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Lived Experiences of Fear of Maternal and Fetal Loss among Pregnant Women with COVID-19: A Descriptive Phenomenological Study

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Abstract

Background: The COVID-19 pandemic disrupted maternity care and amplified psychological distress among pregnant women. Those diagnosed with COVID-19 faced intensified worries about their own health, fetal wellbeing, and loss of support. This study aimed to explore the lived experience of fear of maternal and fetal loss in pregnant women with COVID-19.

Materials and Methods: This qualitative hermeneutic phenomenological study, based on van Manen's methodology, was conducted in Mashhad, Iran. The study involved 14 pregnant women in the second or third trimester who had laboratory-confirmed or clinically diagnosed COVID-19. Participants were recruited purposively, and data were collected through in-depth, semi-structured interviews conducted face to face or online until data saturation was achieved. Data were analyzed using van Manen's phenomenological approach with MAXQDA software (version 20).

Results: Analysis produced three main themes: (1) Dread of infection and the looming threat of loss; (2) Burden of care—reduced support and compromised self-care; and (3) Psychological disruption and existential rupture. Participants reported pervasive anxiety about fetal viability and maternal deterioration, recurrent fear of infecting family, and heightened vigilance about pregnancy outcomes. Enforced isolation, caregiving strain, interpersonal conflict, and guilt amplified helplessness, exhaustion, sleep disturbance, and depressive symptoms. Perceived healthcare inadequacies and limited access intensified distress and deepened uncertainty about pregnancy and childbirth.

Conclusion: COVID-19 in pregnancy was a multifaceted crisis—persistent fear of maternal and fetal loss, uncertainty, reduced support, isolation, caregiving burden, and severe psychological distress. Perceived healthcare inadequacies eroded trust. Maternity care during infectious outbreaks must complement clinical monitoring with proactive psychosocial measures: telehealth education, virtual counseling, continuity of obstetric/midwifery support, and targeted outreach to reduce isolation and restore trust.

Key Words: COVID-19, Fear of loss, Lived Experience, Phenomenology, Pregnancy.

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1- INTRODUCTION

Pregnancy is a major ontological transition accompanied by increased bio-psychosocial vulnerability. Physiological and immunological adaptations of pregnancy—reduced functional residual capacity, diaphragmatic elevation, and shifts in T-helper cell responses—can increase susceptibility to severe respiratory infections and adverse maternal outcomes, including from SARS-CoV-2 (1,2). The COVID-19 pandemic therefore posed not only a biological threat but also disrupted the safety, predictability, and continuity essential for maternal wellbeing (3).

The clinical manifestations of COVID-19 in pregnancy—fever, dyspnea, and systemic complications—have been well described. Evidence from related coronaviruses (SARS-CoV, MERS-CoV) raised concerns about obstetric risks such as miscarriage, preterm birth, and maternal mortality (4, 5). Early uncertainty about vertical transmission, together with quarantine measures, intensified anxiety among pregnant women (6, 7).

Beyond individual distress, the pandemic strained maternal and child health systems, threatening nutrition and early developmental outcomes and underscoring the need to clarify neonatal risks and systemic consequences of maternal infection (8, 9). The subjective meaning of being pregnant during the pandemic is shaped by cultural norms, coping resources, and perceived healthcare adequacy—factors particularly salient in low- and middle-income countries where mental health services are limited (10).

Although quantitative studies document clinical and epidemiological patterns, they cannot fully capture the nuanced lived experience of pregnant women facing COVID-19 (11). Phenomenological methods are therefore suited to explore these women's perceptions, existential concerns, and the pervasive fear of maternal and fetal loss (12).

In Iran, particularly in metropolitan centers like Mashhad, pregnant women faced not only the clinical threat of the virus but also the strain of a healthcare system under extreme pressure. There is a critical lack of qualitative evidence exploring how these women interpreted the threat of maternal and fetal demise during the peak of the outbreak. Therefore, this study aims to elucidate the lived experience of "fear of loss" among pregnant women diagnosed with severe COVID-19, providing a deeper understanding that may inform person-centered maternity care and tailored psychosocial interventions in future public-health crises.

