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Becoming a Mother During COVID-19

Adjustments in Performing Motherhood

Clémence Jullien and Roger Jeffery

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Abstract

Based on online semi-structured interviews with middle-class women who were pregnant or had recently given birth in Western Europe (France, Spain, the United Kingdom, and Switzerland), this study analyses how motherhood has been experienced and performed during the COVID-19 pandemic. The article reflects on the specific new risk assessments and responsibilities that emerged during the pandemic by showing women's coping strategies concerning lockdowns and other public health measures. Using a COVID-19 lens also allows a broader analysis of middle-class families' concerns about performing 'good motherhood'. By highlighting the discrepancies between women's expected and actual experiences, the prescriptive aspects of pregnancy, delivery, and the postpartum phase are revealed and analysed, prompting us to consider parenting as a form of doing and proving. By underlining the importance attached to the expectant mother's wellbeing, the partner's involvement, the support of relatives, and the future socialisation of the baby, we argue that women face a myriad of imperatives to ensure a meaningful experience of motherhood.

Keywords

COVID-19, Responsibility, Motherhood, Performance, Family ties.

Introduction

What is missing is this idea of the community part, of meeting for real, the fact of meeting with the babies and saying, 'this happened to me'. I think that, beside the experience of the labour, this is what has made the biggest difference [when compared to my expectations]. Sharing this experience of parenting with other mothers and friends, even if they don't have children (Martina, Spain, administrative professional, 36, no other children).

Since 2020, the COVID-19 pandemic has amplified many existing dynamics of power and social relations and has also shed light on how motherhood is performed. At the beginning of the pandemic, media highlighted the virus as being of particular risk to pregnant women and their babies. While the findings on the risks of viral transmission during pregnancy or childbirth were often inconclusive, such concerns reinforced several well-established ideas about the uncertainties of pregnancy and delivery and how to deal with them. While leading to the identification of pregnant women as a vulnerable category of people, constraints imposed by the COVID-19 pandemic also displayed the 'pathologisation process where birth can never be imagined to be normal until it is over' (Scamell and Alaszewski 2012, 219). Less often attended to was how the pandemic affected the 'social side' of pregnancy, such as couple relationships, and babies' integration into family and friendship networks. The most striking aspect of this study, based on testimonies from expectant middle-class heterosexual parents in Western Europe, is probably the variety of injunctions mothers took into consideration to prove their sense of responsibility and embody motherhood. This article reflects on the embodiment of good parenting and also focuses on understanding how the COVID-19 pandemic provides a pertinent lens through which to grasp the significance of such injunctions. This study thus uses COVID-19's disruptive context to analyse middle-class mothers' concerns about performing 'good parenting'—as well as how pregnancy, childbirth, and early contact with the new baby contribute to performing 'family'.

Amplifying risk management

As the sociology of risk (Giddens 1990; Beck 1992) and parenting studies (Furedi 2002; Faircloth 2013; Lee et al. 2014) shows, risk consciousness became pervasive by the end of the 20th century. With the growth of neoliberal ideas and the emergence of 'parental determinism', parents are expected to be 'entrepreneurial individual[s]', who are 'responsible' for helping their children develop as 'good' citizens' (Geinger et al. 2014, 489). In 'normal' times, 'the liberal governance of pregnancy mobilizes a discourse of risk, and risk prevention and reduction, that enlists the co-operation of the "responsible" pregnant woman' (Ruhl 1999, 95).

The COVID-19 pandemic offers an optimal context in which to reflect on the distinctions between risk consciousness, the regulation of prenatal care, and the idea of good citizenship in neoliberal times. COVID-19 has heightened the paradox according to which expectant parents—and particularly expectant mothers—are autonomous individuals responsible for the good health of their baby, yet simultaneously citizens expected to follow the advice of political and medical experts (Lupton 2012; Chadwick and Foster 2014), and who are increasingly relying on obstetrical biotechnologies such as ultrasound scans, foetal monitoring, caesarean sections or epidurals (Davis-Floyd 2001; Coxon, Sandall, and Fulop 2014). COVID-19 has encouraged maternity services to extend their responsibility for the assessment, management, and prevention of risks (Mitchell and McClean 2014); simultaneously, however, authorities have focused on the individual in the self-management of epidemiological risk (Giritli Nygren and Olofsson 2020). Knowing that recommendations made by public health agencies early on in the COVID-19 pandemic were often both changeable and ambiguous, deciding what measures should be followed in order to best protect their baby became an even greater challenge for parents.

North American research shows that such concerns tend to be more prevalent among middle-class pregnant women. These women often try to manage the process of pregnancy as a part of exercising control over their lives (Lazarus 1994) and to refer to their delivery experience as a personal achievement (Martin 1990). As Ruhl (1999, 104–5) puts it, middle-class, well-educated women are most likely to endorse the individualised risk model of pregnancy and birth.

Revealing the ‘social part’: Performing motherhood

Like other radical disruptions to everyday life such as earthquakes and forced migration (Ivry, Takaki-Einy, and Murotsuki 2019; Lowe 2019), using a COVID-19 lens helps to highlight less visible dynamics that not only mainly pass unnoticed in academic discussions of ‘normal times’, but also do not attract attention from the media. For instance, in Europe and the United States, where motherhood is considered highly medicalised and institutionalised, the anthropological study of reproduction has focused on ‘medicalization, technologization and disruption’ (Han 2013, 172), neglecting ‘ordinary pregnancies’. Unsurprisingly, during the COVID-19 pandemic, public debates were focused on the possible impact of the virus on the foetus, and the measures that hospitals were implementing to minimise possible cross-contamination. What one of our interviewees called the ‘social part’ of motherhood, however, received little attention.¹ We argue that the significance and implications of this ‘social part’ of motherhood have evoked concern from

1 The movement for natural birth and home birth, as an alternative to re-humanise and de-medicalise childbirth, has mainly focused on labour and delivery.

mothers and their partners because women have been unable during the pandemic to experience their motherhood in the ways they expected.

By 'social part' we refer to several different practices or discourses that surround pregnancy and childbirth and that go beyond the concerns for a healthy mother and baby, as defined in medical terms. Our starting point is the literature on embodiment in pregnancy. When Deborah Lupton discusses this literature she 'adopts the social constructionist approach to embodiment' (2012, 332) and notes that:

[B]odies are complex and dynamic admixtures of cultural, social and biological processes. The role played by symbolic representation, material objects such as technologies, ideas, discourses and practices also is important to acknowledge (Ibid.).

