support systems were disrupted? By adopting a phenomenological approach focused specifically on social isolation and disrupted support systems, this study aims to deepen understanding of the relational dimensions of pregnancy during public health crises and to contribute to the evidence base for culturally responsive maternal health policy.

Methods

Study Design

This study employed a qualitative phenomenological design within an interpretivist epistemological framework to explore how pregnant women made sense of social isolation and diminished social support during the COVID-19 pandemic. Phenomenology was selected because it enables an in-depth exploration of how individuals interpret and give meaning to their lived experiences (28). The study is reported in accordance with the Standards for Reporting Qualitative Research (SRQR) (29).

Setting

The study was conducted in Istanbul, Turkey, during April–May 2020, a period marked by strict COVID-19-related public health restrictions. During this period,

pregnant women faced restricted hospital access, mandatory COVID-19 testing before admission, visitor limitations, and reduced opportunities for in-person antenatal consultations. Istanbul is a large metropolitan city with substantial socioeconomic and residential variation; however, district-level differences within Istanbul were not systematically examined in this study.

Participants and Recruitment

Participants were pregnant women residing in Istanbul, Turkey, during the COVID-19 pandemic. Eligible participants were aged 18 years or older, able to communicate in Turkish, and willing to participate in audio-recorded interviews. Women with serious health conditions that could affect communication were excluded.

Participants were recruited using purposive and snowball sampling. Purposive sampling was used to identify pregnant women who were experiencing pandemic-related stay-at-home restrictions and disruptions to routine social contact. Snowball sampling was then used to reach additional participants through referrals. Twelve women participated in the study. Their gestational age ranged from 12 to 36 weeks (mean 23.4 weeks), and their age ranged from 23 to 32 years (mean 26.7 years). Participant characteristics, including employment status, education level, and parity, are presented in Table 1.

In this qualitative phenomenological study, sample size was determined by considering information power, experiential depth, and thematic redundancy. According to the concept of information power, the more relevant information a sample provides in relation to a narrowly defined study aim, the fewer participants are required to achieve sufficient analytic depth (30). Given the focused research aim, the specificity of the participant group, and the richness of the interview accounts, the sample was considered to provide adequate information power. Previous methodological research has also suggested that relatively small samples may be sufficient in focused qualitative studies when rich experiential accounts are obtained (31). Data collection and analysis were conducted concurrently, and recruitment ceased after the 12th interview, when sufficient experiential depth and thematic redundancy had been achieved. At this stage, additional interviews were not expected to contribute substantial conceptual richness to the analysis.

Data Collection

Because of pandemic restrictions, interviews were conducted via secure online video-conferencing platforms at times convenient for the participants. Each interview lasted approximately 25–30 minutes and was conducted in Turkish. Before each interview, participants were asked to confirm that they were in a private and comfortable setting where they could speak freely.

A semi-structured interview guide was developed based on the relevant literature and the study objectives. The interview guide included open-ended questions and prompts addressing four domains: experiences of social isolation during pregnancy; perceived changes in support from partners, family members, friends, and healthcare professionals; experiences related to healthcare access during the pandemic; and coping strategies for managing uncertainty and emotional distress. Example questions included: "How did the pandemic affect your daily social interactions during pregnancy?", "What changes did you experience in the support you received from people around you?", "How did the pandemic affect your access to pregnancy-related care?", and "How did you cope when your usual sources of support were reduced?"

Although the online format was necessary due to pandemic-related restrictions, efforts were made to foster rapport by allowing participants to choose a convenient interview time, confirming privacy before the interview began, and using a conversational, participant-led interview style. Remote interviewing may have limited the observation of non-verbal cues and may have influenced the depth of disclosure. However, it also enabled women to participate safely from their own homes during a period of strict public health restrictions. It may have facilitated discussion of sensitive experiences in a familiar environment.

