ORIGINAL ARTICLE

Care during childbirth and the puerperal period during the COVID-19 pandemic: implications for the humanization of care

Atenção ao parto e puerpério durante a pandemia de COVID-19: implicações na humanização do cuidado

Atención al parto y puerperio durante la pandemia de COVID-19: implicaciones para la humanización de la asistencia

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ABSTRACT

Introduction: to know the implications of the COVID -19 pandemic in the humanization of care in two public maternity hospitals in Southern Brazil from the perspective of the multidisciplinary health team. **Methods:** qualitative study conducted with 16 health professionals who worked in public maternity hospitals during the COVID-19 pandemic. Data collection was performed from April to June 2021 through a semi-structured interview. The interviews were recorded, transcribed and analyzed thematically. **Results:** health professionals were concerned about adapting to the context of the pandemic without losing focus on the humanization of care. Changes were needed in maternity hospitals, which compromised the implementation of good practices, such as restricting the presence of a companion and separation of mother and baby in the case of patients with COVID-19. **Conclusion:** the restrictions imposed by the pandemic were necessary in that context, as there were many doubts about how to intervene in childbirth and postpartum period care. However, they affected several achievements in relation to the humanization of care, limiting individual rights in favor of collective interests.

Descriptors: COVID-19; Humanization of Assistance; Parturition; Postpartum Period; Qualitative Research.

RESUMO

Introdução: *conhecer as implicações da pandemia COVID-19 na humanização do cuidado em duas maternidades públicas no Sul do Brasil na perspectiva da equipe multiprofissional em saúde.* ***Métodos:*** *pesquisa qualitativa realizada com 16 profissionais de saúde que atuavam em maternidades públicas durante a pandemia da COVID-19. A coleta de dados foi realizada de abril a junho de 2021 por meio de entrevista semiestruturada. As entrevistas foram gravadas, transcritas e analisadas tematicamente.* ***Resultados:*** *os profissionais de saúde apresentaram preocupação em se adaptar ao contexto da pandemia, sem perder o foco na humanização da assistência. Foram necessárias mudanças nas maternidades que comprometeram a implementação das boas práticas, como a restrição à presença do acompanhante e a separação entre mãe-bebê no caso de pacientes com COVID-19.* ***Conclusão:*** *as restrições impostas pela pandemia foram necessárias naquele contexto, pois existiam muitas dúvidas sobre como intervir na atenção ao parto e puerpério, entretanto afetaram diversas conquistas em relação à humanização do cuidado, limitando os direitos individuais em prol de interesses coletivos.*

Descritores: *COVID-19; Humanização da Assistência; Parto; Período Pós-Parto; Pesquisa Qualitativa.*

RESUMEN

Introducción: *conocer las implicaciones de la pandemia COVID-19 en la humanización de los cuidados en dos maternidades públicas del sur de Brasil desde la perspectiva del equipo multiprofesional de salud.* ***Métodos:*** *investigación cualitativa realizada con 16 profesionales de salud que trabajaron en maternidades públicas durante la pandemia de COVID-19. Los datos se recogieron entre abril y junio de 2021 mediante entrevistas semiestructuradas. Las entrevistas se grabaron, transcribieron y analizaron temáticamente.* ***Resultados:*** *los profesionales de salud mostraron preocupación por adaptarse al contexto pandémico, sin perder de vista la humanización de la atención. Fueron necesarios cambios en las maternidades que comprometían la aplicación de buenas prácticas, como la restricción a la presencia de un acompañante y la separación entre madre y bebé en el caso de pacientes con COVID-19.* ***Conclusión:*** *las restricciones impuestas por la pandemia eran necesarias en ese contexto, ya que había muchas dudas sobre cómo intervenir en la atención al parto y al puerperio, sin embargo afectaron a varios logros en relación con la humanización de la atención al limitar los derechos individuales en favor de intereses colectivos.*

Descriptores: *COVID-19; Humanización de la Atención; Parto; Periodo Posparto; Investigación Cualitativa.*

INTRODUCTION

The pregnancy-puerperal period is a physiological process of a woman's life and comprises the process of pregnancy, delivery and puerperal period. It demands quality technical humanized care anchored in good practices[1].