For middle-class women, pregnancy is increasingly marked by the preparation for a series of stages that are a mixture of public and private, and perceived as both social and medical.² For instance, in the European and American contexts, ultrasound scans in pregnancy are not only an opportunity to assess the health of the foetus but are also an opportunity for partner bonding (Roberts, Griffiths, and Verran 2017). The discovery of the foetus' sex may now be marked by 'gender-reveal' parties (Gieseler 2019). Arrangements for 'baby showers', preparations for decorating the baby's room, and plans to display the baby to wider kin and friends are made well in advance. Anne Oakley has criticised a lack of sociological interest in considering what childbirth means for women, and these semi-ritualised events form part of her exploration of having a child as being a human life event with 'many kinds of life change' (Oakley 2016, 693). In sum, pregnancy and childbirth are thus medically managed, with women expected to self-regulate in the interests of having a safe delivery and providing the best possible start for the newborn. But at the same time, childbirth and early motherhood are also normatively expected to provide a framework for creating and performing family relationships. During the COVID-19 pandemic, how did women discursively construct and perform motherhood and reflect on their experiences of doing so?

Following Sallie Han, we argue that 'the ordinary is as prescriptive as it is descriptive' (2013, 172). For middle-class women in western countries, giving birth to a healthy baby is no longer enough. Expectant women face many imperatives. 'Good mothers' follow the experts' nutritional and lifestyle advice. They also take care over their social activities during pregnancy, believing that these influence the outcome of the delivery and the baby's transition into a social being. Mothers

2 Medical anthropologists and sociologists of health and illness have shown that even the apparently purely medical is socially constructed. Here we draw attention instead to actors' definitions of their pregnancy, delivery, and immediate postpartum experiences.

ensure that their partner is fully involved throughout the pregnancy, delivery, and postpartum period, believing that active partner involvement strengthens couple relationships after birth and benefits the baby's early years (Sandelowski 1994; Eddy and Fife 2020).

By considering parenting as a form of doing and proving—rather than simply a form of being—we better understand the importance ascribed to these 'social parts' of pregnancy and early parenthood. Considering parenting as 'performativity' is key: 'being a parent is not just a status, but also a performance' (Geinger et al. 2014, 490). Neiterman (2012, 372–3) concurs:

The process of 'doing' pregnancy includes (1) the process of learning to be pregnant (by reading relevant literature and listening to the advice of others); (2) the process of adapting to pregnancy through mastering the daily routines of self-care (such as eating, drinking, exercising, walking, sleeping); and (3) constant performing of pregnancy (ensuring that the process of 'doing' pregnancy is acknowledged and approved by others).

In our study, pregnant women deplored not being able to live these social experiences 'properly' during the pandemic and tried to use new means of taking back control.

Analysing how the COVID-19 pandemic has unsettled the social expectations surrounding pregnancy and childbirth experiences is epistemologically valuable. Firstly, because expectant mothers are constrained within a disrupted social fabric to reflect on their expectations and adjust their practices, the new situation reveals details of daily life that, although usually overlooked, nonetheless make the process of motherhood meaningful. Secondly, since the interactions at work in the performance of motherhood are jeopardised, our analysis of how the structure and the agency—understood as 'the ability to define one's goals and act upon them' (Kabeer 2018, 7)—of individuals can be interpreted using a framework derived from theatrical imagery; in other words, theorised dramaturgically. Despite the constraints we see that the sense of performing remains even in contexts where the settings and social interactions are challenged.

Sample and structure

Between April and June 2020, Clémence Jullien conducted 51 online interviews involving six fathers and 45 mothers (including some in their first pregnancy) living in Spain (11), France (12), Switzerland (13), and the United Kingdom (9).³ As we wanted to document and analyse the different impacts of the COVID-19 pandemic

3 The ethical review committee of the School of Social and Political Science at the University of Edinburgh gave clearance for this research.

on the experience of motherhood, we selected countries which had introduced a range of different measures: some with strict lockdowns and restrictions on travel between regions (France and Spain) and some which implemented measures either later than others (the UK) or only partially (Switzerland). Yet, contrary to our starting hypothesis that national differences in COVID-19 restrictions and parental policies would have significant and differing effects on the experiences of pregnant women, respondents in our sample described their experiences in similar ways. Given the high regional diversity within the countries in which the respondents live,⁴ the speed with which health protection measures evolved, and the varying hospital policy responses, it is dangerous to draw robust links between national contexts and lived experiences. It is beyond the scope of this research to speculate on the specific impacts each context had; rather, this study offers snapshots of the pregnancies of women who were based in Western Europe as the first wave of the pandemic unfolded.

Interviewees were selected through snowball sampling, and they shared their experiences either orally through semi-structured video interviews, or by responding to an online open-ended questionnaire, which was available in French, Spanish, English, and German. Snowball sampling may have biased the sample in favour of mobile women, often living far away from their parents, who, being more greatly affected by restrictions on movement introduced in response to the pandemic, may have been more likely to reflect on their experiences. In a third of cases in our sample (17 out of 51 respondents), either the woman, her partner, or both are settled outside their birth country. Almost all of the couples are settled in major cities, including Barcelona, Paris, Zurich, Geneva, London, and Manchester, and held managerial positions or professional jobs which require higher education (including those in medicine, law, and engineering). We can thus observe that the respondents come from urban, well-educated, cosmopolitan middle-class backgrounds.

The sample has several strengths. It includes both women who had not previously had a child and women who already had children; respondents were from a range of ages, the youngest being 26 and the oldest 41 (Table 1), and they were at different stages of motherhood (Table 2). Twenty-nine of the women were pregnant and 16 had given birth during the early stages of the COVID-19 pandemic. The sample has two significant limitations. First, all the interviewees are in heterosexual relationships. Second, despite being invited to take part, only six men participated, four jointly with their partner and two by themselves. We consider

4 Regional restrictions were particularly prevalent in the Swiss cantons and Spain's autonomous communities, which have a high degree of autonomy and could implement their own policies and measures.

the voices of these men where possible, but this article mainly reflects women’s experiences.