2- MATERIALS AND METHODS

2-1. Study Design

This qualitative study used a hermeneutic phenomenological approach, guided by van Manen's methodology, to explore the lived experiences of fear of maternal and fetal loss among pregnant women diagnosed with COVID-19. Hermeneutic phenomenology was selected because it goes beyond description to interpret the deeper meanings embedded in participants' lived experiences, as they understand and describe them in everyday life (13, 14). The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (15).

2-2. Setting and Participants

The study was conducted from April 2021 to May 2022 in selected health centers and referral obstetrics hospitals affiliated with Mashhad University of Medical Sciences, Mashhad, Iran. Participants were recruited purposively to identify pregnant women who could provide rich, first-hand accounts of the phenomenon under study.

Inclusion criteria were: being in the second or third trimester of pregnancy, having a laboratory-confirmed (RT-PCR) or clinically diagnosed COVID-19 infection during the current pregnancy, having a viable pregnancy confirmed by obstetric evaluation, and willingness to describe personal experiences related to pregnancy during the COVID-19 pandemic. Women with severe pre-existing or pregnancy-related obstetric complications, cognitive impairment, or psychiatric disorders were excluded, as were those who withdrew or were unwilling to continue participation.

Sampling continued until data saturation was reached, defined as the point at which no new themes or conceptual variations emerged from the interviews. A total of 14 participants were enrolled in the study (16).

2-3. Data Collection

Data were collected through semi-structured, in-depth individual interviews. Depending on participants' health status and preferences, interviews were conducted either face to face in a quiet, private clinic setting under health protocols or virtually through secure online platforms.

Each interview lasted approximately 60 to 90 minutes. Interviews began with broad open-ended questions, such as: "Can you describe your experience of being pregnant during COVID-19?" and "What fears or concerns did you experience regarding yourself or your baby?" Probing questions were then used to clarify meanings and deepen exploration of participants' experiences. All interviews were audio-recorded with permission and transcribed verbatim immediately after each session.

2-4. Data Analysis

Data analysis was conducted concurrently with data collection using van Manen's hermeneutic phenomenological method (13). Each transcript was read repeatedly to gain a holistic understanding of the participant's account. The analysis involved reflection, writing, and rewriting to identify essential themes of the phenomenon (17). To support systematic coding and theme development, established qualitative procedures for coding and thematic clustering were followed, and MAXQDA software (version 20) was used to manage the analysis (14).

2-5. Trustworthiness

To ensure rigor, the criteria of credibility, dependability, confirmability, and transferability were applied (18). Credibility was strengthened through prolonged engagement with the data, repeated reading of transcripts, peer review of coding, and member checking. Dependability and confirmability were supported through ongoing team discussions and maintenance of a detailed audit trail of analytic decisions. Transferability was enhanced by providing a detailed description of the study context, participants, and data collection procedures, along with direct verbatim quotations.

2-6. Ethical Considerations

The study received ethical approval from the Ethics Committee of Mashhad University of Medical Sciences (Ethics Code: 991419). Written informed consent was obtained from all participants after providing information about the study purpose, procedures, duration, possible risks and benefits, and data handling. For participants who could not read, the consent was given orally in the presence of a witness.

Confidentiality and anonymity were maintained by replacing names with unique codes and storing the code key, consent forms, and audio files in secure, access-restricted locations (encrypted digital storage and locked filing).

Participation was voluntary; participants could decline questions, pause or withdraw at any time without consequences, and were offered contact details and referrals if discussing sensitive topics caused distress.

3- RESULTS

3-1. Participants' Characteristics

Fourteen pregnant women diagnosed with COVID-19 participated in the study. Their ages ranged from 25 to 44 years, and their educational backgrounds ranged from primary school to postgraduate level. All participants were married, and four had been hospitalized because of severe COVID-19 symptoms. The semi-structured interviews lasted between 45 and 90 minutes.

3-2. Phenomenological Themes

Hermeneutic phenomenological analysis of the transcripts yielded three main themes and seventeen sub-themes, reflecting the participants' lived experiences of fear of maternal and fetal loss (**Table 1**).

Theme 1: Dread of Infection and the Threat of Loss

1. Fear of fetal loss and complications

Participants described their strongest anxiety as concern for the fetus's survival and health. This fear was especially intense during the first trimester, when they perceived the pregnancy as more vulnerable. One participant (P6) said, "I used to cry even when I heard that a baby somewhere was infected. I desperately did not want this to happen to me."