Table 1. Participant Characteristics (N=12)

Participant	Gestational age (wk)	Age (y)	Employment	Educational level	Parity
1	20	32	Employed	High school	Multiparous
2	25	28	Employed	Bachelor's	Multiparous
3	26	26	Unemployed	High school	Multiparous
4	30	26	Employed	Bachelor's	Multiparous
5	24	30	Employed	Bachelor's	Multiparous
6	16	26	Employed	Bachelor's	Primiparous
7	18	23	Unemployed	High school	Primiparous
8	26	26	Employed	Bachelor's	Primiparous
9	12	23	Unemployed	Bachelor's	Primiparous
10	18	24	Employed	Bachelor's	Primiparous
11	36	30	Employed	Bachelor's	Multiparous
12	30	26	Employed	Bachelor's	Primiparous

All interviews were audio-recorded with informed consent and transcribed verbatim by the research team within one week of completion. Field notes were taken during and immediately after each interview to capture contextual details and observable interactional cues within the limits of the online format. The transcripts were anonymized before analysis to ensure confidentiality.

Researcher Reflexivity

The interviews were conducted by the first author, an experienced midwife with more than ten years of clinical experience in maternal health. This professional background facilitated empathetic communication and familiarity with pregnancy-related concerns, which may have encouraged participants to speak openly about sensitive experiences. At the same time, the research team remained aware that the interviewer's professional identity, clinical experience, and shared disciplinary assumptions could shape the interview process, the interpretation of participants' accounts, and the construction of themes.

To address this, the first author maintained a reflexive journal after each interview to document personal assumptions, impressions, and potential sources of bias. Analytic memos and regular analytic discussions within the research team were used throughout the analytic process to critically examine emerging interpretations. To strengthen trustworthiness, the study used reflexive journaling, analytic memos, regular analytic discussions within the research team, and maintenance of an audit trail documenting analytic decisions. These strategies supported analytic transparency and helped ensure that interpretations remained grounded in participants' accounts. No prior relationship existed between the researchers and participants.

Data Analysis

Data were analyzed using reflexive thematic analysis as described by Braun and Clarke (32). NVivo 12 qualitative data analysis software was used to support data management and coding.

The analytic process involved repeated reading of the transcripts, field notes, and reflexive journal entries to support familiarization with the data. Coding was primarily semantic and inductive, with codes generated directly from participants' accounts rather than from a pre-existing theoretical framework. Initial codes were iteratively refined throughout the analytic process. Candidate themes and subthemes were then developed through repeated examination of patterns of meaning across the dataset and organization of related codes into an initial thematic structure.

Themes were reviewed and refined through ongoing comparison with the transcripts and regular discussions within the research team to ensure conceptual coherence, internal consistency, and analytic clarity. The final themes were defined, named, and supported with illustrative participant quotations. Detailed information regarding the six phases of reflexive thematic analysis applied in this study is provided in Supplementary file 1.

Coding was conducted directly on the original Turkish transcripts to preserve the emotional, cultural, and contextual nuances of participants' expressions. Participant quotations included in the manuscript were translated into English by the research team for publication purposes. To preserve meaning and contextual accuracy, the translated quotations were reviewed collaboratively and checked against the original transcripts during data analysis and manuscript preparation.

Results

Twelve pregnant women participated in the study. Participants' ages ranged from 23 to 32 years (M = 26.6), and gestational age ranged from 12 to 36 weeks (M = 23.4). Nine participants (75.0%) were employed, and most had a bachelor's degree (n = 9, 75.0%). Seven participants (58.3%) were primiparous, and five (41.7%) were multiparous. Complete participant characteristics are presented in Table 1.

Three main themes and nine sub-themes were identified to describe pregnant women's experiences during the COVID-19 pandemic. These themes, along with their corresponding sub-themes and descriptions, are summarized in Table 2.

Theme 1: Concerns about Physical Health

Physical health concerns were not limited to infection-related anxiety; they were embedded in participants' perceptions of a rapidly changing healthcare environment that they experienced as uncertain and potentially risky. Media narratives, local reports of infection, changes in hospital organization, and disruptions in continuity of care contributed to a heightened sense of maternal and fetal vulnerability.

Subtheme 1.1: Media Exposure

Pandemic-related media coverage intensified participants' perceptions of risk, particularly among those preparing mentally for birth and the postpartum period. For Participant 4, a multiparous woman at 30 weeks of gestation, news about maternal and neonatal deaths was interpreted as personally relevant and emotionally distressing rather than as distant public health information: "*Lately, I saw on the news that there was a pregnant woman in Kocaeli... After she passed away, her child died two or three days after her. When I heard it, I was deeply affected... I was obviously more focused on pregnant women and babies during this period.*" (Participant 4, 30 weeks)