During the COVID-19 pandemic, pregnant and postpartum women up to two weeks after giving birth were included in the risk group for the new coronavirus (SARS-Cov2)[2]. Research has identified repercussions of COVID-19 on pregnancy, childbirth and the puerperal period, such as increased risk of maternal morbidity and mortality, high rates of miscarriage, premature birth and intrauterine growth restriction[3]. In the case of pregnant women, it affected the way they experience the process of becoming pregnant and giving birth[4], including increased stress, changes in sleep patterns, difficulties in practicing physical exercises and impairment in social interactions[5].

In the first months of the pandemic, protocol changes were imposed in health institutions around the world to prevent the transmission of the virus, which modified pregnant women's expectations in relation to childbirth, causing additional levels of fear, concern and uncertainty. In Brazil, the presence of a companion, guaranteed by Law n. 11.108/2005, was affected by the new routines adopted in maternity hospitals, as well as the Golden Hour, late umbilical cord clamping and early breastfeeding of the newborn. In other countries, these practices were also impaired, mainly regarding the presence of a companion, in addition to others such as the prohibition of baths and birthing pools, suspension of home births and other conducts that directly interfered with humanized childbirth[6-8].

The reorganization of care in maternity hospitals caused a feeling of powerlessness in women and their families, who, when subjected to protocols of institutions, lost their right to choose at various times[9]. Furthermore, there were difficulties with antenatal and puerperal follow-up, scheduling appointments and exams.

In addition to the preventive measures instituted in health services, it is essential to guarantee quality obstetric care based on the principles of humanization. Such a concept is understood as a polysemic term encompassing the conception of childbirth as a physiological event, emphasizing the protagonist role and autonomy of women, recommending behaviors that promote respectful embracement and evidence-based conduct[10].

In this context, Good Practices of Delivery and Birth are part of the scope of humanization of care in the pregnancy-puerperal period. They comprise the categories related to usefulness, effectiveness and risk, that is, a classification of common practices in the management of labor and birth that guides health professionals so they enable a positive experience for the mother-baby dyad[11]. In these perspectives, when reflecting on their practices, health professionals commit to considering the physical and emotional changes of the pregnancy and puerperal cycle associated with the economic and psychological repercussions of the pandemic[12].

Thus, in view of the above, the aim of this study is to know the implications of the COVID-19 pandemic in the humanization of care in two public maternity hospitals in Southern Brazil from the perspective of the multidisciplinary health team.

It is expected that the present study will contribute both to record the changes that occurred in the context of the pandemic, and to the reflection of professionals and managers of maternity hospitals regarding the institutional routines established in times of crisis and their impact on the experience of childbirth and birth in each family. The results may support the development of pu-

blic health policies that safeguard women's rights even in such an adverse and complex context and reinforce the importance of maintaining and improving these practices even in non-critical scenarios.

METHODS

Qualitative study conducted in two public maternity hospitals in the South of Brazil, with participation of 16 professionals from the multidisciplinary team from April to June 2021.

Maternities were chosen because they are references in labor and birth care. Both have the title of *Hospital Amigo da Criança* (Baby-Friendly Hospital Initiative) and offer humanized care for pregnant, puerperal women and newborns.

The inclusion criteria were: professionals who participated in the process of implementing routine changes in the care of pregnant, parturient and postpartum women during the pandemic. Professionals on leave by leave of absence or other reasons, and professionals hired after the implementation of new routines in maternity hospitals were excluded.

Participants were selected by means of the Snowball method. The initial participants or key informants were two nurses chosen by the researchers for their outstanding performance in maternity hospitals. They were contacted by email and invited to participate in the study and each one indicated new professionals. The interviews were scheduled on a day and time preferred by participants, carried out through the Google Meet® platform (2021, Google LLC, United States of America). During the interviews, professionals were in a place chosen by them, without the presence of other people. All interviews were conducted by the same researcher with previous experience in data collection in a virtual environment and skills to give fluidity to the interview in order to explore the depth of the theme.