	Pregnant with first child	1 child	2 or 3 children	Total ⁵
25–30	3	2	3	8
31–35	9	12	5	26
36–40	3	3	3	9
41–45	0	1	0	1
Total	15	18	11	44

Table 1. Age of the women and number of children.

Stage of pregnancy	France	Spain	Switzerland	UK	Total
1st trimester	0	1	1	0	2
4th–5th month	0	1	1	3	5
6th–7th month	2	3	5	1	11
8th–9th month	7	1	2	1	11
Postpartum	3	5	4	4	16
Total	12	11	13	9	45

Table 2. Location of the women and stage of pregnancy.

The article is structured sequentially, analysing the contrasts between expected and actual experiences through pregnancy, delivery, hospital stays, and the postpartum integration of the new baby into the parents’ social worlds.

Being pregnant during a lockdown: Expectations and disillusionment

Caroline, a 36-year-old pharmaceutical company employee in France, pregnant with her first child, explained that she simply did not experience the pregnancy she had planned because events systematically prevented her from seeing her relatives, leaving her quite isolated. Laughingly, she recalled how the gatherings of the *gilets jaunes* had crippled Paris, preventing her from sharing the news with family members who live more than an hour’s walk away:

I announced it in a carpark on a Monday evening. I wanted to do it differently. And then two months later, corona[virus] came. We can’t say that we live in a time where we are bored!

5 One 40-year-old respondent did not state the number of her children.

She regretted, as did many other expectant mothers, being unable to share her pregnancy with her relatives, as well as the fact that family members (particularly the grandparents-to-be) felt excluded from the pregnancy.

Although many women explained that they were adjusting to the changes and trying to accept the situation, they often simultaneously confessed to feeling both regret and frustration, particularly at not being able to share an experience that is supposed to be a joyful and sociable moment. Neus, a 35-year-old doctor in Spain, pregnant with her first child, last saw her parents-in-law when she was only seven weeks pregnant and regretted that they might not see each other again before the 24th week of her pregnancy:

It makes me a little sad to see how they can't enjoy this moment with us. As it's my first pregnancy, although I'm sure the same thing will happen with my second, it is exciting to meet with the family so they see how the belly grows, explain how they experienced it themselves and see their reactions while showing the ultrasound scans ... but *we're missing out on all these experiences*.⁶

Emma, a 34-year-old international relations and artist development employee in the UK, also pregnant with her first child, described well this idea of missing out on an experience. She had planned to return to Barcelona, her hometown, in order to:

[S]hare this beautiful moment I'm living with them. Not being able to do so has felt very disappointing, almost a bit like this pregnancy is happening in a different dimension and *I'm not getting to experience it as a shared thing*.

Besides the importance given to sharing the experience of pregnancy with one's family, many interviewees regarded pregnancy as a great opportunity to make new friends. In the UK, the preventive measures taken meant that most prenatal yoga and National Childbirth Trust (NCT) antenatal courses were taking place online. Expectant mothers, especially those who had only one child, feared not being prepared for the birth of their second. Besides the physical and psychological preparation these courses were expected to provide, the online format deprived the mothers from making friends with others in the same position. As Nancy, a 35-year-old graphic designer pregnant with her first child, said, 'virtual classes' prevent expectant mothers from experiencing the social side of pregnancy:

NCT classes are also *a great way for new mums to make friends*—so that element might be missing a bit. I've found that being pregnant during coronavirus does make you feel a little isolated and lonely, so not meeting

6 The emphasis in this quotation (as elsewhere in the text) is ours.

people at NCT classes adds to this as *it's a social part of being pregnant that I'll be missing out on*. I just hope that everyone participating in the virtual classes can exchange numbers and potentially meet at a later date when things are safe again.

In line with the idea that pregnancy is a moment that should be shared socially, gatherings or parties were sometimes planned by expectant mothers. Martina wanted to hold a 'baby shower' with friends, and to spend a weekend with her partner as a 'rite of passage' of parenthood. She felt extremely lucky as she had been able to do both, in late February 2020, since the lockdown in Spain had started on 14th March. Only a few women were concerned by missing 'baby showers'; rather, their disappointment focused on missing moments of 'unique' quality time as well as on the 'cancellation of all the little pleasures', as cited by Marie, a 32-year-old communications officer in France, who had one previous child. Others lamented the disruption to the preparation of the baby's room. Nathalie, a 31-year-old engineer in Switzerland, pregnant with her first child, described her feelings:

Corona[virus] has changed maternity leave, *I had thought of it in an idealised way with coffees on the terrace, museums, enjoying the leave*. This is the one time in your life where you are allowed not to work while not having children either! But swimming pools were closed, museums were closed, I couldn't go to prenatal yoga either, all sports stuff were closed. I thought I will be doing things but no way ... Yes, I forgot to say that [earlier], but *it had an impact*.

Although the concerns Nathalie expressed might appear trivial at first sight, unpacking this discourse allows us to reflect on the expectations surrounding how to become a mother as well as the extent to which pregnant women are subject to broader imperatives. Expectant mothers' choices are constrained by what some call an intrusive medicalisation that prevents them from having control over their childbirth experience (Neiterman and Fox 2017; Ruhl 1999). Emily Martin (1990) interprets the investments made by women in the practices of everyday life and rituals during their pregnancies as ways of re-appropriating their experience of maternity. One could also argue that interviewees' concerns over 'missing the social part' is only an illustration of a general feeling of social isolation triggered by the pandemic. Yet, we argue that women saw these lacks and gaps in 'social aspects' because they saw them as being required to ensure a successful experience of motherhood. This is (partly) because the status of a pregnant woman depends on one's relatives' recognition of the pregnancy ('let them see how the belly grows!'). Expectant women's concerns around taking care of themselves (as evidenced by the respondents' references to 'quality time', 'little pleasures', 'enjoying the leave', beautiful things', and so on) is all the more important as

mothers see a causal link between the emotional wellbeing of the mother and the healthy development of the newborn (Gélis 1984, 155). As such, it is not about simply missing a ‘social part’, but rather about fearing that this ‘missing out’ may have irrevocable effects on the baby. Women’s disappointment resulted largely from the prescriptive nature of an idealised pregnancy where they are expected to progressively endorse their new roles and ‘make the baby real’ (Staneva et al. 2017).

