http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
DOI: 10.4025/ciencuidsaude.v23i0.66780

ORIGINAL ARTICLE

IMPLICATIONS OF THE COVID-19 PANDEMIC ON HOSPITAL CARE FOR PARTURIENT WOMEN FROM NURSES' PERSPECTIVE

Juliana Amaral Prata*
Karolayne Rosa Oliveira**
Jane Márcia Progianti***
Adriana Lenho de Figueiredo Pereira****
Camilla Ribeiro Freitas da Silva*****
Aline Caramez Costa******
Wanessa Candioto Barbalho de Souza*******

ABSTRACT

Objective: to know the implications of the COVID-19 pandemic on hospital care for parturient women from nurses' perspective. **Method:** a descriptive and qualitative study, with 20 nurse-midwives from the state of Rio de Janeiro. Data were collected from May to July 2021, through a semi-structured interview carried out via videoconference, and subjected to thematic content analysis. **Results:** the implications included: parturient women were admitted to maternity wards in advanced labor and had little information about parturition; and increase in medical interventions, expressed in the indiscriminate adoption of practices that require clinical indications, are of judicious use or are proscribed. On the other hand, the implications for nurses' care revealed adaptations in the offering of non-invasive technologies in light of COVID-19 control protocols, in order to preserve humanization and the rights of women in childbirth, even if they have hindered the manifestation of relational skills. **Final considerations:** it is considered that the pandemic interfered with the access and use of educational activities in prenatal care, and the measures implemented in hospital care for parturient women resulted in the erasure of good practices and the resurgence of medicalization. However, the potential of nurse-midwives is evident, as they respected health regulations and provided safe and respectful care.

Keywords: COVID-19. Parturition. Perinatal Care. Nursing Care. Obstetric Nursing.

INTRODUCTION

The COVID-19 pandemic, a disease with an initially unknown clinical evolution and high transmissibility and morbidity and mortality, brought economic, political and cultural impacts, accentuating social inequalities and weaknesses in health systems around the world[1,2]. In this context, specific population groups were defined as at risk, in which pregnant and postpartum women were included given the possibility of unfavorable outcomes associated with changes inherent to pregnancy and situations of high obstetric risk[3-5].

It is known that the repercussions of contamination by SARS-CoV-2 during the pregnancy-puerperal cycle are related to premature rupture of membranes, compromised fetal well-being, high rates of prematurity and cesarean sections, severe respiratory conditions and deaths[4]. As a result, there was a significant increase in maternal deaths, especially in Brazil, which by May 2021 totaled 911 deaths due to COVID-19, exceeding the 544 reported in 2020[6].

Given this scenario, the question arises about the assistance offered to women during the pandemic, since, especially during the first wave, there was a reduction in care in primary care due to the prioritization of investments in directly combating COVID-19 and the fear that permeated the population[7], which interfered with input supply,

*Nurse. Doctor in nursing. Professor. Nursing school. State University of Rio de Janeiro - UERJ. juaprata@gmail.com. https://orcid.org/0000-0003-1315-7595
**Nurse. Specialist in obstetric nursing. UERJ. karolayneoliveira1804@gmail.com. https://orcid.org/0000-0002-0340-1649
***Nurse. Doctor in nursing. Professor. Nursing school. UERJ. jmprogi@gmail.com. https://orcid.org/0000-0003-3843-5192
****Nurse. Doctor in nursing. Professor. Nursing school. UERJ. adrianalenho.uerj@gmail.com. https://orcid.org/0000-0002-2563-6174
*****Nurse. Specialist in obstetric nursing. Master's degree student. Postgraduate Program in Nursing. UERJ. camilla.ribeirof@gmail.com. https://orcid.org/0000-0002-1644-4031
******Nurse. Specialist in obstetric nursing. Master's degree student. Postgraduate Program in Nursing. UERJ. alinecaramez.enf@gmail.com. https://orcid.org/0000-0001-9901-2877
*******Nurse. Specialist in obstetric nursing. Master's degree student. Postgraduate Program in Nursing. UERJ. wannecandioto@gmail.com. https://orcid.org/0000-0003-0864-0128

access and use of essential services, such as sexual and reproductive health care[8,9].

It is worth considering that this situation was faced with challenges that already existed in Brazilian obstetric care. In this regard, inadequacies in infrastructure stand out, with the persistence of collective birth rooms and the timid adoption of rooms with prenatal, childbirth and postpartum (PCP) beds and bathrooms for exclusive use[10,11].

