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Interrupted dreams: birth experiences during the covid-19 pandemic

Sonhos interrompidos: experiências de parto durante a pandemia de covid-19

Sueños interrumpidos: experiencias de parto durante la pandemia de covid-19

ABSTRACT

Objective: To analyze women's experiences in relation to childbirth during the covid-19 pandemic. **Method:** Qualitative research, carried out with women diagnosed with covid-19 since the beginning of the pandemic. Semi-structured interviews and thematic content analysis were used. **Results:** For the 20 women in the study, the covid-19 pandemic was an experience that caused insecurity, fear, and the need to reorganize birth plans. The results were organized into two thematic units: "On the way to childbirth: uncertainty and insecurity" and "Childbirth: from a family event to isolation". **Conclusion:** The search for care by women who needed obstetric care during the pandemic was marked by difficulties, exposing and intensifying weaknesses in the health system, especially access to services and the use of good practices, with negative repercussions on their experiences in childbirth.
Descriptors: Covid-19; Parturition; Family; Social isolation.

RESUMO

Objetivo: Analisar as experiências de mulheres em relação ao parto durante a pandemia de covid-19. **Método:** Pesquisa qualitativa, realizada com mulheres diagnosticadas com covid-19 desde o início da pandemia. Utilizaram-se entrevista semiestruturada e análise de conteúdo na modalidade temática. **Resultados:** Para as 20 mulheres do estudo, a pandemia de covid-19 foi uma experiência que provocou insegurança, medo e necessidade de reorganização dos planos de parto. Os resultados foram organizados em duas unidades temáticas: "A caminho do parto: incerteza e insegurança" e "Parto: de um evento familiar ao isolamento". **Conclusão:** A busca por cuidados pelas mulheres que necessitaram de atendimento obstétrico durante a pandemia foi marcada por dificuldades, expondo e intensificando fragilidades do sistema de saúde, especialmente o acesso aos serviços e à utilização de boas práticas, repercutindo negativamente em suas experiências no parto.
Descritores: Covid-19; Parto; Família; Isolamento social.

RESUMEN

Objetivo: Analizar las experiencias de las mujeres en relación con el parto durante la pandemia de covid-19. **Método:** Investigación cualitativa, realizada con mujeres diagnosticadas de covid-19 desde el inicio de la pandemia. Se utilizaron entrevistas semiestructuradas y análisis de contenido temático. **Resultados:** Para las 20 mujeres del estudio, la pandemia de covid-19 fue una experiencia que causó inseguridad, miedo y la necesidad de reorganizar los planes de parto. Los resultados se organizaron en dos unidades temáticas: "En el camino hacia el parto: incertidumbre e inseguridad" y "El parto: de un acontecimiento familiar al aislamiento". **Conclusión:** La búsqueda de atención por parte de las mujeres que necesitaron atención obstétrica durante la pandemia estuvo marcada por dificultades, exponiendo e intensificando las debilidades del sistema de salud, especialmente el acceso a los servicios y el uso de buenas prácticas, con repercusiones negativas en sus experiencias en el parto.
Descriptores: Covid-19; Parto; Familia; Aislamiento social.

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INTRODUCTION

Delivery is considered a unique event that permeates the entire pregnancy process in the form of expectations and anxieties and continues to be remembered for years, leaving a profound mark on the history of the mother and child. A positive birth experience can improve maternal well-being and facilitate the mother-baby bond, while a negative experience can generate psychological suffering, as well as serious forms of illness, with long-term repercussions on the lives of these mothers and their families[1].

In Brazil, the obstetrics scenario has achieved many achievements in recent years, with the National Humanization Policy and the Stork Network Strategy, in force at the time, which implemented good practices for care during labor and birth, such as encouraging facilitating exercises, monitoring fetal well-being, offering oral nutrition, respecting freedom of position, presence of a companion of the woman's free choice, encouraging skin-to-skin contact and breastfeeding, making delivery an event centered on the woman and her protagonism[2].

In 2020, when the world was affected by the COVID-19 pandemic, a previously unknown disease with high transmissibility, with an undefined clinical course and treatment, many health services, including maternity hospitals, underwent changes in the provision and organization of services in order to minimize the risk of contamination. In these maternity hospitals, humanization practices in labor and birth care, which in many places were still in the implementation phase, suffered a series of restrictions[3].

This situation affected the lives of women throughout the pregnancy and puerperium cycle, as well as their partners and family members, especially in relation to the prevention of the presence of a companion, a reduction in the support network, in addition to the need to deal with an overload of news, financial difficulties, a greater risk of domestic violence and remote work and school activities[4].

