



REPERCUSSIONS OF THE COVID-19 PANDEMIC IN THE ASSISTANCE TO THE PARTURIENT WOMAN: NURSING GAZE

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ABSTRACT

Objective: to identify the repercussions of the COVID-19 pandemic on parturient care from the perspective of nursing. **Method:** qualitative research with nursing professionals working in an obstetric center of a teaching hospital in Paraná, carried out through semi-structured interviews, via WhatsApp, between May and July 2020, with thematic content analysis. **Results:** there were changes in the flow of obstetric care, with an exclusive environment for pregnant women with suspected viral infection, and influence on the mode of delivery. There were setbacks in obstetric care, difficulties in accessing information about labor and birth due to the suspension of groups of pregnant women. The absence of a companion during the parturition period compromised the emotional state of the parturients and increased the women's feelings of anxiety, sadness and insecurity. For emotional support to parturients, strategies were used to approach the family, such as the use of cell phone video calls. Nursing professionals provided sensitive and empathetic care, although with increased work demand and surrounded by fear of viral contamination. **Final considerations:** institutional adjustments were made, new care demands had to be met by nursing professionals, concomitantly with the setback of others, increasing the challenges to plan and carry out care for the parturient woman.

Keywords: Coronavirus. Nursing care. Obstetric nursing. Pandemics. Childbirth.

INTRODUCTION

COVID-19 is an acute respiratory disease caused by the coronavirus, specifically the viral subtype SARS-CoV-2, transmitted through aerosols and contact with the droplets of the infected person's respiratory tract, through coughing or sneezing. It is an emerging disease, first identified in 2019 in the city of Wuhan, China. In January 2020, the World Health Organization (WHO) declared the outbreak of the disease as a global public health emergency and, in March of the same year, it was characterized as a pandemic⁽¹⁾.

Worldwide, more than 660 million cases have been confirmed and more than six million deaths from COVID-19 have been recorded, from the onset of the disease to the beginning of 2023. The European continent is responsible for the highest incidence of the virus, followed by the American

continent. The United States of America has the highest number of cases, followed by India, France, Germany and Brazil⁽²⁾. Despite the high number of infected by the virus, the amount may be underestimated, considering that asymptomatic individuals often do not access health services and are therefore not identified and reported.

In Brazil, more than 36 million cases and more than 695 thousand deaths from COVID-19 have been recorded, from the beginning of the pandemic until January 2023⁽²⁾. The country has the highest rate of maternal mortality due to the disease, being 3.4 times higher than in other countries of the world, corresponding to 10% of the total number of annual maternal deaths in the country. It is noteworthy that the highest occurrence of maternal deaths due to COVID-19 was reported in the puerperal period⁽³⁾.

Pregnant women have changes in the immune system that make them vulnerable to viral and

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respiratory infections, such as COVID-19⁽⁴⁾. They are also more susceptible to complications resulting from viral infection with this disease⁽⁵⁾. In addition, the low quality of prenatal care may contribute to negative outcomes for women during pregnancy and the postpartum period, particularly during the pandemic, which constitutes a barrier to access to health⁽³⁾.

The suspicion or diagnosis of COVID-19 can elevate stressful conditions in pregnancy⁽⁵⁾ and impact women's mental health by maximizing feelings prior to delivery, such as anxiety⁽⁶⁾. In this sense, nursing professionals should develop actions to avoid viral contamination and provide positive experiences in childbirth⁽⁵⁾. Above all, to ensure adequate nursing care, it is essential to combine childbirth care with the performance of practices based on updated scientific evidence⁽⁷⁾.

The study aimed to identify the repercussions of the COVID-19 pandemic on nursing care.

METHOD

Exploratory, descriptive, qualitative study, derived from a project of the Institutional Program of Scientific Initiation Scholarships (PIBIC), this study aimed to understand the perspective of nursing professionals about the assistance to women in labor and delivery in a public school hospital in Paraná, developed from May to July 2020.

Nurses and nursing technicians working in an obstetric center of a teaching hospital in the West region of Paraná were included in the study. Professionals who were away from work due to sick leave or vacation during the data collection period were excluded. For the collection, the selection of participants was for convenience. Twenty nursing professionals participated, five nurses and 15 nursing technicians.

The explanation about the study, invitation to participate and scheduling of the interviews occurred through initial telephone contact. The interviews were conducted individually, by a nursing graduate, PIBIC scholar, in a private environment, through the WhatsApp application, by signing the Informed Consent Form (ICF), sent by e-mail to participants and returned signed by them.