Furthermore, good practices in childbirth and birth care were not a reality in most hospitals and maternity wards in the Stork Network, resulting in a low or medium level of implementation: of actions to promote the physiology of parturition (presence of a companion of women's free choice, role of nurse-midwives in low-risk childbirths, use of non-pharmacological methods for pain relief and encouragement of vertical positioning); of timely cord clamping; of skin-to-skin contact; of breastfeeding in the first hour of newborns' life; and of the parsimonious use of obstetric interventions (amniotomy, lithotomy position, venous catheter, episiotomy and uterotonic medications)[12,13].

As found in other countries[5,14,15], the pre-pandemic overview of obstetric services, together with the high demand for care, made it difficult to implement health measures to control COVID-19, mainly due to restricted physical space of hospital facilities, inadequate ventilation conditions, scarcity of inputs, reduction in bed supply in some sectors and lack of isolation rooms properly equipped to care for positive cases[4,6,7,9,16].

In view of these notes and considering that nurse-midwives, due to the humanistic and demedicalized characteristics of their care process[17], are recognized as strategic professionals in the implementation of good practices in childbirth and birth care, the following question emerged: what are the implications of the COVID-19 pandemic on hospital care for parturient women from nurses' perspective? Thus, the present study aimed to understand the implications of the COVID-19 pandemic on hospital care for parturient women from nurses' perspective.

METHOD

This is a descriptive and qualitative study, carried out with 20 nurse-midwives, who work in different municipalities in the state of Rio de Janeiro. Nurses specialized in obstetric nursing and who worked in the care of parturient women for at least 12 months of the COVID-19 pandemic course were included. Nurses who worked only in the private network and in home childbirth services were excluded.

The process of gathering participants took place through the snowball technique, where an individual with the appropriate profile for the study is selected to be the first interviewee, called the seed. The seed is asked to nominate other potential participants, who nominate new contacts with the desired characteristics, and so on, until the sample is saturated, i.e., there are no new names offered or the names found do not add new information[18].

The study included three seeds intentionally selected, based on the researchers' contact with nurse-midwives who met the inclusion criteria. Thus, three chains of indication were created, which were finalized when no new themes emerged in the analysis phase. Thus, there were eight refusals, justified by work overload. There was no loss of participants, and inductive saturation was identified in the eighteenth interview, confirmed with two more interviews.

Contact with potential participants took place through a messaging application, for clarifications about the research and invitation to participate, with a request for an email in case of interest. Subsequently, an email was sent with the link to the Informed Consent Form, in which participants formalized their acceptance and indicated a date for the virtual interview.

Data collection took place from May to July 2021, through virtual semi-structured individual interviews, following a script divided into two parts. The first consisted of closed-ended questions, for a brief characterization of interviewees. The second contained the following open-ended question: did you notice changes in hospital care for parturient women and in their care process in relation to the period before the pandemic? If so, talk about the changes you noticed.

In compliance with health safety standards in the pandemic context, the interviews took place on the date proposed by participants, using a videoconferencing platform, and were carried out by three authors, who received prior training and took

turns conducting data collection. It is noteworthy that three pilot interviews were carried out, which showed the instrument suitability and, therefore, were included in the study.

With the permission of participants, the interviews were recorded with a screen and audio recorder application, and lasted an average of 40 minutes. After transcription, the material was subjected to thematic content analysis, going through three stages: pre-analysis; exploration and categorization; and data processing and interpretation[19].

From this perspective, successive readings of interviews began, allowing them to be imbued with content of thematic relevance, which allowed identifying units of record and context based on exhaustiveness, representativeness, homogeneity and relevance of content with the objective of the study. Subsequently, significant sections were selected and recording units with similar meanings were organized.

As strategies adopted to ensure the credibility of the interpretative and analytical process, it is worth clarifying that the first two stages of the analysis were conducted by the three authors who carried out the interviews, followed by debriefing sessions with two other researchers on data coding, meaning cores of recording unit cluster and the constitution of categories: "Implications of the pandemic on hospital care for parturient women"; and "Implications of the pandemic on the process of nurse-midwives' care". Finally, the findings were discussed with inferences from the researchers in dialogue with the literature relevant to the contents that emerged from the interviews.

The ethical and legal aspects of Resolution 466/2012, which deals with guidelines and standards on research involving human beings, and Circular Letter 02/2021 of the Brazilian National Research Ethics Commission, which defines procedures for studies carried out in a virtual environment, were respected. The study was approved by the Research Ethics Committee of the *Universidade do Estado do Rio de Janeiro* (UERJ), under Opinion 4,518,637 of February 1, 2021. To guarantee participant anonymity, the letter "N" was adopted, referring to the nurse, followed by a number, which represents the order in which the interview was carried out.