For parturients diagnosed with COVID-19, this situation became even more intense, due to the deprivation of skin-to-skin contact with the newborn (NB), the absence of a companion and the difficulties imposed on breastfeeding. These conditions, which generate anxiety, can lead to significant maternal and fetal complications, such as hypertension, reduced placental blood flow, premature labor, obstetric complications during delivery, and changes in the child's neuropsychomotor development[5].

In addition to the risk inherent to the disease, the determination of social isolation brought about changes in the population's way of life and in the organization of health services, causing a reduction in the time of consultations during pregnancy and even restricting the access of postpartum women and newborns to post-discharge monitoring. These changes created an important gap in knowledge about how these changes impacted the birth experience and the lives of women and their families during the pandemic.

By exploring the implications of the pandemic on delivery and obstetric care, the results of this study may support more humane and effective intervention strategies for monitoring pregnant women in crisis situations such as that caused by COVID-19, in addition to guiding the development of new public health policies aimed at improving obstetric care services

and promoting women's comprehensive health in adverse contexts.

Since COVID-19 is a new disease, there is a need for research, especially with maternal populations, to understand the impacts of the pandemic on this population considered vulnerable and susceptible to so many adverse effects. In this period marked by uncertainty, the changes in the organizational dynamics of the obstetrics service and their implications on the experiences of these parturients are the subject of this study. In this sense, the objective of this research was to analyze women's experiences of giving birth during the COVID-19 pandemic.

METHODS

Study design

This is an exploratory research, with a qualitative approach, based on comprehensive theory[6]. To structure the analytical support, contributions from the National Humanization Policy[7], National Guidelines for Assistance to Normal delivery[2] and the principles of the Stork Network[8] were used.

This work is part of the study "The covid-19 pandemic and its effects on management and health care in the SUS". The research followed recommendations from the Consolidated Criteria for Reporting Qualitative Research (COREQ), with the following question outlined: What were women's experiences of giving birth during the covid-19 pandemic?

Study location

Data collection was carried out from November 2020 to May 2021, in two highly complex maternity hospitals that are references for COVID-19 care in Maranhão, Brazil, both located in the state capital, São Luís. These two maternity hospitals provided an isolation area for pregnant and postpartum women, as well as an isolated neonatal intensive care unit (ICU) for newborns with suspected or confirmed COVID-19.

Study participants

The study participants were women treated for COVID-19 in the selected maternity hospitals, during pregnancy, delivery and/or postpartum. The inclusion criteria were: having had a confirmed laboratory diagnosis (RT-PCR for COVID-19), verified in the medical records, and having given birth up to six months before data collection. The exclusion criteria were: occurrence of cognitive, hearing and speech problems that could make reporting difficult or impossible. Based on the inclusion criteria, the sample was intentionally defined, seeking to contemplate the diversity of situations encountered, considering the following sociodemographic and clinical characteristics of women and newborns: age, education, marital status, number of children, income, place of residence (urban or rural), gestational age, parity and place of hospitalization (ward and/or ICU). To close the sample, the saturation of meanings technique was adopted, which indicates the interruption of the collection when the data do not bring new information to the object studied[6], which happened after the 15th interview, since the five interviews conducted after this confirmed saturation.

Stages for data collection

The first stage was to approach the research sites to identify the participants. The survey of the study population took place from September to November 2020,

based on the admission records of women hospitalized for COVID-19 in the two maternity hospitals.

From this list, the medical records were consulted to characterize and define the sample. These data were organized into tables for each maternity hospital and categorized, creating typologies in which the women were separated into groups. After this, telephone contact was initiated to present the research and invite them to participate. There were no direct refusals; however, after three unsuccessful attempts to contact the participant, the participant was replaced by another participant from the same group with the same sociodemographic and clinical characteristics. There was no prior relationship between the researchers and the women interviewed.

To supplement the information, the researchers observed and recorded the behavior of the interviewees, including nonverbal communication, such as crying, laughing, choked speech, and silence. This information was noted and considered when interpreting the results.

Data collection technique and instruments

The technique used was the semi-structured individual interview, conducted in a single meeting, led by four of the authors of this study, with training in the health area, three professors, and one PhD student, all with previous experience in qualitative research. Workshops were held to validate the interview script and discuss the approach.