Women often simultaneously emphasised alternative resources or put their concerns into perspective. Although making new acquaintances was difficult, WhatsApp groups for expectant mothers often played a crucial role in the exchange of information. Amina, a 30-year-old teacher in the UK, who was pregnant with her first child, described sharing her concerns in one such group of other expectant mothers who were attending the same hospital. A WhatsApp group that Jennifer, a 34-year-old housewife with one other child, belonged to was the means of alerting her to the significance and spread of COVID-19 in Switzerland, and the perceived need to buy and store groceries. In the UK, 33-year-old Ella, a doctor pregnant with her first child, used her WhatsApp antenatal group to receive updates about the new policies and COVID-19-related measures that her hospital was implementing. Undoubtedly, health uncertainty and social restrictions have led to new channels of solidarity and means of searching for and sharing information, indicating the significance of belonging to a community (as well as the search for alternative solutions) in making the experience of motherhood meaningful.

Much like *Éléonore* in France—a 33-year-old anthropologist with one other child—several interviewees expressed regrets that they were not properly equipped for the baby’s arrival, while simultaneously putting the problem into perspective or emphasising forms of resourcefulness. *Éléonore* confessed to being particularly panicked when the lockdown started as the baby equipment she had kept from her first child was still stored in their former apartment in the south of France:

It’s the first thing that made me anxious, everything was closed, we had nothing! After 2–3 days I bounced back: I checked the ads on *Leboncoin* [a popular French website for selling goods] and there you go; and then my family started to organise and helped me. My sister had a child two years ago, she packed a suitcase and put some things aside.

A few mothers, like Martina, gained a critical and, for them, salutary awareness of the normative framework that surrounds pregnancy by suggesting they had interiorised a romanticised idea of pregnancy, or by critically reflecting on what is and is not necessary. Martina described her daughter’s bedroom as ‘a disaster’:

The basics were there but beautiful things or things that make it special were missing. The things that would have made me happy were missing. It was a different and unexpected experience, but it was a great lesson of life. Life goes on and, in the end, one does not need a fancy room, everything will be fine!

Women may thus recognise being at odds with the 'good pregnancy' or the consumerist traits of motherhood (Taylor, Layne, and Wozniak 2004) while not considering that their identity as a mother is compromised as a result. In an era in which the dominant discourse of the good mother is said to promote guilt and foster maternal distress, forms of self-reflection triggered by the COVID-19 pandemic provide a subsidiary yet interesting avenue for future research.

The hospital: Restrictions and resources

While couples are regularly reminded that ultrasound scans provide critical information regarding the health and development of a foetus, the acceptability of obstetric ultrasound is partly related to how ultrasound imagery has been valued outside the clinical context (Taylor 2000, 397). Ultrasound examinations are an opportunity to see the baby, bond with it emotionally, discover its sex, be reassured that it is developing 'normally' and get a picture to take back home (Ibid.) Taylor (2000) argued that many women in the United States look forward to having an ultrasound scan as this 'increasingly come[s] to be constructed as a matter of consumption' (392).

For the expectant mothers in our study, ultrasound examinations represented a key opportunity to perform parental responsibility. The advent of the COVID-19 pandemic highlighted this concern, as partners were suddenly banned from attending ultrasound examinations. Almost all interviewees lamented or feared going alone, mentioning feeling 'sad', 'upset', 'sorrowful', or 'resigned'. These regrets are not surprising as women considered ultrasound examinations as fundamental moments for the family, whether for reasons of gender equality, family bonding, or emotional support. For women like Aurélie, a 34-year-old doctor in France, pregnant with her first child, excluding fathers clearly undermined the effort being made by her and her partner to live their parenthood in an egalitarian way:

Since the beginning of the pregnancy, *we try to maintain a certain equality in everything possible*, especially the presence of both parents at the medical follow-up. This is already difficult in 'normal' times, as the father is present but often less considered than the mother during consultations. The arrival of COVID-19, and the measures currently in place, even when seen as necessary, exclude the father from follow-up.

The husband of Ursula, a 32-year-old shop manager in Switzerland, also pregnant with her first child, was particularly involved in the pregnancy. She felt his exclusion as punishment, and even more difficult to handle as she had a high-risk pregnancy:

The sad thing is that my husband is not allowed to be present at the ultrasound examinations. He is especially happy to become a dad, and *he also likes to be around*. I am also a risk patient with diabetes type 1, at least in general, so I have little understanding for this matter, and I was absolutely alone with the health professional and my gynaecologist, he [my husband] would even have been willing to wear masks and gloves ... unfortunately, we got a 'no' here too!

Many couples expected the ultrasound examinations to be moments of family bonding, where the father would vividly realise that he is going to have a child, and where the couple would feel strengthened by this joint project. For Vanessa, a 33-year-old communications specialist in France, ultrasound examinations 'should be a nice moment of sharing and allowing the father to project himself and visualise a baby he can [as yet] only imagine'.

Having the partner banned from the ultrasound examination room also enhanced anxiety. For instance, in Switzerland, 29-year-old social education worker Amanda, who was expecting her first child, could not feel calm or safe since her husband was excluded from the hospital in Bern. Partners of women who had high-risk pregnancies, or who had a long hospital waiting time or extended ultrasound examinations, found themselves asked to wait in a hall or in a car park outside the hospital, spending long periods of time worried about what was happening inside.

Nancy's 12-week scan coincided with 'the worst week of infections in the UK'. She wanted her partner to see their first scan and to have his moral support, yet her partner had to wait outside in the car park:

I was told the appointment would be approximately 40 minutes long, but I was in the scanning room for over one and a half hours. Luckily everything was OK, and when I spoke to [my husband] after the appointment, he was massively relieved to hear the good news—but he explained that he'd really started to worry something was wrong because I'd been in there for so long and that waiting in the car not knowing what was happening was extremely stressful for him as well.

For some women, the exclusion of the baby's father from some key events were compensated by them being more at home and following the pregnancy more closely than if they had been working as usual at the office. Aurélie was probably the most detailed in explaining how the lockdown has brought 'a lot of happiness' with respect to the bond with their expected child:

Being together as a group of three (father, mother, foetus already assimilated to a child fully part of our daily life) all day long allowed us *to take advantage of all the little moments of the little one*: trying to interact with the one we have been calling the ‘baby’ for several weeks now, talking to him, reading to him, watching for his slightest gestures/strokes, tracking his movements through the abdominal wall ... *So many simple things that we would not have been able to do*, or in any case could not have shared in the same way, nor for as long, without the confinement of COVID. COVID, especially in a period of confinement, will have made us fear that we might lose this child (rightly or wrongly), but it will also have *allowed us to fully focus on it, to spy on it, and to already build our father–mother–child relationship*, before its birth.