RESULTS

All participants were female and the majority were between 30 and 35 years old. They received their training in the specialty through residency and worked in the field of obstetric nursing for between 5 and 10 years. Regarding employment at the time of data collection, 15 worked in maternity wards and five combined this employment with another at a childbirth center. Regarding the type of employment relationship, 12 were statutory public servants and eight worked under the CLT (Code of Brazilian Labor Law) regime.

Implications of the pandemic on hospital care for parturient women

The nurse-midwives in this study noticed that, in the first year of the COVID-19 pandemic, women arrived at the maternity ward in advanced labor and with little information about the birth process, associated with fear of contamination in health institutions, especially in hospital settings, and the weaknesses in access to prenatal information, due to reduction in supply and demand for this service.

> It's a lack of preparation in prenatal care! […] I notice a decrease (in the number) of women in the hospital because they go more during expulsive periods. So, I see fewer prodromes, more expulsions, or more active periods. (N04)

> With the pandemic, I realized that the basic units had to close. […] when they opened, they were afraid to go and had little access to prenatal care… they were poorly provided prenatal care in the sense that they had little adherence and little demand due to fear! It was better to stay at home and not get anything than to go to prenatal care. […] in relation to the women we assist, we noticed their fear of going into maternity. Before, they would arrive with 5-6cm dilation and began to arrive during the expulsion period, due to the fear of leaving home and looking for a health unit. (N13)

> If she had guidance, better prenatal information, it would be much better. But, often, they arrive here without any idea and it gets complicated because, during prenatal care, they don't provide guidance. The stork groups are not having them due to the pandemic, the few places that had workshops… I think they are not happening either. So, the only place would be in the consultation itself. […] many times, the woman arrives here […] with a lack of knowledge about what is going to happen, what her body will go through,

what it will be like and what she can or cannot expect! (N20)

Compared to the pre-pandemic period, they noted an increase in interventionist medical procedures in childbirth care for women with suspected or confirmed COVID-19, such as indications for unjustified cesarean section, routine use of oxytocin, episiotomy and upper airway aspiration in newborns, adoption of obsolete practices not recommended by scientific evidence, such as the Kristeller maneuver and cervix reduction, as well as routines that deprived women and newborns of the full experience of giving birth and being born, expressed in the suspension of skin-to-skin contact.

In April 2020, an institutional protocol was created saying that the childbirth of women with suspected or confirmed COVID-19 should be shortened. So, she stayed in the isolation bed, few people from the team could circulate in that room and the childbirth had to be high risk. The medical team attended and shortened this moment! It was to reduce the cervix, put the serum with oxytocin, Kristeller, episiotomy... (N13)

Sometimes, there is no need to indicate a cesarean section and, when it takes a long time, they indicate a cesarean section [...] this is happening more because of the pandemic, because she arrives with a cold, but I don't have the rapid test of COVID-19... so, they immediately recommend a cesarean section because it can cause complications and will be worse. (N17)

The intervention that I saw most was on the part of pediatricians in neonatal care, in order to aspirate the airways, depriving women of skin-to-skin contact with newborns... (N01)

I believe that everyone can be less patient, less expectant... they can, perhaps, offer more intervention due to tolerance, which, in general, is lower. I think that, as a result, this intervention may have increased! […] he (referring to the medical professional) waits less time and will intervene! […] before, perhaps, I would have given it a little more time, but today I no longer understand that so much. The feeling it gives is that we are taking a step back from what was built, and that is bad for women! (N02)

Implications of the pandemic on the process of nurse-midwives' care

To control the spread of COVID-19 in hospital settings, the care protocols implemented in obstetric services determined physical distancing in care that, associated with the clothing necessary to protect patients' and professionals' health, it interfered with non-verbal communication, attitudes of proximity and touch, considered by nurses as fundamental elements for building bonds and close care.