The interviews were conducted in person or online, according to the participants' choice. In total, 20 interviews were conducted, nine by telephone, five at home, five at the hospital (on the dates of the woman's or newborn's follow-up appointments), and one through the Google Meet digital platform. The interviews took place on the days and times most convenient for the participants, with a mean time of 40 minutes. In the case of in-person interviews, all health safety measures were followed, such as wearing a mask, social distancing, hand hygiene and use of alcohol gel. The statements were recorded with consent and later transcribed. In each situation, the location was carefully chosen to ensure confidentiality, autonomy and privacy, with only the interviewer and the participant being present.

The instruments used included a structured questionnaire containing sociodemographic data and information about the clinical history of the woman and the newborn, in addition to a semi-structured script with questions about the women's experiences of giving birth delivery during the COVID-19 pandemic. The data were stored in electronic documents and organized in folders, identified by the date of the interview.

Data analysis

Thematic content analysis was carried out according to the four stages proposed by Minayo (2014)[9]: 1. Data ordering: the transcripts were organized and formatted in Microsoft Word and later organized in an Excel spreadsheet. 2. Data classification: repeated readings were performed to familiarize and initially understand the women's experiences and identify significant words, phrases and paragraphs. 3. Processing of the results obtained: this initial categorization was reorganized into thematic groups arranged in columns in Excel spreadsheets and

coded. 4. Interpretation: when the aim was to understand the meaning of the data in relation to the problem in question. The identified themes were reviewed in analysis workshops, allowing the collaborative development of an analysis map in Excel, which visually organized the categories and the relationships between them, structuring the emerging thematic units. Based on this map, the results were interpreted, relating them to the research objectives and the theoretical framework adopted.

Ethical aspects

The research was approved by the Research Ethics Committee of the University Hospital of the Federal University of Maranhão, CAAE number 35645120.9.0000.5086, based on Resolution 466/2012 of the National Health Council. The participants signed the Informed Consent Form (ICF), and were identified by flower names to preserve anonymity.

RESULTS AND DISCUSSION

The 20 interviewees were between 17 and 40 years old, most were black or mixed race[16], lived in urban areas[17], had completed high school[10], declared themselves to be evangelical[10], were employed[13], lived with their partner[13] and had a family income of up to one minimum wage[10]. Regarding parity, eight were primiparous and 12 were multiparous. The number of living children ranged from one to 11. The delivery method, for the majority, was cesarean section[16] and they did not have a companion during the delivery [11]; of these, seven were black or mixed race and four were white.

Of the 20 women interviewed, eight had comorbidities, such as anemia, gestational hypertensive syndrome, type 2 diabetes mellitus, idiopathic hepatitis, osteosarcoma and obesity. During the period in which they contracted COVID-19, three did not require hospitalization and returned for the delivery later, while the others[17] required hospitalization: seven were hospitalized in the second quarter of pregnancy, ten in the third, and of these, seven remained hospitalized until the postpartum period. In addition, three required ICU care due to the severity of COVID-19.

The interviewees reported that they had built expectations regarding the delivery, based on previous experiences and/or those of other women in their family and social circles, and that being pregnant during the pandemic led to the need to reorganize their plans. Furthermore, receiving the news of the COVID-19 pandemic was an experience that caused insecurity and fear.

In this context, the statements were organized in order to understand these experiences, arranged in two thematic units: "On the way to delivery: uncertainty and insecurity" and "Delivery: from a family event to isolation".

On the way to delivery: uncertainty and insecurity

When seeking care and assistance during delivery, many women reported difficulties in accessing health services. The first of these was related to transportation to the maternity ward, which became even more difficult during the pandemic. Most women traveled by private transport or with the help of family members.

"If we didn't have a car, it would certainly be a great difficulty, because the buses had reduced in number. So we would have had difficulties in this regard"

(Camélia, 28 years old, self-employed, primiparous, without comorbidities).

"We went by car; we had to pay for a taxi" (Lis, 33 years old, housewife, second-time pregnant, with comorbidities).

As some services were suspended, mothers also reported that, initially, they did not know where they could receive care, due to the presence of respiratory symptoms.

"But since everything there [the unit where I received prenatal care] was closed and I didn't have any more appointments, I was afraid of where I would go when I gave birth. And as it was in the middle of the outbreak: 'Will there be a vacancy? What will it be like? If this hospital is going to be very full, with the COVID issue, what will it be like?'" (Iris, 32 years old, physical therapist, primiparous, with comorbidities).

The health measures restricting the movement of people on the streets, reducing public transport and suspending some health services, with the aim of containing the spread of the virus, made access to delivery care services difficult.