Resilience—understood here in a broad sense, as ‘facilitating successful adaptation in the face of adversity through pre-emptive disaster risk reduction strategies’ (Barrios 2016, 28)—was also visible through creative and adaptive solutions. As the involvement of the father was particularly important for Aurélie and her partner, they recorded him reading stories so that Aurélie could play these recordings after the birth in case partners were (still) not allowed on the ward.

While it is generally assumed that the ‘quality’ of the foetus is fully within the control and proper behaviour of the pregnant woman (Lupton 2012, 11), the expectant father is increasingly expected to closely follow the phases of the pregnancy. Since the 1990s, a new model of fatherhood is being promoted whereby men are required by policymakers to be emotionally involved with their children and actively engaged in aspects of perinatal care (Faircloth 2014).⁷ Thus, the exclusion of partners is problematic as it causes frustration, jeopardises possibilities of projection as a future father and does not enable proper family or couple bonding. UK studies (Oakley and Rajan 1991; Redshaw and Henderson 2013) have underlined that men who live with working class women are less likely to accompany their partners to the clinic than are middle-class men, and that the former are also usually less supportive during pregnancy. Women may not have thought about social distinctions while talking about the involvement of their partners in their pregnancy and postpartum experiences. Yet a clear sense of pride could be heard as they spoke about having a partner actively engaged in pregnancy, a situation which allows middle-class couples to portray themselves as both modern and responsible. Knowing that equal sharing of parental responsibilities is increasingly promoted by experts and is socially valued (Faircloth 2014), women seemed to distinguish themselves from other couples—whether their contemporaries or those of previous generations—while praising the

7 In the UK for instance, the ‘Think Fathers’ campaign promotes the recognition of ‘fathers’ significance in their children’s lives’ and advocates for systematic changes in how this is acted upon in British culture, politics, and public service. See: <http://www.fatherhoodinstitute.org/2009/about-the-think-fathers-campaign/>.

involvement of their partner and their willingness in building a ‘father–mother–child relationship’.

Besides not being able to have one’s partner present during antenatal visits, women described how their experiences of delivery were marked by several restrictions, in particular the limitations on visits from partners and relatives, mask-wearing in the labour room, and the permitted length of hospital stay. In this respect, the media, feminist collectives (such as Stop VOG, led by Sonia Bisch) and obstetrics associations portrayed the conditions of childbirth—the use of the mask in delivery rooms and refusing entry to partners—as violating human rights or as a form of obstetrical violence. Such a focus was also reported by social scientists who renewed their emphasis on the various infringements on reproductive healthcare rights during the pandemic. However, they relied entirely on secondary data, such as NGO reports, posts from childbirth activists (see e.g., Barata, Morgado Neves, and Santos 2020; Drandić and van Leeuwen 2020); or official health guidelines (see e.g., Sadler, Gonzalo, and Olza 2020; Yuill, McCourt, and Rocca-Ihenacho 2020).

Even though forms of anxiety and disappointment were definitely present in the testimonies we collected, autonomy and empowerment were also visible when interviewees explained the conditions in which they gave birth. For instance, while describing the challenges of delivering with a mask, women from France and Switzerland simultaneously showed they had the resources to cope with them. Charlotte, a 35-year-old communications manager in France, with three children, said her delivery ‘happened normally’, even though she described the use of the mask during the labour process as ‘quite uncomfortable’. Acceptance was particularly clear in the explanation given by Nathalie:

We were masked during the whole period, even though we understood that we shouldn’t have been given masks, that wasn’t the procedure ... The whole medical staff was masked but it wasn’t very shocking because finally, I had expected to be in a very clean operating room with people in scrubs and masks and in fact, I was in a kind of office so it seemed nicer than what I had in mind!

Coping strategies were also visible in how lonely women dealt with (lack of) support in the hospital. Amina had to spend two nights in the hospital following a caesarean delivery. This she described as being ‘difficult’ because no visits were allowed for her husband, or friends. Yet, she quickly added, there was a great sense of solidarity among mothers; they would open the curtains to support each other when a woman cried. Others, in private rooms, relied on the kindness and availability of caregivers: Nathalie praised the staff she called three times in one night because she no longer had the strength to cradle or change her daughter’s nappy after a sleepless night.

Though these women worried about the conditions in which they would have to give birth, they often highlighted their capacity to find resources, negotiate, and cope. By either developing a Stoic worldview, relying on the solidarity of women or building strategies with their partners, women demonstrated their resourcefulness. By considering women's resources at the hospital, our goal is not to take an ideological position on the supposedly strong nature of women. Rather, we explain that women highlighted having some flexibility during their experiences as, in exercising it, this indicated how they embodied maternal responsibility. This is particularly evident with regards to negotiating the length of the hospital stay, regardless of the country of residence or the pandemic policies implemented. Many young mothers commented that they had been discharged from hospital within a day or two due to perceived risks of COVID-19 infections and limited space in wards. While they expected or experienced (in comparison with previous deliveries) a longer postpartum hospital stay, most mothers appreciated not staying long at the hospital. Some, like Nora, a 36-year-old banker in Switzerland with two children, asked explicitly for a short stay, for example, due to the fear of contamination. Sophie, a 33-year-old designer in the UK, with one child, feared a possible long period of separation from her partner. Juliette, a 31-year-old woman in France with two children, was desperate not to be locked up in a room with limited washing facilities (no shower). For Nora, her choice to leave the hospital 'as fast as possible' was painful. As her objective was to stay only 24 hours, Nora knew she should opt for as little intervention as possible and therefore decided to give birth without an epidural. She insisted that 'under normal circumstances' she would have asked for it and, laughingly, concluded: 'It was because of the corona[virus], and all the people, the midwives said I was totally right!'

Narratives shows that expectant mothers are custodians of a triple responsibility: women in this study were concerned by the medical risks at stake in a delivery, the potential risks of COVID-19 infection in hospital as well as the benefits of early bonding within a more holistic perspective of what constitutes a 'good birth'. In other words, acceptance of the biomedical model of childbirth no longer appears to be sufficient proof of responsibility: even when the constraints linked to the pandemic are added to the constraints of the hospital, women showed their sense of responsibility by reporting how their choices were well-considered and well-argued, as well as by rationally relegating their personal needs or concerns.