This perception of risk became more immediate when infections were reported in participants' local surroundings. Participant 10, a primiparous woman at 18 weeks of gestation, described how hearing about COVID-19 cases in her neighborhood intensified her

Table 2. Themes, Subthemes, and Descriptions

Theme	Sub-theme	Description
1. Concerns about Physical Health	1.1. Media exposure	Media reports increased anxiety, especially regarding risks to pregnant women and unborn babies.
	1.2. Hospital environment	Hospitals were perceived as high-risk spaces, leading to avoidance and increased stress.
	1.3. Disrupted continuity of care	Limited access to doctors increased anxiety, while midwives were seen as supportive and trustworthy.
2. Reconfigured Social Support	2.1. Partner support	Partners provided emotional support, although this varied depending on working conditions.
	2.2. Family and friends	Lack of physical contact with loved ones caused emotional distress despite virtual communication.
	2.3. Online support	Online platforms served as alternative support systems and sources of information.
3. Coping with Isolation and Uncertainty	3.1. Spirituality	Spiritual practices provided comfort and emotional relief.
	3.2. Home-based activities	Home-based activities helped manage stress, but could not replace outdoor experiences.
	3.3. Feeling safe at home	Home was perceived as a safe space, sometimes leading to consideration of alternative birth options.

anxiety: "*When I heard that someone had Coronavirus in our neighborhood... I was very, very worried when one or two buildings were next to each other.*" (Participant 10, 18 weeks)

Subtheme 1.2: Hospital Environment

During the pandemic, hospitals were often perceived not only as places of care but also as potential sources of infection. This perception contributed to hesitation about seeking in-person care. For Participant 1, a multiparous woman at 20 weeks of gestation, fear of infection extended even to the anticipated birth process: "*I prefer to avoid going to the hospital as much as possible, because there are COVID patients... I don't even want to go during the birth process.*" (Participant 1, 20 weeks)

Organizational changes within hospitals also increased uncertainty. For Participant 12, a primiparous woman at 30 weeks of gestation, the relocation of the maternity ward reduced her sense of predictability regarding the birth environment: "*The maternity ward has been relocated... I don't know what awaits me right now... it's kind of stressing me out.*" (Participant 12, 30 weeks)

Subtheme 1.3: Disrupted Continuity of Care

Continuity of care emerged as an important source of reassurance during the pandemic. For Participant 11, a multiparous woman at 36 weeks of gestation, the sudden absence of her regular physician was a major source of anxiety. As she approached birth, the loss of a familiar provider weakened her sense of safety: "*I suddenly found out that my doctor was on leave. I used to see my doctor, and that made me feel safer. This situation is the biggest factor increasing my anxiety.*" (Participant 11, 36 weeks)

In contrast, accessible professional support helped some participants manage uncertainty. Midwives were described as trusted sources of information and reassurance within a disrupted healthcare system. For Participant 7, a primiparous woman at 18 weeks of gestation, the midwife represented a reliable professional figure: "*A midwife knows everything... at least I can trust without hesitation.*" (Participant 7, 18 weeks)

In participants' accounts, midwives were positioned not only as sources of clinical information but also as trusted figures who helped restore a sense of reassurance within an uncertain care environment.

Theme 2: Reconfigured Social Support

Participants' accounts showed that social support during the pandemic was not experienced as uniformly reduced or preserved. Rather, support was reconfigured according to household arrangements, partners' availability, physical separation from extended family, and access to digital communication. Although some women described increased emotional closeness within the home, others experienced a sharper sense of loneliness when usual sources of support were physically unavailable.

Subtheme 2.1: Partner Support

Stay-at-home restrictions altered the domestic support environment by increasing the amount of time some participants spent with their partners. For several women, this was experienced as a source of emotional closeness and helped make the period of isolation more manageable. Participant 2, who was 25 weeks pregnant, described how her partner's presence reduced the emotional difficulty of staying at home: "*Being at home would be very depressing without him... we watched movies or did things together. We couldn't do things like that before.*" (Participant 2, 25 weeks)

However, partner support was shaped by partners' work obligations. Participants whose partners continued to work outside the home, particularly in duty-based roles, described feeling more alone during moments of physical discomfort or uncertainty. Participant 9, who was 12 weeks pregnant, described being alone at home while experiencing abdominal cramping: "*I had such a cramp in my stomach. I'm the only one in the house... My husband*

is already on duty... There is no one with me anyway." (Participant 9, 12 weeks)

These accounts indicate that partner support was experienced in contrasting ways. For some participants, the partner's presence became a central source of emotional support; for others, the partner's absence during work duties intensified the sense of being unsupported at home.