The interview script consisted of demographic and professional data and two guiding questions: What has changed in the care of pregnant/parturient/postpartum women in the face of the pandemic? How did the changes in care imply the work of the multidisciplinary team?

The interviews lasted an average of 16 minutes and were recorded using an audio application and transcribed in full. Data analysis comprised three steps[13]: pre-analysis including transcription; skim reading and exhaustive reading of the interviews; and understanding the central idea of the object of study. When exploring the material, significant excerpts were highlighted, and a spreadsheet was created to group the reports by themes and categories, analyzing the similarities and differences, creating connections between the excerpts and interpreting the results obtained. In the treatment and interpretation of results, inferences and interpretations were carried out inter-relating with what public health policies advocate in relation to the humanization of care.

This study was approved by the Research Ethics Committee under opinion number 4.593.679. The Informed Consent Form was sent by e-mail to participants, for reading and consent prior to the interview. Participants were informed about the purpose of the study, risks and benefits. The closure of data collection occurred when no new findings were identified, that is, when achieving data saturation. A code was adopted to maintain anonymity, including the abbreviation N (nurse), D (doctor), P (psychologist), Nut (nutritionist), SW (social worker), PH (physiotherapist) and S (speech therapist), followed by the sequential Arabic number according to the order of interviews, for example, N1.

RESULTS

Six nurses, two doctors, three physiotherapists, a speech therapist, two social workers, a nutritionist and a psychologist participated in the study. All were female, aged 30–59 years; 56% were aged 30–39 years, 31% were 40–49 years, and 13% 50–59 years. The time working in the maternity ward ranged from one year and nine months to 25 years and six months, with an average time of seven years.

Two categories emerged from the interviews: Adapt without losing focus on humanization; Separation between mother and baby during hospitalization.

Adapt without losing focus on humanization

In this category, it was possible to learn that the multidisciplinary team experienced challenges and tensions to provide humanized care, centered on women's needs and on biosecurity measures recommended for the first year of the pandemic.

One of the issues that most affected humanization was the restriction on the companion's presence due to the health measures instituted in the first months of the pandemic.

In the investigated institutions, in early March 2020, it was established that the presence of the companion would be suspended during labor, delivery and postpartum period with the aim to reduce the circulation of people within the place and ensure social distancing. Later on, this restriction was maintained only in the puerperal period, as revealed in the statements below:

The main change was the companion issue. At the beginning of the pandemic, the companion was prohibited at any time, this was very harmful... (D1)

[...] having lost the possibility of having [...] a companion in the puerperal period is complicated. Although I understand this is it, it is a pandemic and nobody chose it, it is an important loss for women, for their reproductive rights, really. (D1)

Restricting the presence of a companion is characterized as a violation of women's reproductive rights guaranteed in the law of the companion. In a condition of emotional vulnerability, marked by fear of the pandemic and lack of support from a trusted person, the team found it difficult to bond with the woman:

*[...] in an extremely emotionally vulnerable condition, I found it difficult to bond, because she had another basic and essential need, which was to have the presence of someone she could trust at that moment. [...] how much she wanted the baby's father or her mother to be there with her, or anyone else she wanted. (*SW1)

The team sought to provide safe care by minimizing the impacts of the pandemic and maintaining care with a focus on the humanization of care:

Our issue in maternity is to adapt assistance without losing our humanization north. Without losing our guidelines [...] how to maintain humanization in an adapted way in times of COVID? [...] it was a great impact for the team, everyone had to reinvent themselves. (P1)

We try to do as much as possible for the pregnant woman within humanization. We are going through a difficult moment [...]. Now it turned out that everyone is more adapted, but within humanization, we try to do our best. (N6)