Before the start of the COVID-19 pandemic, there was already a flow of pregnant women from peripheral regions towards places where there is a greater concentration of health services. It is emphasized that the greater the distance to be traveled by the pregnant woman, the more difficult it is to access and the lower the likelihood of adapting her needs to the services offered. The inefficiency of a public transport system and failures in the referral system were the main determinants[10].

With the pandemic, the search for hospital services became more centralized, especially for women with suspected or confirmed COVID-19, considering the possibility of rapid worsening of the clinical condition, with repercussions that could generate the need for intensive care. This increased the need for long trips and pilgrimages[10].

Pilgrimages, a national difficulty that had already been addressed with efforts to reorganize the flow of care for women in labor through public policies, were exacerbated by the COVID-19 pandemic. The limitations on care for symptomatic women, who could only seek out referral maternity hospitals, and the reduction in the supply of public transportation reduced the possibilities of access[10].

It is worth noting that some women needed more than one means of transportation to get to the location for care. The increased cost and distance traveled caused even more difficulties, in a context of increasing financial precariousness.

"And sometimes mothers have little money, few resources [for transportation]" (Jasmim, 29 years old, self-employed, multiparous, without comorbidities).

During the pandemic, traveling to the maternity ward also involved fear of contamination. Women often sought to be sure that they were in labor, thus avoiding unnecessary travel. However, while on the one hand they were afraid of going out, on the other they also reported being afraid of staying at home and having complications. This ambivalence between the fear of going out and getting infected and the fear of getting sick at home and not being able to get to health services was determined by the reduction or lack of transportation.

Alleged failures in referral to specialized services are associated with comor-

bidity, in the patient's assessment, which is considered a risk for negative pregnancy outcomes.

"In my opinion, she should have asked me more questions and referred me right away, because since I have sickle cell anemia, my pregnancy was high risk. So I get worried, because if the doctor I went to on the first day had referred me right away, maybe my baby would be alive now" (Melissa, 17 years old, student, primiparous, with comorbidities).

It is worth noting, in the case in question, that the low availability of obstetric beds in the region, the lack of organization and definition of referral flows, overcrowding in hospitals and the difficulty of safe transportation, aggravated by the pandemic, may have been factors associated with adverse outcomes.

The obstetric beds available in the capitals were insufficient to meet demand and were often overcrowded. With the pandemic, the situation worsened, with expected harm to the safety and quality of the care provided. A situation of instability was established, both in the supply and quality of perinatal care, and hospitals were operating with an overload of services[11].

The referral of parturients with COVID-19 and comorbidities and/or complications should occur based on a flow established in the health network[12], given the need for early detection of severity in this risk group. When the women interviewed managed to get to the maternity ward, they began to face new barriers, with a common point in their statements being the long waiting time for care.

"Well... I went in, it was eight o'clock, like I said, and it took a long time, I was seen for almost ten hours, right, and then after I was seen" (Petúnia, 40 years old, nurse, multiparous, no comorbidities).

"I went at noon and the transfer was only done at 9 p.m. So I spent the whole time in a room, on a surgical stretcher, without being able to go to the bathroom" (Rosa, 28 years old, teacher, primiparous, with comorbidities).

The delay in care was possibly associated with the high demand, which exceeded the capacity of the units to provide care, and the insufficient number of professionals. This condition, admittedly, interferes with the quality of care for pregnant women, aggravated by the pandemic situation that gave new contours to this context.

The SARS-CoV-2 virus changed the behavior of society and, in particular, of pregnant women, who were advised to reduce the use of health services to avoid contamination and also to prioritize urgent cases. The new organization sometimes emptied some health services and overcrowded others. The protocols adopted to reduce and prevent contamination by the virus during and between appointments at the units, especially emergency care, increased the waiting time for care[11].

The delay reported was also associated with the segregation of pregnant women with suspected or diagnosed COVID-19, who, upon arriving at the services, were sent to an isolation room, where only a limited number of trained and equipped employees provided care. All of these logistics occurred at the same time that the demand for cases increased, as did the number of professionals on sick leave.

An important factor for the safety and quality of maternal care is timely ac-

cess to obstetric services, because even without imminent risk of death, delays in care are significantly associated with the severity of adverse maternal and neonatal outcomes[13].

Another result related to changes in protocol and the overload of professionals concerns a perception of contradictory behaviors and, at times, confusion in health service care.

"There has to be a human being there in that call center... who stays and who doesn't. Because it's inhumane! I'm not going to lie to you. [...] The testimonies of mothers who are being treated at the beginning of COVID-19... are sad" (Jasmim, 29 years old, self-employed, multiparous, without comorbidities).