Subtheme 2.2: Family and Friends

Physical distancing also changed participants' relationships with family members and friends. Although communication could continue through telephone or video calls, participants often described this contact as insufficient compared with in-person presence. For Participant 1, who was 20 weeks pregnant, the inability to visit her father was particularly distressing because he lived nearby but remained physically inaccessible during the restrictions: "*Not being able to see my parents… I don't have my mother; she passed away… My father lives nearby—there are only two streets between us; we are very close*." (Participant 1, 20 weeks)

This account illustrates how geographical closeness did not necessarily translate into perceived support when physical contact was restricted. The loss of ordinary family contact was experienced not only as reduced interaction but also as emotional separation from familiar sources of comfort.

Participants also described limits to digital communication. Participant 2, who was 25 weeks pregnant, expressed that video calls did not feel equivalent to real social interaction: "*I don't even want to talk on the video call, sometimes... it's not like it's real. It's like you're acting*." (Participant 2, 25 weeks)

For this participant, video communication allowed contact to continue but did not fully replace the sense of authenticity and closeness associated with face-to-face interaction.

Subtheme 2.3: Online Support

In the context of reduced in-person support, some participants turned to online and telephone-based networks for information, reassurance, and practical advice. These networks included family messaging groups, friends, and acquaintances with healthcare knowledge. Participant 8, who was 26 weeks pregnant, described using both family-based and informal professional networks to seek support: "*We have our own groups… I get support from my family… My close friends are already healthcare workers, and I ask them even the smallest questions*." (Participant 8, 26 weeks)

For some participants, online support therefore served as a partial substitute for disrupted face-to-face support. It appeared particularly useful for obtaining information and reassurance; however, as reflected in the accounts above, digital contact did not fully replace the emotional comfort of in-person relationships.

Theme 3: Coping with Isolation and Uncertainty

Participants described several ways of managing the emotional strain associated with social isolation, uncertainty, and reduced access to usual sources of support. These strategies included turning to spiritual practices, engaging in home-based activities, maintaining daily routines where possible, and redefining the home as a place of safety. Although these strategies did not eliminate participants' concerns, they helped some women create moments of reassurance and emotional stability during the pandemic.

Subtheme 3.1: Spirituality

Some participants described spiritual practices as an important source of emotional relief. Prayer, reading the Qur'an, and turning toward spirituality helped them manage fear and uncertainty during pregnancy. Participant 4, a multiparous woman at 30 weeks of gestation, described spirituality as a way of finding inner peace during the pandemic: "*I can say that I was more spiritual... I found inner peace by praying, reading the Qur'an, and turning to spirituality*." (Participant 4, 30 weeks)

Her account indicates that spiritual practices provided a personally meaningful way of coping with anxiety and helped her regain a sense of calm in a period marked by uncertainty.

Subtheme 3.2: Home-based Activities

Participants also described using home-based activities to structure their days and manage the psychological effects of isolation. These activities included reading, cooking, caring for pets, and engaging in domestic routines. Participant 9, a primiparous woman at 12 weeks of gestation, described everyday activities at home as part of how she spent time during the restrictions: "*I read books during the day... I have my cat... I'm cooking and doing things at home*." (Participant 9, 12 weeks)

For some participants, however, home-based activities did not fully compensate for the loss of outdoor routines. Walking outside, particularly in the open air, was described as a valued activity that became restricted during the pandemic. Participant 4, a multiparous woman at 30 weeks of gestation, expressed frustration about being unable to continue walking with her husband: "*I wanted to go out... but it is not possible right now. We usually love to walk in the fresh air with my husband*." (Participant 4, 30 weeks)

This account shows that coping was not limited to finding activities within the home. Participants also experienced the loss of familiar outdoor routines as a disruption to their usual ways of maintaining well-being during pregnancy.

Subtheme 3.3: Feeling Safe at Home

For some participants, the home was experienced not only as a place of restriction but also as a place of protection.