The interviews were guided by a semi-structured questionnaire, subject to a pilot test,

and started with a guiding question: Talk about your perspective on nursing care for women in labor and delivery. They had an average duration of 50 minutes each, were recorded on an electronic audio device and returned by WhatsApp for conference by the participants. Data collection was terminated after reaching theoretical saturation⁽⁸⁾.

Data analysis was performed through thematic content analysis proposed by Minayo⁽⁸⁾. In the pre-analysis, the floating and interpretative reading of the data was carried out, followed by an exhaustive reading to define the thematic units and study categories. In the analysis of the material, the content attenuation, the identification and formation of the categories were performed. In the interpretation of the results, we sought to conference the data considering the consistency of the thematic categories.

To ensure anonymity, participants were identified by the letters "N" and "NT", relative to nurse and nursing technician, respectively, followed by Arabic numbering, according to the order of the interview (N1...N5, NT1...NT15). It should be noted that 13 of the 20 participants were chosen to represent the content of the categories identified. The project was approved by the Research Ethics Committee, under opinion number 2,053,304/2016.

RESULTS

The nurses and nursing technicians participating are female, with a mean age of 42.5 years, 10.5 years of operation in the obstetric center and with time of 12.4 years in the teaching hospital. Of the five nurses, two had a specialization in obstetrics and one was in progress. Of the 15 nursing techniques, five had undergraduate degrees in nursing, one was attending and four had specialization in obstetrics.

The results will be presented in five thematic categories that discuss the changes in the flow of care for delivery and delivery, commitment to prenatal care and delivery, setbacks in the assistance to the parturient woman, sensitive, empathic and creative nursing care, and work organization of nursing professionals.

Changes in the flow of care for labor and birth care

According to the professionals, as a result of the pandemic, a new flow of care for pregnant women in childbirth care was instituted. They had to undergo triage before being admitted to the obstetric center. Pregnant women suspected or diagnosed with viral infection were hospitalized in an exclusive sector for COVID-19 and the birth scheduled by cesarean section. A team from the obstetric center was assigned to care for the woman and the newborn in the surgical center:

[...] now they [women] can't go up without going through triage [...] if they are going to [...] the guards at the reception desk who go up to bring the belongings [...] messed with the entire flow of the hospital. (TE3)

[...] the suspected or confirmed pregnant women are not hospitalized in the obstetric center, they are hospitalized in another hospital unit [...] a specific ward has been opened [...]. (NT4)

[...] when she arrives with suspicion [...] they don't go up [...] she goes straight to the operating room, does the cesarean section and then goes straight to the COVID ward. It doesn't get to stay here inside the obstetric center [...] a technician goes to the surgical center, a resident and a doctor to perform that cesarean section. (NT15)

In addition to changes in the flow of care, the use of masks became mandatory for the health team and parturients to prevent transmission of SARS-CoV-2. However, even with the guidance on wearing a mask, some women removed it during labor. Condition understood by professionals, but which exposes the parturient woman to the risk of viral contagion:

[...] we advise patients who are hospitalized to wear a mask, but nobody supports wearing a mask 24 hours a day and the patient in labor can't do it [...] so they take it off [...] there are few who stay. (NT15)

Commitment to prenatal care and childbirth

After the woman's admission to the service, nursing professionals noticed an increase in the interval between prenatal consultations. An increase in cases of diabetes and gestational hypertension was also identified, which may be related to a decrease in prenatal visits, making early diagnosis and treatment difficult:

[...] they are not having direct assistance with the

obstetrician [...] they do the exams and everything, but when they go to the health center they go with the general practitioner [...] increased patients with diabetes and hypertension [...]. The stations were closed [...] (N5);

[...] we take a patient whose last consultation was in February and arrives to have a baby in July [...]. They say that it is due to the closed post [...]. (NT4)

Prenatal consultations were suspended at the beginning of the pandemic, as well as meetings of groups of pregnant women, who offered support and provided guidance on childbirth and birth. What may have influenced the level of knowledge of women about the parturitive process. The visit of pregnant women to the obstetric center was interrupted, making it impossible for them to know the delivery environment in advance.