"Everything was crazy, because of the pandemic, changing isolation areas, transferring to another wing and all that confusion... I went to a room with several people and then: 'no, she can't stay in the room with another person...' and everyone, the nurse ended up saying that I had COVID in the room and there was another couple and the other couple almost died of a heart attack" (Rosa, 28 years old, teacher, primiparous, with comorbidities).

The moment a pregnant woman arrives at the maternity ward in Brazil has been the subject of much attention in recent years, with reception being one of the guidelines of the National Humanization Policy(7), supported by Stork Network[8]. During the COVID-19 pandemic, the health services provided by the SUS were overwhelmed by the high demand; in addition to this, the lack of public policies and resources with responses to the moment of the health emergency caused disorganization in the system[14]. In terms of care, the stress of health professionals, caused by the overload of tasks and the lack of information and scientific evidence, led to the compromise of the quality of the service and consequent dissatisfaction of patients[15].

In 1994, Thaddeus and Maine proposed the Three Delays Model to facilitate the identification of indirect factors that contribute to maternal death. The Model identifies three critical phases that can have direct consequences on the survival of the mother and baby: delay in the decision to seek care (First Delay), delay in identification and arrival at the health unit (Second Delay) and delay in reception at the unit (Third Delay)[16].

Access to health services was hampered by several obstacles, including doubts about where to seek care, reduction of public transportation, changes in the organization of services for priority care and the reduction in the number of professionals due to illnesses.

The participants were poor, black, and peripheral women, conditions that create barriers to accessing healthcare in a country marked by social and regional inequalities. In social isolation, these women were more vulnerable to the negative impacts of the COVID-19 pandemic, with short, medium, and long-term consequences. They avoided using healthcare services both because of recommendations and because of fear of contamination. Thus, the pandemic compromised women's access to services, whether due to changes in the healthcare network or uncertainty related to safety when seeking care.

Delivery: from a family event to isolation

During the pandemic, the fear of delivery was greatly aggravated by loneliness and associated with the fear of one's own death and/or the death of one's child.

"I felt bad, very sad; I thought I was going to die. I was so afraid of dying and leaving my daughters, who are all small" (Violeta, 38 years old, security guard, multiparous, with comorbidities).

"So the fear of losing [the child] was very great. But later, when we saw that he had been born and that everything was fine, it was a relief" (Iris, 32 years old, physical therapist, primiparous, with comorbidities).

Fear of delivery is a common condition among pregnant women, especially those in the last quarter, and is described as a debilitating fear that interferes with domestic and occupational functions, social activities and relationships. Its genesis includes the fear of pain, medical interventions such as episiotomy, loss of control during delivery and lack of support[17].

The crisis caused by COVID-19 added a sequence of situations that anticipated and accentuated the fear of delivery among pregnant women and their families: the unknown and unpredictability of delivery in the midst of the pandemic; greater risk of serious infection in pregnant women; exposure to danger and lack of safety; subordination to the protocols of health institutions, with the cancellation of the possibility of personal choices; the difficulty in obtaining quality care and uncertainty about the future[18].

The effects of the pandemic were capable of intensifying feelings of fear and anxiety. Intense fear of delivery can promote physiological changes in the maternal organism, such as increased blood pressure, greater risk of pre-eclampsia, premature birth, emergency cesarean section, operative vaginal delivery, postpartum depression, reduced breastfeeding rates and greater admission of newborns to ICUs[19].

In this reality, the discussion has already been spreading about the need to look at and provide support for the psychological consequences of women who faced the process of pregnancy and delivery in the midst of the pandemic. In view of this, it is important to highlight the need for a set of cognitive, behavioral and emotional strategies that respond to the challenge of fear of delivery in pregnant women, especially in atypical situations.

Regarding expectations for the moment of delivery, in general, each participant explained more than one type of unfulfilled expectation. Only two of the 20 interviewees did not mention interrupted expectations. It was observed that the women wanted the delivery to occur at the expected time (full term), to be able to experience the physiological sensations that announce labor and to be able to return home with their children.

"It changed, because I thought I was going to have a normal 9-month pregnancy, you know?" (Açucena, 34 years old, self-employed, multiparous, without comorbidities).

"It did change. Because I thought... my imagination was like this: 'I'm going to stay at home, I'm going to feel pain or my water is going to break and I'm going to go to the hospital. When I got there, they would see me, I would have my baby and then I would leave the next day. And that wasn't what happened. I had to go... spend

almost a month in the hospital to have my baby, and then I would come home. I had to spend a long time in the hospital" (Jasmim, 29 years old, self-employed, multiparous, without comorbidities).