Staying at home reduced perceived exposure to infection and created a sense of safety, particularly when the outside environment was associated with vulnerability. Participant 4, who had previously been working, described being at home as both restful and protective: "*When I was working, I was missing being at home and my bed to have a rest... You feel safe at home rather than vulnerable outside.*" (Participant 4, 30 weeks)

This sense of domestic safety also appeared in relation to thoughts about childbirth. Participant 9, a primiparous woman at 12 weeks of gestation, described searching for information about home birth during the pandemic: "*Nowadays, I search for birth at home... I wish such a thing were done... it would be much better if it was at home.*" (Participant 9, 12 weeks)

Her account suggests that the perception of home as a safer environment could extend beyond everyday life and shape how some participants imagined childbirth during the pandemic.

Discussion

This study provides a phenomenological account of how pregnant women in Istanbul experienced social isolation and diminished social support during the early phase of the COVID-19 pandemic. The findings indicate that isolation was not limited to reduced physical contact; rather, it was experienced at the intersection of health-related uncertainty, perceived disruption in maternity care, altered interpersonal support, and efforts to regain emotional stability. In this sense, social isolation emerged as a multidimensional phenomenon shaped simultaneously by concerns about physical health, reconfigured social support, and culturally embedded coping strategies.

Consistent with previous research, participants reported heightened psychological vulnerability during the pandemic (7,33). However, the present findings add qualitative depth by showing that this vulnerability was closely connected to specific contextual conditions, including media-driven fear, local reports of infection, perceptions of hospitals as unsafe environments, and uncertainty surrounding access to familiar healthcare providers. These findings suggest that pregnant women's experiences of isolation during a public health crisis are shaped not only by fear of infection itself, but also by the disruption of the relational and institutional structures that ordinarily support pregnancy.

Concerns about physical health were also strongly linked to perceptions of healthcare safety. Hospitals were frequently viewed as high-risk environments, and changes in routine maternity services intensified uncertainty. Similar patterns have been reported in both high- and low-resource settings, where fear of infection was associated with reduced engagement with antenatal services (9,34). These findings suggest that the hospital environment was experienced not only as a site of clinical care but also as a space associated with uncertainty, possible exposure, and reduced predictability.

Disrupted continuity of care was also experienced as a key dimension of perceived support. The findings show that pandemic-related isolation was co-constructed by interpersonal separation and disruption within maternity care systems. This supports the interpretation that isolation during pregnancy should not be understood merely as a social condition, but also as a care-related and embodied experience (2,35,36). The pandemic disrupted not only where women could go and whom they could see, but also how safe, supported, and accompanied they felt within the maternity care pathway.

Beyond structural barriers, the loss of contact with known and trusted providers—particularly gynecologists—was distressing, whereas some participants perceived midwives as more accessible and reassuring. These findings underline the importance of continuity-based maternity care. Rather than positioning doctors and midwives in opposition, the results point to the need for coordinated care models that preserve clinical expertise, relational trust, and professional availability. This is particularly important during public health emergencies, when service disruption may intensify women's uncertainty and weaken their sense of safety.

Changes in social support networks were associated with diminished emotional and practical support during pregnancy. This reduction was particularly evident in support from extended family and friends, which appeared to decline because of distancing measures. In contrast, partner support was often maintained or, in some cases, strengthened. The findings also suggest that pandemic restrictions did not produce a uniform reduction in support; rather, the meaning and availability of support depended on household arrangements and partners' work obligations. Partner support during public health restrictions appeared to be contingent not only on relationship quality but also on structural conditions such as employment demands and physical presence.

Support from extended family and friends was often reduced because of distancing measures. This finding aligns with prior research reporting disruptions to traditional support structures during the pandemic (2,36). Importantly, the findings suggest that different forms of support were not fully interchangeable. Although informational and practical support could be partially sustained through digital communication, the emotional reassurance associated with physical presence was more difficult to replicate. This is consistent with emerging evidence suggesting that virtual support may help maintain communication but cannot fully replace embodied relational contact (35,37).

The cultural context of the present study is important for interpreting these findings. Much of the qualitative literature on pregnancy during the COVID-19 pandemic has been produced in Western settings, where social support is often discussed in relation to partner

involvement, professional care, and digitally mediated peer networks (21,36,37). In contrast, pregnancy in Turkey is commonly embedded within broader familial and intergenerational relationships, including support from mothers, mothers-in-law, sisters, relatives, and close neighbours (25,38,39). Within this culturally relational context, pandemic-related distancing measures did not merely reduce social contact; they disrupted a culturally expected network of embodied care, practical assistance, emotional reassurance, and intergenerational guidance. This may explain why participants described virtual communication as insufficient despite continued contact through digital platforms. The loss of face-to-face family involvement was therefore experienced not only as interpersonal separation, but also as a disruption of culturally familiar ways of being supported during pregnancy (25).