[...] having to stop with the group is necessary for them {women} because it is a way of receiving guidance [...] greatly influences labor [...]. (NT3)

[...] the monthly meetings were not continued because there cannot be crowds, so there are no visits to the sector {obstetric center}. (NT9)

[...] with the pandemic there is no one else, neither in this group at the HU [university hospital] nor [...] at the health center and I'm sure this harms the woman because she loses guidance [...]. (NT4)

In addition, health professionals noted a reduction in the number of women who unnecessarily sought care in the hospital environment for pregnancy complaints:

[...] decreases was the volume of patients who "unnecessarily" sought hospital care due to the pandemic [...] a complaint that could be resolved at the basic unit [...] theoretically the correct thing would be to seek the university hospital in cases of bleeding, fluid loss, labor, lack of movement of the baby, more directed to "I'm losing my baby" or "I'm having my baby". (NT4)

Setbacks in parturient care

The COVID-19 pandemic has generated setbacks in the care of the parturient woman, such as the absence of a companion in childbirth and the restriction of free access to food due to measures to reduce viral spread. The companion was allowed in the institution only for underage pregnant women, who remain in the obstetric

center until the end of the hospitalization, with no possibility of exchange:

[...] We got a companion from 2018 to here [...] it has improved a lot. They feel safer, they have more support, it has improved a lot [...]. (NT5)

We restrict the companion due to the risk [...] to their safety, to avoid contamination. (N5)

Before the pandemic, she could have a companion of her choice during the entire hospitalization and he could be changed every 12 hours [...] in cases of underage, this companion has to come in and stay during the hospitalization until the time of discharge [...]. The intention is to have the smallest number of people circulating inside the hospital [...]. (NT4)

[...] there is no way to accommodate this companion because of the structure [...] because it is a very small place [...]. (NT15)

Commonly, women who do not speak Portuguese are accompanied by a person who helps in communication between the pregnant woman and health professionals. Nursing professionals described difficulties in communicating with immigrant women, mainly Haitians, and may lead to delays in testing and diagnosis of COVID-19:

[...] the biggest concern is Haitian women, because we have difficulty communicating. They cannot understand [Portuguese] and we cannot understand them [...]. No one understood exactly what it was, the other week the COVID test was requested and it was positive [...] divergence and difficulty in communication [...]. (NT4)

The presence of the companion reduces anxiety, provides security to the woman, helps with pain relief, and reminds the woman of the guidelines offered by the team. The absence of the companion compromised the emotional state of the parturients, and consequently increased the demand of nursing professionals:

Before, when they {companions} were there [...] it was very good [...] because it reduced their anxiety a lot. (NT9)

The companion helps and guides. Often the patient does not want to listen, and the companion is there, he listens [...]. (NT8)

[...] what we say and advise, sometimes they don't accept much because they are so alone [...] the companion [...] is an extra strength that we have

[...]. (NT14)

[...] before they had support from their husband, from the mother who was accompanying them, now [...] there is no one to ask for support except us {team}, but we are unknown [...]. (NT15)

When the companion is with them, they are distracted, sometimes they put on music, talk about other things, when it's time to walk, they walk together [...] it's quite different. (NT13)

With the restriction of the companion, women felt insecurity, fear and sadness. However, they understood that the reason for this restriction was to protect them and newborns from COVID-19:

[...] now, in the pandemic, it got worse [...] without them [companions] the psychological comfort of the patient is much more demanding [...]. (NT14)

[...] we see their insecurity, they feel totally unprotected [...] so the companion during labor is fundamental [...]. (NT7)

[...] now [...] they are more tearful, more discouraged [...] they feel much more insecure. (N3)

[...] they get much more desperate, they scream more [...]. (NT13)

[...] they feel insecure, they returned to insecurity [...] they are afraid. (NT4)

They are sad, but most are understanding, because they have other children at home. We try to explain the risk of the companion here, who then goes home and stays with the children at home or with the parents [...] most understood [...] they understand the risk, they even say "I'm already here taking the risk, they don't need to come here and run the risk of catching the virus". (NT8)

With regard to feeding during the delivery process, the snacks and teas that were previously available in the unit, became restricted to the canopy to reduce manipulation by several people. Access to food was restricted to meal times or offered by the nursing staff at the request of the woman:

[...] there is a counter that has tea, biscuits and bread, now with the coronavirus we had to leave it in the pantry so that it is less manipulated, but we [nursing staff] always take it to them when they ask [...]. (N3)

Sensitive, empathetic and creative nursing care

Nursing professionals demonstrate sensitive, empathetic and creative care to meet the emotional needs of women. The professionals transmitted security by staying more time next to them, talking and offering support:

We try to support as much as possible [...] we try to stay there by her side [...] it's natural to go through this pain, but [...] being isolated and alone is inhuman [...] we [the team] try to be as humane as possible because it is a very important moment, [...] we try to stay the whole time assisting her so that she feels safe and supported. (N5)

[...] without the companion, we have to do our best [...] we try to stay in the room more [...] accompanying her to see if everything is okay and talk and say that we are there to help [...]. (NT14)

[...] we [team] try to do everything to compensate for the lack of a companion by providing support and staying with her as much as possible [...] the R1 [...] are much more involved with the patient [...] the doctor is much more present inside the room [...] this is very good, it even makes the care more humanized. (NT4)

Some strategies were adopted at the time of delivery to approach the woman with the family, such as allowing the use of the cell phone. After the birth of the baby, the team encouraged the woman to cut the umbilical cord, an act previously linked to the partner or professional; allowed video calls from the cell phone and sending photos to the companion and family.

[...] now that there is no companion, we ask if the patient wants to cut the baby's umbilical cord [...]. (N3)

[...] it was allowed for everyone to keep the cell phone. They manage to get in touch with the family [...]. (NT4)

[...] we have been taking pictures of the mother and the baby for them to send to the family members [...]. (NT14)

[...] at the time the baby is born there are some who want to make a video call [...] take a picture to send to their husband with the little baby there in the chest and make a video call. The husband cries on the other side, she cries there. (NT11)

However, due to periods of overcrowding, the provision of sensitive and empathetic care in the delivery process was not always possible:

[...] all the support [...] nursing now provides [...], but they are not always able to stay and provide the support she needs [...]. (N4)

[...] sometimes the sector is overcrowded and we cannot give each one the attention they deserve [...]. (NT13)

Due to the pandemic, teaching activities in the obstetric center were suspended, consequently there was a reduction in interventions in labor. With the absence of medical students, the examination of vaginal touch was performed less frequently in the parturitive process:

Now [during the pandemic] that there are no more medical students, the touch is less frequent [...]. (NT13)

[...] medical students, now it doesn't have to because of the pandemic [...] they [...] want to keep playing every hour. (NT10)

[...] we are not having [students], but it is a teaching hospital [...] they have to learn, they have to examine, even those who are not examining [...] they have to be together looking [...] greatly improved [touch] [...] currently it has decreased. (NT9)

Organization of the work of nursing professionals

Nursing professionals reported working with fear due to exposure to the virus and that the absence from work of professionals due to suspicion or diagnosis of COVID-19 or being a risk group generated an increase in demand to those who remained active. Vacations of employees who were not in the risk group were suspended.

[...] we have to work the same and we work with fear because we don't know if the person who arrives there at the door has COVID or not and we work very exposed [...] the vacations were all canceled [...] the employees got sick [...] there are not enough employees to offer the assistance that the patient would need [...] overloaded the employees who stayed working. (NT4)

[...] we work with a lot of difficulty [...] it unfolds a lot [...] you have to cover the missing employee [...] try to close the scale [...] on my night there were two away, then I walked away, and then two more walked away from the other night [...]. (NT15)

There were employees who were suspicious and some were confirmed, several employees were suspended [...]. Most of the people who were removed were from nursing [...] the doctors who were removed were due to their age, because they belong to the risk group (NT3)

[...] many people on the team tested positive, even more than in the COVID ward [...]. (NT14)

The parturients, in the opinion of the professionals, were afraid to be contaminated by COVID-19 and contaminate the newborn. Therefore, the use of masks, hand hygiene, materials and equipment were intensified.

Women are afraid of contaminating themselves and the baby, they had this insecurity. The team is also afraid of becoming contaminated [...] we don't take off a mask, hand washing has increased 100% [...] we are more concerned [...] with bed care, stretcher, washing of hands, surface, everything [...]. (NT3)

[...] we learned to take care of ourselves a little more as a health professional. (NT15)

DISCUSSION

Care for women in the postpartum pregnancy period, during the COVID-19 pandemic, should ensure the minimum possible exposure in order to minimize the risk of viral contamination⁽⁹⁾. For this, new care flows were elaborated, such as respiratory screening. When presenting symptoms suspected of COVID-19, pregnant women should be directed to a specific sector for care⁽¹⁰⁾.

In the delivery environment, the parturients used the surgical mask during labor, and the mask was allowed to be removed during the expulsive period, provided that the health team was properly parameterized in order to reduce the risk of viral transmission⁽¹⁰⁾.