(Not) having visits: A blessing in disguise?

In at least two cases, women not only feared not having their relatives at their side after the birth, but they also noted that disappointment or tensions could arise should family members have different attitudes towards COVID-19. Angela's sister saw 'the danger of this illness everywhere', and stopped visiting her family,

including Angela. For Marieke, a 34-year-old anthropologist in Switzerland with one child, her parents' reluctance to visit was less explicit, yet she could feel they were postponing their visits for fear of becoming infected or of themselves infecting the baby.

Besides lamenting being deprived of 'special moments' or 'beautiful family moments' with their relatives, most mothers felt entitled for their parents—especially their mother—to come a few weeks after a birth to help them. Several had organised logistical aspects months in advance. Alba, a 31-year-old doctor in Spain with a first child, deplored the absence of her closest relatives. Because it was their first child and their family was living in different Spanish cities, COVID-19 had made 'things even more difficult'. Jennifer and Eva, both Brazilian women settled in Switzerland, should have received support from Brazil, but there were no flights between the two countries. Eva, a 32-year-old teacher with two children, explained that her mother belonged to a higher risk group and because borders between countries were likely to close she had cut short her visit and returned in haste to look after her business. For Eva this moment was particularly challenging, as she could do nothing without her husband's help. Like Jennifer and Eva, many women pointed out that despite planning logistics well in advance, they ended up with no support. Nora had planned to have her parents and her in-laws make twice-weekly, alternating visits over the course of two weeks. But her mother could visit them in Geneva only for a few days and did not stay long: she was particularly anxious and scared of catching COVID-19. Nora herself was relatively safe as she was on maternity leave before the birth for several months. Yet Nora's partner, Mehdi, continued to work and did not self-shield. Nora had only a few days with her mother, and nobody offered to visit them after the birth; at best, friends would drop gifts at the doorstep. The feeling of deprivation among respondents was particularly significant when the family lived abroad and when parents were having a child for the first time—or when women had experienced, as had Lynn, a 38-year-old researcher in the UK, a previous traumatic birth.

In some cases, alternative solutions were quickly found by families who, as in the case of Amina, opted to form temporary joint households. Amina's mother was supposed to come from the Netherlands six to eight weeks after the birth but, due to her health issues, was officially advised to stay at home and self-isolate for 12 weeks. This situation at first created a sense of panic, but Amina's mother-in-law was able to come daily to help the young parents with cooking and cleaning. She lived close by and had self-isolated at the end of Amina's pregnancy as a precautionary measure. A few women also found alternative solutions, for example those presented through their partners' ability to work remotely. Nathalie's mother-in-law was supposed to visit for three days in Lausanne, and then her own mother would follow for 10 days:

I was afraid of being alone in the house with a child. Actually, I was for the first time alone with her [the baby] after a month. By then, I had already acquired reflexes, I am less afraid. *Elias* [Nathalie's partner] *has replaced my mother* as a helper at home [laughs].

A clearly gendered intergenerational parenting emerges from these narratives. Postpartum support—including logistical help (cleaning, cooking), emotional care, and counselling—should come from female kin (often the mother or mother-in-law). Such gendered postpartum support has already been noted: due to their supposed soft skills (being a good listener) or their own experience (having children, being a midwife), women are portrayed as the most suitable. Men 'are not thought to have the "natural" foundation for fathering that women do for mothering' (Faircloth 2014, 185), and are not considered as having the 'natural' foundation for supporting young parents that female kin do. Even in France and Spain, countries with more generous paternity leave, partners were seen as inadequate substitutes for a helping woman. Yet, while women exclusively bemoaned the loss of female support in the postpartum phase, they also often highlighted their partners' support during their pregnancy and many of them said how important gender equality was for them both. Natalie and many other women did benefit from the support of their partners, who were, with a few exceptions, working from home—but they still said that they wanted the extra support from older women.

COVID-19 might have enhanced this search for gendered postpartum support. The fear of 'missing out' in the postnatal phase was exacerbated by the impression that caregivers could not offer the expected professional advice and support as the hospital postpartum stays were both shorter and with fewer interactions. Actively looking for forms of compensation was important for women like Laura, who considered relatives who were mothers themselves as being the best substitutes:

It's important to be surrounded by other women. You have *to compensate because you are no longer taken care of by institutions*. We need resource persons. For me, it's my cousin, who is my age. I rely more on my family than on my friends. My cousin is someone I'm close to and she has three children, she knows what a kid is, she's a good listener. And then I have my mother who used to be a midwife. If I end up being back home soon after my childbirth delivery, I will need support. There are, in a way, *substitutes for the hospital*. I would need them even more.

As Lee et al. (2014, 8) note with regards to parenting, 'people other than parents have special insights that can and should be brought to bear'. In a COVID-19 context with limited interactions, the fear of a deficit in parental behaviour is

exacerbated and women's urge for external compensatory substitutes shows that the notion of good parenting 'as a form of learned interaction' is widely interiorised.

Most women tried to stick to an ideally planned parenting arrangement and found alternative solutions as obstacles were encountered associated with social distancing, border closures, and other health regulations, but a few happily embraced the absence of social contacts. For instance, Caroline was apprehensive about the expected social dimension surrounding birth and saw pandemic measures as offering a solution. Laughingly she explained 'that's going to be sorted out, problem solved!' Sophie saw post-birth visitors as an additional form of pressure; she saw people as tending to give their advice, even when they are not asked for it:

Being quite headstrong, I don't like people telling me what to do and how to act, we have had to just get on with being parents and figure it out for ourselves, I will always be so proud of us for that.

Martina highlighted other ways that social distancing was a timely solution:

She is the only granddaughter and niece; she is the first one. So we were afraid that the grandparents would jump on her and that it will be hard to set limits to protect ourselves ... One cannot say 'now go home, leave us, I want to sleep' ... Maybe it's a bit cruel, but we've got rid of this [the visits]!

Other women held more ambivalent views. During the pandemic, they had no other choice than getting 'prepared for it mentally' (Maria) or 'review[ing] things a little more simply' than planned (Sélène). Yet, they simultaneously recognised the benefits of not having social contact. Maria confessed they were delighted 'like in a hotel, resting and recovering from the birth and, above all, enjoying the baby.' Sélène told herself it will allow her to extend the moment with the baby so that they can 'gradually detach [themselves] from each other'.