The professionals reported that keeping the focus centered on the woman, on her care needs while maintaining biosecurity issues at the same time generated tension in the team, especially at the time of labor and delivery, when women were unable to maintain the correct use of the mask, according to recommendations of health standards for that moment:

The patient in labor is in pain and can hardly remain wearing a mask [...]. They often end up not wearing a mask, because they need to breathe, they are in pain [...]. So, there are risks that increase tension in the team. (N2)

The multidisciplinary team identified that the pandemic generated a greater need for healthcare in all aspects of care, requiring more time from professionals for listening and paying attention to emotional needs:

It demanded from the whole team a need for an even greater attention than what we already try to give [...]. So, it ends up making the time of my presence with her a little longer than expected, I will hear more of her emotional needs at that time. (SW1)

Separation between mother and baby

In this category, it is evident that the separation between mother and newborn who tested positive for COVID-19 and required intensive care interfered with bonding, breastfeeding and visits within the intensive care unit (ICU) itself. The team sought strategies to minimize this impact on healthcare.

In some cases of patients with Covid-19, the separation between the mother and her newborn was a situation that marked the multidisciplinary team in two aspects: the lack of the mother-baby bond in the first days of life and the performance of the team seeking to minimize this impact:

What impacted me as an intensivist was the baby being born, a premature baby, and the mother having to stay 10, 15 days without being able to meet her child. Of us suddenly having to bring a cell phone into the ICU to make a video so we could send to a mother in another hospital, images of her baby, which she will not be able to hold, she will not be able to get close [...]. these are negative changes. (D2)

[...]. If a bond is lost, mothers are in a period of isolation outside the unit, without having contact with the baby, those who do not evolve well, those who are intubated, who need an Intensive Care Unit [...]. the baby stays there with us, with another family member accompanying [...] it is very sad to separate the mother from the little baby. And sometimes when this mother returns, we realize there is a bit of a loss of the bond. (PH3)

The separation between mother and baby affected the breastfeeding process and the alternative found by the professionals was to resort to the milk bank, considering that the expression of breast milk was suspended given the risk of contamination:

If we have a mother with COVID and her little baby is in the neonatal ICU [...]. Before, when there was no pandemic, this mother could express her milk and offer it to her baby. Now it is not possible to do this, given the risk of contamination. So, many times we have to go after the milk bank while the mother is there full of milk. (NUT1)

The professionals reported that permission for the presence of the family alongside the newborns admitted to the Neonatal Unit was obtained after a long struggle, and that during the pandemic this whole process went backwards to follow safety protocols:

[...] we fought for 10 years, 20 years to get the family into the ICU, so grandparents could meet their grandchildren [...] and suddenly everything was taken away from us and we had to learn to live with it and know there is nothing we can do. (D2)

We took several steps forward in terms of humanization, embracement of the family, keeping the family inside the ICU [...] we had to go back to square one. Several achievements of the Kangaroo Method [...], we had to rethink. (SW2)

DISCUSSION

In several countries, the crisis in the health system generated by the pandemic changed the routine of obstetric services, interfering with care. Delivery and birth care was marked by a setback in relation to good obstetric practices with the prohibition or control of the presence of a companion during labor, delivery and postpartum period; the suspension of the presence of doulas; restriction of visits, reduction of care spaces during antenatal care, among others[9].

Changes in care directly affected several achievements in the humanization of care during the pregnancy-puerperal cycle through the creation of inadequate obstetric protocols that go against what is recommended[6,9]. These negative implications were seen by the maternity hospital staff as significant losses of rights won after many years of struggle.

In the process of pregnancy, delivery and birth, all women have the right to receive qualified care, considering the humanization of the entire health care network. In this perspective, the flows of care to this population must protect their rights and provide safe assistance[4]. In times of a pandemic, we observe the sudden loss of conquered rights.

The teams found it difficult to adapt to the new sanitary measures, considering the need for social distancing and limiting the number of people in the units without losing focus on humanization and good care practices. From this perspective, even in a pandemic context, it is necessary that public health concerns are balanced with respect for autonomy, informed choice and evidence, preventing past mistakes from being committed, also putting the health, safety and integrity of patients at risk[9].