During the study, the type of delivery was defined based on obstetric factors and clinical evaluation of maternal and child well-being⁽¹¹⁾. Probably, the few scientific evidences regarding the vertical transmission of COVID-19 may justify the medical choice by cesarean section⁽¹²⁻¹³⁾. However, it should be noted that Brazil has one of the highest rates of cesarean delivery in the world, regardless of the COVID-19 pandemic⁽³⁾.

The pandemic created fear for pregnant women, in some cases women avoided or postponed prenatal care due to respiratory

symptoms, home isolation or treatment of COVID-19. Prenatal consultations were continued during the COVID-19 pandemic with changes in the form of care, such as the use of telehealth. However, some barriers may have compromised the use of this strategy, such as the absence of technology available for access to remote media⁽¹⁴⁾.

The use of technologies can help in the continuity of care in the pregnancy-puerperal period, without major losses, in order to strengthen ties and provide the necessary support to women in pregnancy, overcoming the difficulties imposed by the pandemic⁽¹⁵⁾. The video call was an alternative for family members to participate and transmit support to women in labor.

The absence of prenatal follow-up can impact maternal health, with the increase in Hypertension and Diabetes Mellitus⁽¹¹⁾, identified more frequently in the pandemic, as reported by the study professionals. This factor may be related to inadequate prenatal care and to the suspension of groups of pregnant women. These groups bring women closer to health professionals and provide early identification of risks to maternal and child health, allowing for monitoring and appropriate treatment⁽¹⁶⁾.

The presence of the companion of choice of the pregnant woman during the entire parturition process is a woman's right guaranteed by law and is part of the best practices recommended during the parturition process⁽¹⁷⁾. The companion provides support, confidence and security to the woman, in addition to enabling better evolution in the physiological process of labor and provide a positive experience of childbirth and birth. Therefore, it is not only a matter of guaranteeing the parturient a right provided for by law, but of favoring her process of parturition⁽¹⁸⁾.

During the pandemic, the right to a companion in childbirth should be guaranteed after screening and evaluation of respiratory symptoms, restricting access to people infected with COVID-19. Some access restrictions were imposed on visitors, such as the permission of only one person for labor and childbirth. The presence of doulas was also restricted due to the COVID-19 pandemic, generating setbacks in the assistance to the parturient woman⁽⁴⁾.

In some health institutions, access to the

companion is released as long as it is asymptomatic. However, in others, their presence is restricted⁽¹⁹⁾. In order to reduce the circulation of people, it was also limited the access of pregnant women between environments, restricting the ambulation of women in labor⁽⁴⁾. Importantly, even with the pandemic, the rights of the parturient woman must be respected.

Restriction of liquids or food is not recommended in childbirth. Feeding should be offered freely according to the tolerance of each pregnant woman⁽⁵⁾. However, in the service studied, although food and liquids were available, access and supply to the parturient woman was restricted to the professionals of the team. In this sense, due to the COVID-19 pandemic, the restrictions established by health services made it difficult to guarantee the rights of parturients.

The nursing professional must perform the assistance in a humanized and quality way according to the needs of each parturient woman, in order to reduce negative experiences during childbirth and birth⁽²⁰⁾. The disclosure of information on COVID-19 and on institutional protocols prior to hospitalization favors the knowledge and understanding of parturients, making them safer in relation to childbirth^(6,21). Social isolation during labor, as well as minimizing external contacts due to the risk of viral contamination, favored the empathy of professionals with women and strengthened the bond and emotional support to parturients⁽²²⁾.

The infection of health professionals by COVID-19 during care is a concern of the health system⁽²¹⁾. Therefore, the number of professionals in contact with suspected patients and infected with COVID-19 should be restricted to the minimum possible. In the case of induction of labor by obstetric indications, methods that minimize the need for monitoring should be prioritized, as well as the minimization of vaginal touches^(21,23).

Quarantine is one of the main measures to reduce the risk of disease transmission. During the study period, the current recommendation was that if a member of the health team was suspected

or diagnosed with COVID-19, their entire team should be removed from the service for at least two weeks⁽¹¹⁾, demands to the other professionals of the institution. In addition to work overload, the uncertainty about the pandemic and stressful situations together with the risks of contagion of the disease directly affected the mental health of health professionals⁽⁷⁾.

FINAL THOUGHTS

The pandemic generated setbacks in obstetric care and interfered in access to information about childbirth with the suspension of meetings of prenatal groups. The absence of a companion in the parturition period due to the pandemic increased the feelings of anxiety, sadness and insecurity of women. Visits to the place of delivery were also restricted previously.