The account that virtual communication sometimes felt "like acting" provides an important phenomenological insight into the nature of support during pregnancy. Pregnancy is not experienced only as a psychological or social state, but as an embodied condition in which vulnerability, reassurance, fear, and care are lived through the body (40,41). From this perspective, support is conveyed not only through verbal reassurance or informational exchange, but also through physical presence, touch, shared space, eye contact, and the felt availability of others.

Theoretically, these findings extend social support theory by showing the limited substitutability of support types during pregnancy. Drawing on House's distinction between emotional, instrumental, informational, and appraisal support (42,43), the findings suggest that informational support was most easily transferred to digital platforms. In contrast, embodied emotional support, practical assistance from extended family, and appraisal support from trusted healthcare providers were more difficult to replace (44,45). From an interpretivist phenomenological perspective, this matters because support was experienced not simply as contact or information, but as a lived form of relational security (40,46). Thus, digitally mediated or substitute support may preserve communication, but it cannot fully reproduce the embodied, practical, and trust-based qualities of maternity support (40,41).

Participants also described several coping strategies in response to disrupted support systems. Spirituality emerged as an important coping resource for some participants, providing emotional comfort, facilitating meaning-making, and fostering a sense of inner stability. In the Turkish context, coping appeared to be shaped in part by Islam-informed practices such as praying and reading the Qur'an, which participants described as providing emotional comfort, facilitating meaning-making, and fostering a sense of inner stability during heightened uncertainty (47–49). These findings suggest that coping was not limited to individual psychological strategies but was also shaped by culturally and religiously meaningful practices. While previous studies have highlighted coping strategies such as maintaining routines, seeking information, and using digital platforms (37,50), the prominent role of spirituality in the present study underscores the importance of culturally embedded coping resources during public health crises.

In addition, participants engaged in home-based activities such as reading, cooking, and caring for pets, while the home itself was often perceived as a space of safety and protection. Coping during isolation involved both adaptation and loss. While some women created new routines within the home, they also experienced frustration when familiar health-promoting or emotionally restorative activities were restricted. In this sense, hobbies and domestic activities should be understood not simply as distractions, but as part of women's efforts to preserve continuity, agency, and emotional balance during an uncertain period.

The meaning attached to home also contributed to women's coping and birth-related thinking. Interest in home birth appeared not as an abstract preference, but as a situated response to perceived risks of hospital-based care, including fear of infection, uncertainty about service changes, and anticipated separation from familiar support networks (34,51). Although the present study does not evaluate the safety or feasibility of home birth, these accounts suggest that birthplace considerations during the pandemic were shaped by the interaction between infection-related fears and the loss of relational support within institutional maternity care (35,52). Future maternity care models should therefore seek to preserve the psychological and relational qualities associated with home while maintaining clinical safety. Home-like birth environments, hybrid antenatal care pathways, and continuity-based midwifery models may be particularly relevant in preparing maternity services for future public health emergencies (36,51). The findings are also relevant beyond the Turkish context. In Turkey, as in many societies characterized by strong family involvement, pregnancy is often embedded within close relational networks that provide emotional, practical, and culturally meaningful support. The disruption of these networks during the pandemic may therefore have had particularly significant consequences for women's well-being. Although grounded in the Turkish context, these findings may also be relevant to other societies in which pregnancy is embedded within strong familial and intergenerational support networks. In this respect, the findings are consistent with studies reporting increased maternal anxiety, disrupted care, and reduced support during COVID-19 restrictions (8,9,33,37). At the same time, this study contributes a context-specific perspective by showing how social isolation was shaped through both cultural expectations of connectedness and the restructuring of maternity care during a public health crisis.