"The plan I had in my head at the time of the delivery was completely changed, already because of the situation, right? And because of the pandemic. So, everything was different. The doctor arrived, did it and it was that quick thing, before I knew it, I was already in the recovery room" (Rosa, 28 years old, teacher, primiparous, with comorbidities).

The emotional and cognitive experience of the woman at the time of delivery has a significant impact on the physical and psychological state after delivery and on the first interactions with the newborn[18]. With the pandemic, women's expectations and experiences were reconfigured. Most of them had to undergo a cesarean section due to COVID-19, although their preference was for natural delivery, except in cases of strict necessity.

In this time of crisis, women were denied respect for the physiology of delivery, which understands birth as something that flows naturally and with minimal external interference, capable of generating empowerment, security and confidence in relation to physiological sensations during labor, promoting a more pleasurable motherhood and with emotional bonds between mother, newborn and family[20].

The crisis caused by the pandemic generated an increase in unnecessary obstetric interventions, such as induction of labor, performing cesarean sections without clinical indication, in addition to prolonging the length of hospital stay, even though early hospital discharge was indicated, when the general well-being of the woman and newborn was confirmed, regardless of the status of the infection. All of this contributes to the increase in gender, obstetric and institutional violence[18].

Another interrupted expectation, reported by Açucena, was the impossibility of carrying out planned interventions for the moment of delivery.

"I also planned to have and make my connection, to connect everything, right? So, I think this change was because of this COVID" (Açucena, 34 years old, self-employed, multiparous, without comorbidities).

The interruption of reproductive and maternal health services made it impossible to perform the scheduled tubal ligation, a discontinuation that results in harm to progress and access to family planning. Such conditions can have a negative impact on women's reproductive experience, on the health of babies, families and the community, and can compromise the positive experience of delivery.

Changes in delivery care practices were also evident, with regard to the adoption of biosafety measures in order to prevent the spread of the virus, as stated below:

"Distancing. Everyone was wearing masks and using alcohol" (Tália, 24 years old, unemployed, pregnant for the second time, with comorbidities).

"They took my baby right away. And before I could pick her [daughter] up, they [professionals] threw alcohol all over my body, cleaned me, and changed my mask, so I could pick her up. Everything" (Iris, 32 years old, physical therapist, primiparous, with comorbidities).

"They didn't even put her [to breastfeed], they cut the cord right away... So everything I heard, that I prepared myself for during prenatal care, about holding the child, about bonding, everything... none of that happened! There was no first contact, there was no attempt at breastfeeding, no suckling, no smell, no touch, nothing... nothing, nothing, nothing" (Rosa, 28 years old, teacher, primiparous, with comorbidities).

"So I expected all of this, as I see it, which is in fact true. "To hold her in my arms, smell her, kiss her, breastfeed her right away" (Camélia, 28 years old, self-employed, primiparous, without comorbidities).

The women also reported that they expected to have contact with their child right after birth, which did not happen, as demonstrated. The documented separation between the mother and the newborn in the immediate postpartum period may suggest that positive COVID-19 testing is associated with health complications in the newborn. The lack of support available to help the sick mother with the baby, due to restrictions on companions and visitors, may also have contributed to the separation.

The pandemic has raised several concerns, as situations have been reported in which skin-to-skin contact, rooming-in, and breastfeeding were discouraged, in suspected or confirmed cases of women diagnosed with COVID-19, under the justification that they were potentially unsafe practices. In this context, several changes have occurred and professionals who provide direct care to women have started to adopt precautionary measures, such as avoiding physical contact, isolating themselves in private rooms and using a lot of personal protective equipment (PPE) to ensure the protection of both the professional and the woman[12].

The lack of direct contact with the pregnant woman has made it difficult to use non-pharmacological methods for pain relief, listening and supporting women to deal with this moment, which demands greater proximity with professionals. The use of PPE, in addition to aprons and face shields, has also distanced those who assist and those who experience the delivery, in addition to the requirement that the woman in labor wear a mask, which can cause discomfort during the process[21].

Such devices have made the relationship between the health professional and the woman in labor more difficult: looking into the eyes, perceiving smiles, pain, as well as other manifestations that professionals use as a resource to assist women during labor, have been suspended due to the protection of both. This led to a split in the process of bonding for this care and accentuated the feeling of loneliness experienced by women. Such practices, which favored the biomedical model, the so-called medicalization of delivery, reinforced women's passivity at the time of giving birth, giving specialist professionals, and not women, the leading role in delivery[21].