Viral infection influenced the choice of birth route during the suspicion or diagnosis of COVID-19, restricted the supply of fluids and food during labor. For the emotional support of parturients, strategies were used to approach the family, such as the use of mobile phone video calls. For humanization of childbirth, women were encouraged to cut the umbilical cord of the newborn, act before tied to the partner or professional.

Institutional adjustments were made, new demands for assistance needed to be met by nursing professionals, concomitant with the setback of others, increasing the challenges to plan and perform the assistance to the parturient woman. However, the assistance was performed through sensitive and empathetic care, even with fear of contamination by the virus and increased demand for health teams.

The study was limited to interviewing nursing professionals from a single institution, however reference for habitual, intermediate and high-risk childbirth in a regional health care center in the state of Paraná, with 25 municipalities. Understanding obstetric care at a time of pandemic, in other realities, considering the vision of the parturient woman, is recommended.

REPERCUSSÕES DA PANDEMIA DA COVID-19 NA ASSISTÊNCIA À PARTURIENTE: OLHAR DA ENFERMAGEM

RESUMO

Objetivo: identificar as repercussões da pandemia da COVID-19 na assistência à parturiente pelo olhar da enfermagem. **Método:** pesquisa qualitativa com profissionais de enfermagem atuantes em centro obstétrico de um hospital-escola do Paraná, realizada por meio de entrevistas semiestruturadas, por *WhatsApp*, entre maio e julho de 2020, com análise de conteúdo temática. **Resultados:** evidenciaram-se mudanças no fluxo de atendimento obstétrico, com ambiente exclusivo para gestantes com suspeita de infecção viral, e influência na via de parto. Houve retrocessos na assistência obstétrica, dificuldades no acesso a informações sobre o parto e nascimento devido à suspensão dos grupos de gestantes. A ausência do acompanhante no período parturitivo comprometeu o estado emocional das parturientes e elevou os sentimentos de ansiedade, tristeza e insegurança das mulheres. Para suporte emocional às parturientes, foram utilizadas estratégias para a aproximação da família, como o uso de chamadas por vídeo do celular. Os profissionais de enfermagem realizaram um cuidado sensível e empático, embora com aumento da demanda de trabalho e cercados de medo da contaminação viral. **Considerações finais:** Adequações institucionais foram realizadas, novas demandas de assistência precisaram ser atendidas pelos profissionais de enfermagem, concomitante ao retrocesso de outras, aumentando os desafios para planejar e realizar a assistência à parturiente.

Palavras-chave: Coronavírus. Cuidados de enfermagem. Enfermagem obstétrica. Pandemias. Parto.

REPERCUSIONES DE LA PANDEMIA DE COVID-19 EN LA ASISTENCIA A LA PARTURIENTA: PERSPECTIVA DE ENFERMERÍA

RESUMEN

Objetivo: identificar las repercusiones de la pandemia de COVID-19 en la asistencia a la parturiente por la perspectiva de la enfermería. **Método:** investigación cualitativa con profesionales de enfermería actuantes en centro obstétrico de un hospital-escuela de Paraná-Brasil, realizada por medio de entrevistas semiestruturadas, por *WhatsApp*, entre mayo y julio de 2020, con análisis de contenido temático. **Resultados:** se evidenciaron cambios en el flujo de atención obstétrica, con ambiente exclusivo para gestantes con sospecha de infección viral, e influencia en la vía de parto. Hubo retrocesos en la asistencia obstétrica, dificultades en el acceso a informaciones sobre el parto y nacimiento debido a la suspensión de los grupos de gestantes. La ausencia del acompañante en el período del parto comprometió el estado emocional de las parturientas y elevó los sentimientos de ansiedad, tristeza e inseguridad de las mujeres. Para apoyo emocional a las parturientas, se utilizaron estrategias para la aproximación de la familia, como el uso de llamadas por video del celular. Los profesionales de enfermería realizaron un cuidado sensible y empático, aunque con aumento de la demanda de trabajo y rodeados de miedo a la contaminación viral. **Consideraciones finales:** adaptaciones institucionales fueron realizadas, las nuevas demandas de asistencia necesitaron ser atendidas por los profesionales de enfermería, concomitante al retroceso de otras, aumentando los desafíos para planificar y realizar la asistencia a la parturienta.

Palabras clave: Coronavirus. Cuidados de enfermería. Enfermería obstétrica. Pandemias. Parto.

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