In maternity hospitals, contact precautions measures were applied regardless of the parturient's infection status, being greater for women who tested positive for Covid-19, with implications for childbirth care. The absence of physical contact distances professionals from care and undermines the professional-parturient bond. In addition, the use of personal protective equipment, although extremely important and necessary, distances the relationship between those who care and those who experience childbirth and may cause discomfort and make the process difficult[14].

It is important to highlight that maternity hospitals must recognize the right of pregnant women to receive humane and safe care, even in a pandemic context[6]. In this sense, technical note number 9/2020 of the Ministry of Health of Brazil published in April 2020 already advised that all pregnant women and their companion should be screened before admission to the obstetric service. The presence of a companion during childbirth is mentioned in the document with the caveats that there is no rotation between companions, the companion is asymptomatic and does not belong to risk groups for COVID-19, but data from this study show that the restriction was applied in large scale[15].

According to interviewee's reports, the ban on the presence of a companion during labor, delivery and postpartum period with the purpose to reduce the movement of people in the place and ensure social distancing was considered the greatest implication brought by the pandemic to the care during delivery and birth, going against a right guaranteed by law and advocated by public health policies.

In addition, since the beginning of the pandemic, the World Health Organization (WHO) has recommended the continuity of the guarantee of safe, respectful and quality care throughout the pregnancy and puerperal cycle for all women and their newborns, including those with confirmed or suspected COVID-19 infection, including mental health care, having a companion of choice, clear communication by maternity staff, appropriate pain relief strategies and mobility in labor whenever possible, position of birth of their

choice, the permanence of women with their babies and skin-to-skin contact[16].

The lack of continuous support from the companion during labor and delivery can harm care. A systematic review study provides evidence that the presence of a companion improves outcomes for women and babies. For women, it increases the chance of spontaneous vaginal delivery and reduces the duration of labor, cesarean delivery, instrumental vaginal delivery, use of any pharmacological analgesia, and negative feelings about the delivery experience. For babies, it reduces the chance of a low rate of Apgar score at fifth minutes after birth[17]. Thus, the restriction on the presence of a companion imposed by the COVID-19 pandemic implies an increase in the vulnerability to which women are exposed and possibly, in unnecessary interventions.

Childbirth is a life event shared by the pregnant woman, her partner and family members, and these people provide support and security, defending the rights of the mother and baby. Thus, the presence of a companion throughout the pregnancy-puerperal period, in addition to understanding and ensuring that the pregnancy should not be lonely, brings more security, confidence and encouragement to the woman, ensuring physical and emotional support, and may contribute to optimize the quality of healthcare offered[18].

Over time, the presence of a companion during labor, delivery and immediate postpartum period in the maternity wards was released. However, the woman and the baby remained unaccompanied in the rooming-in care, a period in which this presence is also important, as the woman goes through numerous transformations, changes and adaptations in the puerperal period, needs support and physical and emotional assistance, not only to care for the newborn, but also for self-care[19].

The right to the presence of a companion emerged in Brazil along with the movement for the humanization of childbirth and guarantees women the presence of a person of their choice during labor, childbirth and the immediate postpartum period in the public health system and supplementary network[5]. In the pandemic context, the United Nations, the World Health Organization and the Ministry of Health issued a recommendation to maintain the right to a companion even in times of a pandemic, with no plausible justification for restricting a companion at any stage of the pregnancy and puerperal cycle as a measure to combat the spread of the coronavirus.

In the absence of a companion in maternity hospitals, women lose this support network and depend more on the support of professionals at maternity hospitals, directly affecting the team's work with an increased workload both in terms of care for the newborn and the puerperal woman, but mainly, regarding the much needed emotional support in this fragile and unique moment of their lives[19].