The findings of this study have important implications for maternity care, public health preparedness, and culturally responsive support during future crises. First, social isolation during pregnancy should be understood not merely as reduced physical contact, but as a disruption of relational security, care continuity, embodied support, and culturally embedded assistance. Emergency-responsive antenatal care pathways should therefore preserve regular contact with trusted providers, provide clear information about service changes, and identify women with heightened anxiety, uncertainty, or reduced support. Second, digital and telehealth-based services should not be designed solely as channels for clinical information. Hybrid models that combine safe face-to-face contact, relational telehealth, partner or family involvement where feasible, and structured psychosocial referral pathways may better address women's support needs. Third, culturally responsive maternity care should acknowledge extended family involvement, spiritual coping resources, and the meaning attached to home during periods of restriction. Women's interest in home birth during the pandemic should therefore be interpreted not simply as a preference for birthplace, but as an expression of the need for safety, familiarity, continuity, and relational support within clinically safe, woman-centred care.

Strengths and Limitations of the Study

This study has several strengths. Its phenomenological design enabled a detailed exploration of women's lived experiences and addressed an important gap in a literature often dominated by quantitative approaches. By focusing on Istanbul, Turkey, the study contributes evidence from a relatively underexplored non-Western context. It offers insight into how social isolation and support disruption were experienced within a culturally relational setting. In addition, the study examined not only distress but also women's adaptive responses, thereby providing a more comprehensive understanding of pregnancy during a public health crisis.

Several limitations should also be considered. All participants were recruited from Istanbul during the early phase of the COVID-19 pandemic, when uncertainty, restrictions, and public fear were particularly intense. Experiences of social isolation and support may therefore have differed in later phases of the pandemic or in settings with different healthcare systems, family structures, or sociocultural conditions. The study employed purposive and snowball sampling via digital networks during a period of strict pandemic restrictions, which may have contributed to a relatively homogeneous demographic profile. Reliance on digital platforms for recruitment and interviewing may also have inadvertently excluded women from lower socioeconomic backgrounds, those with limited digital literacy, or those living in less digitally connected settings. Consequently, the findings may not fully capture the experiences of more socioeconomically marginalized pregnant women whose access to healthcare and social support networks may have been more restricted.

Conducting interviews online enabled safe data collection during the pandemic and may have enhanced participants' comfort speaking from their homes. However, the online format may also limit observation of non-verbal communication and affect rapport development or the depth of interaction in some interviews. In addition, interviews were conducted during an ongoing period of heightened uncertainty and emotional stress, which may have influenced how participants interpreted and narrated their experiences. As with all qualitative research, the findings reflect subjective accounts situated within a specific temporal, cultural, and healthcare context and should therefore be interpreted in terms of transferability rather than statistical generalizability.

Conclusions

This study shows that social isolation during pregnancy in the early phase of the COVID-19 pandemic was experienced as a complex phenomenon shaped by healthcare uncertainty, disrupted interpersonal support, and culturally embedded coping resources. Future maternity care and public health preparedness strategies should therefore protect not only access to clinical care, but also relational continuity, safe family involvement, and culturally meaningful forms of support during periods of restriction.

Authors' Contribution

Conceptualization: Filiz Okumuş, Sayra Lotfi.
Data curation: Filiz Okumuş, İffet Güler-Kaya.
Formal analysis: Filiz Okumuş, Sayra Lotfi.
Investigation: Filiz Okumuş, İffet Güler-Kaya.
Methodology: Filiz Okumuş, Sayra Lotfi.
Project administration: Filiz Okumuş.
Resources: Filiz Okumuş, İffet Güler-Kaya.
Software: Filiz Okumuş, İffet Güler-Kaya.
Supervision: Sayra Lotfi, Filiz Okumuş.
Validation: Filiz Okumuş, Sayra Lotfi.
Visualization: Filiz Okumuş, Sayra Lotfi.
Writing–original draft: Filiz Okumuş, Sayra Lotfi.
Writing–review & editing: Filiz Okumuş, Sayra Lotfi, İffet Güler-Kaya.

Conflict of Interests

Authors declare that they have no conflict of interests.

Ethical Issues

This study was approved by the researchers' institutional ethics committee (Date: 30/04/2020; Approval No: 10840098-604.01.01-E.14683) and by the COVID-19 Research Assessment Commission of the Turkish Ministry of Health. Verbal informed consent was obtained, and the interviews were audio-recorded. Participants were informed about the study purpose, voluntary participation, the right to withdraw, and confidentiality measures. Pseudonyms were used, and all data were handled confidentially.

Supplementary files

Supplementary file 1. The six phases of reflexive thematic analysis as applied to this study

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