Several other women highlighted having more time to get to know their baby and emphasised that the absence of social contact was particularly beneficial for the couple's relationship, reinforcing family bonding. For Rosario, a 32-year-old teacher in Spain with three children, it allowed them to enjoy their family in privacy to the fullest and at their own pace; for Eva, in Switzerland, the absence of social contact helped her to appreciate the necessary and comfortable time with her husband. For Sophie, an individualised parental relationship also legitimised her role as a mother and boosted her self-confidence:

At times through video or distancing, things have been mentioned, I found myself thinking, *I know my baby best*, I've been at home with him for eight

weeks and I may not have felt so closely connected to him if there was more contact with others.

Finally, a few women mentioned the benefits of reconsidering usual post-natal practices, that are marked by intense social interaction. Martina praised ‘the tradition of quarantine’ [*la cuarentena*], describing it as a ‘very beneficial’ practice in Argentina, when mother and newborn rest at home for forty days, as did Amina. During the pandemic, not only are people unable to interfere too much, but as Amina noted mothers can also simply ‘be in pyjamas without worrying, looking presentable or hosting people, having to make coffee or tea’. Caroline agreed:

Apparently, it’s better like that. I’ve read a study which said that by removing visits, mothers are more rested, and babies lose less weight. There is a better parent–child bond because there are no visits. And a midwife said in an article that it could be a reflection for the future because it could be beneficial for parenthood and stress.

As these examples show, the social isolation engendered by COVID-19 could offer diverse advantages. As during pregnancy, where bonding and the wellbeing of the mother are said to positively affect the arrival of the newborn, the peace of mind of young mothers can foster both women’s confidence and postpartum bonding with the baby. These views not only reflect women’s ability to adjust; they also highlight a potential conflict between the recently discovered benefits of focusing on the domestic household and the well-known benefits of being widely supported by social and familial networks in the postpartum period. It is unclear whether the new postpartum practices triggered by the pandemic will continue when social distancing is no longer imposed.

Video calls: An unusual integration of the baby

As social interactions and audience were severely restricted during the pandemic, couples relied heavily on social media and video calls to present their newborn to family members and friends—an event usually nothing like how they had wished or imagined the introduction to be. To share her joy, and respond to her relatives’ requests, Amina developed the habit of taking pictures that displayed their daughter at different moments of her day, in varied situations, and sending them ‘every single day’.

Yet the limitations of pictures and video calls were quickly and often mentioned, underlining the side-effects of virtual encounters or the absences they made so starkly clear. First, video calls cannot replace face-to-face gatherings and cuddling, so family members felt excluded from unique moments. Sophie’s mother and

mother-in-law both melted into tears when seeing the baby online: she described how 'it broke their hearts not being able to cuddle him'. Sophie added:

We have missed out on the excitement of a new baby, to be able to show him off. He is already past the newborn stage which is heart-breaking for everyone to miss. We'll never get that time back to share with others and that hurts the most.

Some mothers also agreed with Olivia, a 37-year-old editor in the UK, with two children, who worried that her son had 'a lot more exposure to screens'. Martina explained that family members were 'all screens' to her daughter. She recalled laughingly the measures she took to mitigate the impact of screen exposure:

We call the grandparents every day on the screen. The first days we used to do video conference but we realised after 3 days, *she was already addicted to the screen! ... So we tricked our parents [engañamos a los abuelos], we turn the camera around*, they see her but she does not see them. She recognises the voice, but not the images because she is too small. *We are tricking the grandparents!*

In using social media parents were proactive, investigating new platforms for video calls but also doing so *responsibly* and making *good use* of them. Regular videocalls with the grandparents to include them also allowed grandparents to perform their grandparenting roles. Sending many pictures helped relatives feel closer to the baby. Smart compromises enabled couples to please grandparents while protecting a newborn from the harmful effect of screens. In other words, 'performing parenting' was noticeable in both the use of video calls and the acknowledgement of concerns with regards to these tools.

Furthermore, many parents wondered if the absence of social contacts would have negative repercussions for the baby's future socialisation. To underline how unusual the context was, mothers often insisted on the age of their baby. Juliane reported that the first time her daughter was in the car and in a pram was only 'at eight weeks'. 'At the age of three months', Nathalie's daughter still had not met anyone other than her parents. While some mothers found the situation ironic, even 'ridiculous', they mainly reflected on the possible long-term impacts. Sophie feared that by not playing with other babies, their own child would be 'reliant' on them. She observed that 'this was something we previously spoke about and that we were trying to avoid' as 'that was part of a pre-lockdown parenting choice'. Sélène, pregnant at the time of the interview, knew the lockdown would still be in effect after her delivery:

I had the idea that, while there are people who don't want to share children, *I wanted to teach him to be in the arms of other people, to teach him to sleep at friends' places everywhere*. But we'll see fewer people. We won't be able to move around.

Some women had already considered introducing the newborn to its siblings, planning a set-up that would ease the transition at home and avoid jealousy. Laure had planned 'a whole phase of presentation to his elder brother':

I had planned the meeting that was to take place at the hospital ... *I would have liked him to be involved in bringing the baby home*. [But] the COVID can turn the script upside down [*ça peut chambouler le scénario*]. It's a project that I wanted to do, that I had planned.

Absence of social contacts was expected to have an impact on the baby's socialisation skills, but it was also feared that habits of social distancing will negatively affect parenting practices. Carla, a 40-year-old teacher in Spain, indicated she would have to work on her fears and control them so that negative emotions would not be transmitted to the baby. For Martina, the interiorisation of the discourse according to which social contact has become a fatal source of risk may have severe repercussions for how she will view people interacting with a baby:

What worries me is that she is only with me and my partner. She only knows our faces, our voices. What will happen when she meets more people in two weeks? *There will be a socialisation phase, what will happen to her and me?* I know she is not mine, I have no property but if I am anticipating that seeing her touched by other people, it may be a little difficult, because I am used to seeing her in our arms. It will be a new experience for me and her. [But] we look forward to it!