In the context of the pandemic and the health repercussions that permeated health services, pregnant women found it more difficult to have their choices heard, welcomed and respected by health services and professionals. Historically, in times of crisis, the needs of women and children are highly penalized[22].

Another right violated during the COVID-19 pandemic, according to the interviewees, was the suspension of women's right to have a companion(s) during labor and postpartum. There were several reports that demonstrate this scenario.

"Oh no, I didn't have [a companion]. My mother, who went with me every time, they didn't let her in. She stayed outside the maternity ward. Without visitors" (Melissa, 17 years old, student, primiparous, with comorbidities).

"They said it was because of the pandemic, that we couldn't have a companion, a nurse would be the one to accompany us. But it didn't take long for the nurse to leave the room too" (Amarílis, 29 years old, businesswoman, primiparous, without comorbidities).

During the pandemic, recommendations were made regarding the presence of a companion during labor and the postpartum period. Initially, in some health services, any companion was restricted; in others, they restricted the companions who would be in the risk group (over 60 years old and people of any age with comorbidities). As the number of COVID-19 cases decreased, the presence of a companion was relaxed. Most of the women in this study underwent the initial guidelines.

Women with COVID-19 faced varying degrees of social isolation around delivery to reduce transmission of the virus. A significant number of women affected by COVID-19 experienced delivery and/or the critical immediate postpartum period without the emotional support provided by close friends or family, due to hospital restrictions[23].

The presence of a support person and his active participation in delivery constitutes a strategy to reduce pain levels, with a view to increasing the woman's comfort and safety, promotes emotional support, and reduces negative feelings during delivery[23]. However, due to the pandemic, most health services have restricted the presence of companions, despite studies recommending greater participation, with the appropriate use of personal protective equipment, monitoring of the virus in the community and immunization[24].

Disrespect and violation of the right to a companion have been known for some time. However, during the health crisis, they were legitimately justified in response to viral containment, leaving women in labor without someone to share their emotions and help them face the pressures arising from the bureaucratic and impersonal order that maternity hospitals imposed, especially in the pandemic scenario in which compliance with the law was relativized[23].

The restriction on companions during the pandemic was configured as a risk factor for situations of obstetric violence, since the chances of eventual situations of mistreatment decrease when someone is present accompanying the woman in labor. Considering the beneficial effects of having a companion for women during delivery, preventive measures aimed at preventing the transmission of COVID-19 resulted in an increase in negative experiences in the lives of women in labor.

It is also important to emphasize that most of the women in this study who did not have the right to a companion during delivery were also black or brown. This fact is noteworthy, since the use of safety protocols against COVID-19 may have been used as a justification for discrimi-

natory practices when selecting women who could or could not have their right guaranteed. It is unacceptable that health services have chosen, as a measure to prevent and control the pandemic, to allow white women to be 2.5 times more likely than black women to have the right to the presence of a companion guaranteed[25].

Finally, these rules restricting companions, in addition to intensifying women's feelings of loneliness and helplessness, also increased the requests from women in labor and postpartum to health professionals, especially nurses, especially those who had a cesarean section. Also due to the total absence of companions, women with COVID-19 lamented the fact that they could not record the moment with videos and photos.

"It was very different, because I was desperate for someone to come in, to film, which I wanted, but it didn't happen, because I couldn't. There was also no one from my family nearby. I felt bad, really sad" (Violeta, 38 years old, security guard, multiparous, with comorbidities).

"And then, what we had planned, to bring family members in, to be able to record the moment, but we couldn't take any photos, none of that could happen..., because of the pandemic... everyone was afraid of each other" (Rosa, 28 years old, teacher, primiparous, with comorbidities).

Recording the birth of a child with photos and videos is part of the imagination of many women about delivery; it would be a way of producing a story and subjectively organizing the experience, in a society that increasingly values the use of images and publicizing them on social media, for example. The practice of recording and sharing moments in life considered important has become commonplace, expected and even dreamed of over the years, especially in situations seen as unique, transformative and full of meaning, such as delivery.

The fact that institutions, in order to avoid contamination, restricted the use of cell phones and companions, preventing recording, generated sadness, frustration and shattered expectations. The pandemic once again interrupted dreams. However, in some cases, professionals, usually nurses were moved by the situation and offered to take photos in the delivery room, which helped to alleviate the situation. It is worth noting that the right to record the moment of delivery, the birth of a child, is part of the humanization of labor[3].