Another participant (P5) recalled her immediate fear after diagnosis: "After five days, when my test came back positive, I was terrified that I would lose my baby." Several participants also worried that the virus might cause developmental problems or growth restriction. For example, Participant 3, who was diagnosed at seven weeks, stated, "At 22 weeks, the doctor told me that the fetus had growth restriction. I was so scared."

Similarly, P6 explained, "Early pregnancy was going well. But at 32 weeks, fetal growth stopped. I felt like I was dying of fear."

2. Fear of maternal mortality and health deterioration

The rising mortality rates reported during the pandemic intensified participants' fear of death and physical decline. This fear often appeared as acute somatic anxiety. Participant 1 noted, "I wasn't that stressed at first, but as the death rate increased, my anxiety became intense."

For some women, denial served as a coping mechanism. Participant 5 shared, "I kept telling myself that we must have had food poisoning, because I simply could not accept that we had contracted Corona."

3. Information gaps and loss of control

The rapid spread of the virus, conflicting information, and the closure of medical centers during holidays left participants feeling helpless and disoriented. Participant 6 described the disruption to her daily life: "I really did not know what to do. I had lost all order in my life. I was crying constantly while searching for masks and sanitizing alcohol."

Perceived high mortality among infected patients also weakened hope. Participant 1 stated, "Many patients lost their morale due to a lack of attention and ultimately died."

Theme 2: The Burden of Care: Diminished Support and Fractured Self-Care

This theme captures the exhaustion of managing self-care during the pandemic, the isolation of quarantine, the burden of guilt, and frustration with the healthcare system.

1. Isolation and weariness in self-care

Participants found the dual responsibility of protecting themselves and their unborn children physically and emotionally exhausting. Participant 6 said, “I felt like everything was a nightmare from which it was impossible to escape. I was physically and mentally drained.”

This burden was worsened by isolation from key support figures, particularly husbands and mothers. Participant 6 described the experience: “The absence of my husband and mother during my illness was terrible. I was quarantined in my child’s room, surrounded by toys and a crib. Even my husband would not step inside.”

Fear of delivering alone was also common. Participant 4 expressed, “Right now, the reason I worry about Corona is that I will have to be completely alone for the birth of my child. I wish this would end.”

2. Guilt and interpersonal helplessness

Difficulty maintaining quarantine boundaries often led to self-blame and blame from others when family members became infected. Participant 1 recalled, “While running a high fever myself, I was still trying to care for my daughter and son. Despite this, my husband blamed me, saying, ‘You infected the children!’”

In other cases, partners failed to follow safety measures, which left the women feeling powerless. Participant 1 added, “I even refused to attend my brother-in-law’s wedding to stay safe. We fought over this, but my husband and children went anyway. They caught the virus and infected the entire household.”

This created a sense of futility. As P1 said, “I took care of myself, but my husband kept going out. He contracted the virus and passed it to me. What could I have done?”

3. Unmet expectations of specialized healthcare support

Participants felt that the healthcare system failed to recognize their vulnerability, especially when private clinics closed. Participant 9 lamented, “The majority of physicians shut down their private practices. I had to seek care at crowded medical facilities. I am pregnant. I am carrying another life, so I should be treated with special care.”

Theme 3: Psychological Disturbance and Existential Rupture

This theme reflects the participants’ psychological distress, including intensified physical symptoms, persistent anxiety and depression, and disconnection from their pre-pandemic lives.

1. Somatic amplification and pervasive anxiety

Psychological distress often intensified the perception of physical symptoms. Participant 8 recalled, “A persistent cough while pregnant, frequent urination, eye pain, edema, loss of taste and smell, bone pain, insomnia, shortness of breath… I was completely disoriented.”

After receiving a positive diagnosis, anxiety quickly took over daily life. Participant 5 shared, “As soon as I found out I had Corona, I became extremely stressed. I would pace back and forth, repeating, ‘I have Corona, I have Corona.’ We were quarantined for 20 days.”