She also felt that social interactions might feel weird in the future. She used to see people as a 'source of joy and sharing' or 'as a resource'; now she feared seeing them solely 'as potential risks'. For her, this resulted from the war rhetoric—such as being 'at war' with the virus, referring to it as 'the enemy' and so on—that had been used by the government and the media.

Conclusion

By giving a voice to expectant mothers' expectations and disillusionment, and by considering the whole experience of motherhood, this study contrasts with those articles that focus only on hospital experiences (e.g., Barata et al. 2020; Coxon et al. 2020; Sadler and Olza 2020). They tend to depict expectant mothers' reactions during the COVID-19 pandemic as either those of passive victims of restrictions or

of engaged women committed to the respect of reproductive rights. By contrast, our study on middle-class mothers' lived experience, which shows disruption to the long-term processes of the responsabilisation of parenting, deals largely with women's agency and reflexivity.

Such an approach is key to grasping the contemporary injunctions of good parenting: since the 1990s, the ability to engage in reflexive thinking and introspection has been promoted by institutions as a key feature of 'good parentality' (Faircloth 2013; Roux and Vozari 2018). This approach also allows a better understanding of how motherhood can be performed when its usual components are jeopardised. Having a baby during the pandemic meant much less socialisation during pregnancy, less logistical and moral support, fewer possibilities of projecting oneself (firstly as a pregnant woman and then as a new mother), and fewer chances to prepare for life with the new baby. Maintaining regular medical check-ups and following health instructions that sometimes changed rapidly were only part of the pandemic-induced changes. As COVID-19 acted as a disruptive force, mothers reflected further on motherhood habitus and practices.

Not only did COVID-19 act as an amplifier, adding new forms of risk to former ones, but expectant mothers' resolution to perform motherhood was highlighted: they constantly assessed and handled new challenges. In other words, the context brought the salience of performing motherhood to light. For our sample, performance is about proving one's sense of responsibility: assessing medical risks, valuing the long-term benefits of the 'social part' of motherhood, and showing resilience or coping strategies reveals the many ways of performing motherhood. 'Performing motherhood' is also about embodying a new status, and it is as much about creating a bond with the baby as about considering the respective roles of fathers, siblings, and grandparents. The involvement of partners moved in two different directions, depending on personal circumstances: men were excluded from some external settings, but in some cases were more available in a domestic arena that became more narrowly focused on the nuclear family. Whether living close to their parents or settled abroad, these young parents expected psychological and logistical support from their female family members. Most young women felt that they were an essential resource, people who should be available to participate in helping nurture the child-to-be in the right ways. Women also shared in the common understanding that their role was to create and foster occasions to help relatives embody their new statuses, whether as father, aunt/uncle, or grandparent. Relatives are also a key audience for women performing the role of motherhood. Thus, relatives are important not only because they provide support, but also because they participate in the 'meaningful work in the making of babies and of mothers' (Han 2013, 10). Furthermore, parentality acts

as ethopolitics (Roux and Vozari 2018): while a growing number of actors determine and supervise the best development of babies, expectant mothers seek the gaze of such adults as a form of doing motherhood.

If this article primarily considers how women dealt with the injunctions of motherhood during the COVID-19 pandemic, we should not ignore how COVID-19 could affect parenting practices and the institution of motherhood in the long term. Good motherhood's key ideological aspects—such as monitoring of maternal decisions, the salience of parental determining, the involvement of fathers and maternal selflessness (Lee et al. 2014)—are still prominent and almost unchanged. Yet COVID-19 does seem to challenge the institution of motherhood. First, women realised that many of the injunctions of motherhood are actually negotiable: the pandemic prompted some women to engage critically with the image of a romanticised pregnancy and encourage them to reconsider some of the socially constructed injunctions of motherhood. Thus, we could hypothesise that women who gave birth during the pandemic might be less rigid regarding the 'package' of recommendations and select those that seem most fundamental to them rather than accepting them wholesale. Second, COVID-19 may have an ambivalent impact on parenting knowledge as it pushed women to be more intuitive (against the current idea according to which good parenting involves 'learning' rather than 'instinct') while prompting them to gather and cross-check information as best they could.

As this research documents a local case study (the experience of middle-class couples in four European countries), further research could investigate whether such trends apply (or not) to women from different social and economic backgrounds. Future research will also show whether and how far the COVID-19 pandemic constitutes a turning point in the institution of parenthood and the performative nature of motherhood. As for now, these elements help to better understand the diligence—as expressed below by Eva—with which women perform motherhood:

I had so many plans ... All of these plans were not implemented, as there were many limitations and it made me frustrated in a way that I cannot put on paper exactly what was going through on my head. All the time I thought about my children and husband that I should be strong for them. I know how much they need me.

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About the authors

Clémence Jullien is a CNRS research fellow anthropologist based at the Centre for South Asian Studies (CEIAS-EHESS/CNRS) in Paris. Her main research lies at the intersection between reproductive healthcare, gender, and biomedicalisation in India. She is the author of *Du Bidonville à l'hôpital. Nouveaux enjeux de la maternité au Rajasthan* (2019), based on her dissertation on northern India. She also coordinated a special issue (with Bertrand Lefebvre and Fabien Provost) on the hospital setting, entitled *L'hôpital en Asie du Sud. Politiques de santé, pratiques de soin* (2019), as well as (with Roger Jeffery) an edited volume—*Childbirth in South Asia: Old Paradoxes and New Challenges* (2021).

Roger Jeffery is a Professor at the School of Social and Political Science, University of Edinburgh. His research on childbearing in south Asia was first conducted with Patricia Jeffery in Bijnor district, north India. Relevant publications include (with Patricia Jeffery): 'Traditional Birth Attendants in Rural North India: the Social Organisation of Childbearing', in *Knowledge, Power and Practice in Medicine and Everyday Life*, edited by Shirley Lindenbaum and Margaret Lock (1993); Patricia Jeffery, Roger Jeffery, and Andrew Lyon: *Labour Pains and Labour Power: Women and Childbearing in India* (1989); and Patricia Jeffery, Roger Jeffery and Andrew Lyon: *Contaminating States and Women's Status: Midwifery, Childbearing and the State in rural North India* (1985). He has also written widely on health policy in south Asia, including (with Clémence Jullien): 'Changing Childbirth in 21st Century South Asia', in *Childbirth in South Asia: Old Paradoxes and New Challenges*, edited by Clémence Jullien and Roger Jeffery (2021).

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