Another implication of COVID-19 refers to the monitoring of newborns in neonatal hospitalization. Premature birth and hospitalization of a newborn cause reactions such as fear, anxiety, helplessness and the need to be with and take care of the child[20]. The need to separate the mother-baby dyad gives rise to feelings of disappointment and frustration, and interrupts the formation of bonding and attachment[21]. These factors are magnetized when the visiting time of parents is reduced within the Neonatal Unit, as occurred in maternity hospitals participating in this study.

Free access and the right to stay in the hospital hampered by the sanitary conditions arising from the pandemic directly interfere with the formation and strengthening of the bond between mother and baby. Furthermore, the lack of family contact with the newborn affects the relational and subjective aspects that constitute the formation of personality, child development and the experience of parenting[22].

When women are prevented from monitoring the hospitalization of newborns in the Neonatal Unit, several aspects of the humanized care policy for newborns (including the Kangaroo Mother Care) advocated in our country are not put into practice. The absence of the mother or a family member to accompany the hospitalization of newborns prevents them from participating in routine care and making skin-to-skin contact, which leads to a distancing that makes it impossible for them to recognize the warning signs in their children[23]. These situations can become a risk to the development of these babies, in addition to negatively affect the mother-baby bond[24].

Another aspect concerns breastfeeding and milk extraction. Breastfeeding has evidence-based benefits in the reduction of mortality from infectious diseases and in the formation of the affective bond between mother and child[25]. The advent of the pandemic brought questions from professionals about the safety of maintaining breastfeeding for mothers confirmed to be infected with SARS-Cov-2. However, as the recommendations were published nationally and internationally, breastfeeding became guaranteed even for women in serious or critical conditions, recommending the ex-

traction of milk to maintain production. For cases of newborns admitted to a Neonatal Unit and the mother in good health, it is recommended to express and offer milk to the baby with hygiene care and the use of a face mask during milking[3,19].

Humanization was compromised in several aspects. The restriction of the companion's presence in the rooming-in was one of the most significant implications that negatively affected the puerperal experience for women, who became emotionally vulnerable without the presence of a reference person as a source of support during this period. The reduction in visiting hours and the numerous cases of women with COVID-19 brought damage to the formation of the bond between mothers and their children.

Finally, it is important to highlight that we still do not know the effects of all these restrictive measures in the medium and long term on the physical and mental health of women, newborns and their families.

A limitation of this study was the fact that data collection was carried out only in the Southern Region of Brazil. However, this reality was experienced in the different services that make up the care network for women and newborns in our country. This study brings results for rethinking the changes that affected the humanization of care, the limitation of individual rights in favor of collective interests, and the importance of guaranteeing already acquired rights that guide public policies in the area of obstetric health. Such results will serve as a basis for facing future adversities that may arise.

CONCLUSION

The pandemic generated changes in the care provided at maternity hospitals. In this study, the multidisciplinary team showed concerns with the implications of these changes in the care provided to women and newborns and in the maintenance of humanized care practices. Despite all the difficulties, they worked to ensure quality care by respecting biosafety standards, protecting the public from the risks posed by COVID-19 and trying to minimize the damage imposed by our context.

The results highlight the fragilities of the management of the Brazilian public health system in the face of emergency situations, the loss of conquered reproductive rights and the way in which these fragilities interfered in the service to the community and in the work of health professionals. In addition, the study seeks to bring reflections on care by stimulating and sensitizing the multidisciplinary health team so they develop strategies for the humanization of care in childbirth and postpartum care in the face of adverse contexts, as in the case of the pandemic.

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CONFLICT OF INTERESTS

None.

CONTRIBUTIONS ROLES – CRediT

CAL: conceptualization; data curation; formal analysis; investigation; methodology; project administration; resources; validation; visualization; writing – original draft and writing – review & editing.

MML: conceptualization; data curation; formal analysis; investigation; methodology; project administration; supervision; validation; visualization; writing – original draft and writing – review & editing.

BBS: validation; visualization and writing – review & editing.

RC: validation; visualization and writing – review & editing.

LAW: validation; visualization and writing – review & editing.

MPD: validation; visualization and writing – review & editing.

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