2. Emotional depletion and existential rupture

Long periods of quarantine contributed to depressive feelings and emotional exhaustion. Participant 2 recalled, “I felt down and completely disoriented from being confined at home for a month without seeing my loved ones. I just cried uncontrollably.”

For many, coping meant withdrawing from the outside world. Participant 3 said, “During this pandemic, there were no New Year’s visits. No one was allowed to come

to our house for three months; we only spoke on the phone."

The constant stream of negative news created a sense of rupture from normal life. Participant 9 noted, "Watching videos online of people collapsing on the ground caused me great fear. It felt as if our world had suddenly changed."

This was echoed by P5: "Hearing the news brought me closer to death."

Table-1: Themes and Sub-themes of the Lived Experiences of Fear of Loss among Pregnant Women with COVID-19.

Theme	Sub-theme	Exemplar verbatim quotation
Theme 1: Dread of Infection and the Threat of Loss	Fear of fetal loss	"I am more worried about my fetus than myself. Fear of losing the fetus or the fetus being incomplete." (P3)
	Fear of fetal complications	"Someone told me that even if I recover, it is not known what harm this virus will do to the child." (P5)
	Fear of losing one's own health	"I was saying to myself that we must have been poisoned. Because I didn't want to accept that we got corona." (P5)
	Fear of unknown or contradictory information	"I did not follow the news. Hearing the news of death from the media made me anxious." (P10)
	Fear of losing loved ones	"Hearing the news brought me closer to death." (P5)
Theme 2: The Burden of Care: Diminished Support and Fractured Self-Care	Disorientation in self-care navigation	"I felt like everything was like a nightmare, it was impossible to get out of it. I was physically and mentally very tired." (P6)
	Physical and mental exhaustion from protective care	"The absence of my husband and mother during my illness was terrible. I was quarantined in my child's room." (P6)
	Solitude in self-care and pregnancy management	"I was weeping because my husband was not with me and I was scared… I felt like my heart was going to stop." (P10)
	Internalized and externalized guilt of infection	"Despite this, my husband said that you infected the children!!" (P1)
	Helplessness in maintaining household quarantine	"My husband and children went to the wedding. They got cold and infected with Corona virus." (P1)
	Sense of futility and failure in self-care efforts	"I took care of myself but my husband was going out. He got the virus and passed it on to me, what could I do?" (P1)
	Unmet expectations of specialized healthcare support	"I am pregnant. I am considered two people, I should be looked at more specially." (P9)

Theme	Sub-theme	Exemplar verbatim quotation
Theme 3: Psychological Disturbance and Existential Rupture	Somatic amplification of physical symptoms	"Corona symptoms changed every day. Just when you thought you were cured, another symptom would appear." (P8)
	Pervasive stress dominating daily life	"As soon as I found out that I have Corona, I became very stressed." (P5)
	Anxiety and depressive symptoms during isolation	"During this pandemic there were no New Year's meetings. No one was permitted to come to our house for 3 months." (P3)
	Emotional and mental depletion	"My lifestyle was leading to increased loneliness. I mean, I was becoming a bit of a loner because I hadn't seen other people in a long time." (P4)
	Disconnection from the pre-pandemic world	"I used to get very upset when I saw the memories and behavior of my roommate's wife. I was mentally drained." (P1)

4- DISCUSSION

The findings of this study suggest that pregnancy during COVID-19 was experienced by Iranian women not merely as a clinical condition, but as a lived experience of fear, instability, loss, and disruption of everyday life. At the center of participants' accounts was fear of loss, including concern for maternal and fetal health, disruption of supportive relationships, and erosion of psychological security. This finding is consistent with previous studies reporting increased anxiety, depression, and disruption of the natural experience of pregnancy during the pandemic (19–21). Compared with other groups in society, pregnant women may have experienced a deeper existential distress because they were simultaneously concerned for themselves and their unborn child (19).

One of the most prominent dimensions of this experience was persistent concern about vertical transmission and its uncertain consequences for the fetus. Pregnant women were confronted with contradictory information, rapidly changing guidelines, and scientific ambiguity, all of which undermined their sense of reassurance. This finding is in line with previous studies identifying fear of fetal harm and uncertainty about pregnancy outcomes as major concerns among women during the COVID-19 pandemic (22–26). In the present study, however, this fear was not merely cognitive; it was embodied in constant vigilance, restlessness, and hesitation in everyday decision-making. From a phenomenological perspective, confrontation with the possible loss of an existentially significant being, such as one's unborn child, can profoundly alter the lived world and intensify protective responses.