The women reported that there was no correspondence between the care they received and the expectations of adequate and humanized care built from previous experiences.

"Because, I don't know, it seemed like they were disgusted with me, I don't know if it was because I was sick with COVID, they didn't even stay in the room for long. Then they would go there, look at me, look at my face and then leave. It was completely different, completely different" (Flora, 37 years old, unemployed, second-time pregnant, no comorbidities).

"When I went to have my first baby, like, it was completely different, there were other treatments, extra attention. Like with COVID, I believe it failed a little because there are so many patients. Yes, there is also the fatigue of the professionals. Anyway, I believe that the failure comes from that" (Tália, 24 years old, unemployed, pregnant for the second time, with

comorbidities).

"So... there was a lack of that relationship of involvement. So, from what I remember, I was on a stretcher, I was anesthetized and it was that very quick thing, 'let's go', and they talked about the pandemic" (Rosa, 28 years old, completed higher education, primiparous, with comorbidities).

The crisis caused by the pandemic has led to a reduction in the quality of care during labor: reduced rates of individual care, reduced mobility and lower rates of intermittent auscultation. It is worth noting that health professionals involved in dealing with this health crisis have presented problems, such as physical fatigue and psychological stress, affecting the care provided to patients[18].

In the name of contingency plans for COVID-19, years of good obstetric practices have been set aside, with regard to equal access, quality care during the perinatal period and the protection of rights provided for by law, such as the right to be accompanied during delivery. Despite the recommendations of the World Health Organization (WHO) and the Brazilian Ministry of Health, regarding the maintenance of breastfeeding, skin-to-skin contact between mother and baby and ensuring respect for the woman's autonomy during delivery, these were disregarded in many cases[21].

Thus, the moment of delivery, in times of pandemic, ceased to be a family event for many women, becoming a solitary event, as social distancing or isolation was necessary, as well as some recommended changes in care. Loneliness was experienced due to the absence of a face-to-face support network, a reduction in the quality of care and changes in the arrival of the "new mother" and reception of the newborn.

FINAL CONSIDERATIONS

The search for obstetric care was marked by difficulties exacerbated by new adjustments to the routines of the health network. Access to health services was directly influenced by problems related to travel; referral and safe transportation; reduction in the number of obstetric beds; overcrowding and increased waiting times for hospitalization; due to the adoption of protocols to contain the virus. The moment of delivery, sometimes planned and idealized, was marked by unfulfilled expectations and additional levels of fear, concern and uncertainty. These challenges in obstetric care highlight the need for protocols that balance sanitary measures with the physical and emotional demands of pregnant women, respecting the centrality of women.

During the first year of the pandemic, there was a significant setback in good practices for labor and birth, compromising many of the advances achieved in the last decade. Historically achieved rights were denied, such as encouragement of walking, free diet, respect for freedom of position, presence of a companion of free choice, encouragement of skin-to-skin contact and breastfeeding in the delivery room, among others. The new logic imposed by the health crisis has generated negative experiences that can be felt in the life stories of these women. Situations such as the crisis caused by the pandemic suggest that rights that have been achieved have been fragile and should be understood so that they are not repeated in similar situations.

A limitation of this study is the fact that most of the interviews were conducted online due to the pandemic, which may have restricted the observation and analysis of nonverbal communication. Another obstacle was the concentration on a single setting (referral maternity hospitals), which reduces the generalizability of the results to other realities of obstetric care. In addition, the long-term experiences of these women were not analyzed, which would be essential for a more comprehensive understanding of the impacts. However, up until the time of data analysis, there was a lack of precedent regarding the experiences during delivery of women with COVID-19 in maternity hospitals in the Northeast. Data collection took place during the pandemic, close to the time of delivery, reducing recall bias. As this is a qualitative study, the analysis of women's experiences regarding delivery and the birth of their children, in the context of a global event, contributes to reflections regarding the effects of political, economic and health measures on the care of women's lives in local locations.

Further studies are needed to assess the long-term consequences of changes in obstetric practices during the pandemic, considering different geographic contexts and the inclusion of other socioeconomic and cultural variables, which can broaden the understanding of the diverse experiences lived.

The research reinforces the need for responses to the crisis that guarantee humanized care and protection of women's rights during delivery, even in adverse contexts. In addition, training health professionals so that they can adapt their practices without compromising the quality of care and the uniqueness of each parturient. Delivery requires special attention to the emotional subtleties that can directly impact maternal and child well-being, especially in contexts that seek to reduce the spread of diseases.

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