Another important finding was the erosion of support and the emergence of a burden of care in the context of crisis. Hospital restrictions, reduced routine visits, difficulties in accessing services, and limits on companion presence left many women feeling abandoned and insufficiently cared for. This experience is consistent with studies reporting disruption in routine maternity care and a diminished sense of safety during pregnancy and childbirth in the pandemic period (21, 22,

27). In this context, maternity care was not experienced solely as a medical service; rather, it functioned as a relational network of reassurance, continuity, and support that became fractured under crisis conditions.

Insufficient support from husbands and family members further intensified this psychological burden. Participants described how responsibility for protecting both themselves and their fetus fell largely on their own shoulders, resulting in loneliness, fatigue, and emotional exhaustion. Previous evidence has similarly shown that family and spousal support can reduce pregnancy-related stress, whereas its absence is associated with greater anxiety (28, 29). In the present study, however, the issue extended beyond inadequate support and pointed to a disruption in the experience of belonging and being-with-others. Women's strong desire for their husbands' presence during care and treatment reflected a deep need for meaningful companionship in times of crisis (29, 30).

Fear of death and of the unknown consequences of the disease was also strongly present in participants' narratives. Continuous exposure to news of death and ambiguous bodily symptoms led many women to interpret even minor physical changes as signs of imminent danger, reflecting a form of somatic amplification. In the COVID-19 literature, fear of death and uncertainty have been identified as major sources of psychological suffering (31, 32). During pregnancy, this fear may become even more intense because the woman perceives herself and her fetus as simultaneously at risk, transforming anxiety into a persistent existential condition that reshapes the meaning of pregnancy itself (19, 23).

From a phenomenological standpoint, the pandemic can be understood as producing a rupture in pregnant women's being-in-the-world. The taken-for-granted order of daily life, the predictability of care, and the sense of continuity were all disrupted. In the Iranian context, this rupture appears to have been intensified by structural limitations in the healthcare system, economic pressures, and cultural meanings attached to pregnancy and family life. As a result, pregnancy during COVID-19 became, for many women, an experience marked by loss of control, loss of support, and loss of certainty. Nevertheless, the findings also suggest that despite structural and cultural differences, the core concerns and underlying structure of fear among mothers during this crisis had a transnational and universal character (23, 30).

Given these findings, care for pregnant women during public health crises should not be limited to clinical follow-up alone. Educational, psychological, and social dimensions of care should be addressed simultaneously. Fully online educational classes, virtual counseling, remote follow-up, and accessible health education platforms may help strengthen self-care, reduce anxiety, and enhance women's sense of security during pregnancy (6, 30). In addition, the active involvement of husbands and family members, whenever feasible, should be considered part of supportive care strategies. These recommendations are particularly important in crisis situations, when vulnerable groups such as pregnant women may be unintentionally deprioritized within healthcare systems and left to bear their psychological burden in isolation.

This study also had several limitations. Limited access to participants, difficulty conducting face-to-face interviews because of rapid discharge and infection-control protocols, and differences in health literacy may have influenced how experiences were expressed. Nevertheless, the use of virtual interviews in some cases provided a safer and more flexible setting and may have enabled participants to share their experiences more openly and comfortably.

5- CONCLUSION

Pregnant women diagnosed with COVID-19 experienced profound challenges in their everyday lives and self-care practices. Their experience extended far beyond physical illness and was marked by fear, uncertainty, loneliness, disrupted support, and deep psychological distress. In such circumstances, fully online education and virtual counseling may provide important informational, psychological, and social support and may help strengthen self-care. Establishing accessible platforms for personal health education, particularly for pregnant women, is therefore essential. At the same time, public health crises may inadvertently marginalize vulnerable groups, leaving them to endure psychological suffering in isolation. Health policy should therefore respond not only to the immediate clinical demands of crises, but also to the emotional and supportive needs of vulnerable populations such as pregnant women.

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7- CONFLICT OF INTEREST: None.

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