The protective measures for the professional and the patient interfere a little with touching because we have to stay fully dressed. We always work with touch, hugs... this whole outfit makes it a bit difficult to hug the patient [...] and for the massage, we include the companion more in the touch issue. (N09)

If you are a pregnant woman who is suspected of having COVID-19, you end up having greater distance. But this is very complicated, because we have this need for contact with women. I think that, due to PPE (personal protective equipment), you bring this distance. (N03)

Our relationship is very close during labor assistance. It's a relationship of touch, of care... all this clothing ends up causing a certain distance. We maintain the look, but facial expressions, even to provide comfort without having to say anything during the birth process, make non-verbal communication a little difficult. […] the patient only sees our eyes. She barely sees us because of the mask, the cap... so, this distance is a challenge to maintain the bond and generate care that is so close and intimate. […] and we have to overcome this distance by using some strategies, with dialogue, for example. (N07)

In addition to these protocols, sanitary measures to provide individualized care environments, avoid sharing equipment and reduce the movement of people in areas of collective use have imposed certain limitations on the development of some non-invasive care technologies.

In this sense, the participants reported the following adaptations: they intensified the incentive to walk around the box; in the case of technologies that use instruments, they reinforced hygiene and availability close to the bed; in common spaces, they limited the number of women and established rotations for the use of Swiss ball, stool and birthing stool; given the restriction of childbirth in water, they offered a bath with warm water for relaxation during labor; and further encouraged the companion's participation, with prior guidance.

If we use the Swiss ball, we have to clean it very well between changing patients. If we use the stool, we

> have to be extra careful! [...] we continue to indicate in the same way (referring to non-invasive care technologies). The difference is that we respect the issue of hygiene a little more! (N06)

> With the patients in their own bed, I take the Swiss ball or stool so they can be isolated from the other patients. In order not to generate too much crowding [...], I send one to the bath and leave, at most, three patients. They take turns: one is on the Swiss ball, another on the birthing stool and another on the stool. (N14)

> In the beginning, we were reducing walking as much as possible, allowing them to move around pre-childbirth. I always tell them, "You can walk in the box, walk around here, do a pelvic movement…". I often offer the Swiss ball so women don't wander around outside. It's a technology that we can do right there in the space where it is. (N15)

> We have been providing much more guidance on this woman's free movement, but she is no longer allowed in the corridor. She is restricted to her room. (N4)

> We suspended childbirth in water because, until then, we didn't know... we didn't know anything about COVID-19 and, to date, it remains suspended. We use the bathtub, the warm water, as technology for relaxation, but for childbirth, we haven't used it again yet. (N11)

> This issue of hugging, I avoid. I no longer hug women like I used to... it was a very natural thing! You teach the woman how to waddle, the contraction comes, she grabs her neck, hugs you and you end up hugging her too. At this time of pandemic, I don't do that anymore. I ask the father to do it with her and guide him on how to do it. (N05)

DISCUSSION

The COVID-19 pandemic context determined the creation of protocols to protect health and mitigate the spread of SARS-CoV-2 in obstetric services, which reorganized care for pregnant women, parturient women and postpartum women based on changes in routines and the use of physical spaces[6,9,14,20].

In prenatal care, teleconsultations were implemented interspersed with in-person consultations, direct communication channels and online educational activities. However, these initiatives faced inequalities in digital accessibility and low adherence and/or abandonment of monitoring, due to difficulties in accepting this remote modality of care, illness or fear of leaving home[2,4,6,9,14,21,22].

Furthermore, given the growing curve of infections and maternal deaths, lack of reliable information and media interference[4,6,14,16,23,24], pregnant and parturient women experienced uncertainty, concerns and doubts related to the fear of: contamination; vertical transmission; clinical and obstetric complications; encounter barriers in accessing health; death; fetal loss; need for care in intensive environments or neonatal hospitalization; and changes in maternity hospital routines, such as restrictions on the presence of companions at childbirth and visits[4,7,9,14,23,24].

Added to these circumstances are the anguish and insecurity of these women associated with urban displacement and the fact of entering a health service and giving birth in the hospital, considered critical environments with a greater risk of transmission and contagion of SARS-CoV-2[23,25]. Therefore, many women avoided attending prenatal consultations and considered home childbirth as an alternative to avoid exposure[15,24].

This complex overview, which interfered with access to prenatal care and added psychological distress to pregnancy and birth during the pandemic, had an impact on the way parturient women arrived at maternity wards, as perceived by the nurse-midwives in this study. Despite the fear of contamination in the hospital environment and the lack of information about childbirth care protocols, such as conditions that increase stress and are associated with negative experiences of childbirth[7,14], it is important to consider that the admission of women in advanced labor may have been beneficial, as the hospitalization of parturient women in the active phase of childbirth is a recommendation that is related to lower chances of being subjected to unnecessary interventions[13].

In line with other research that highlighted non-compliance with good practices in childbirth and birth care as a repercussion of obstetric care reorganization to control COVID-19[7,15-16], the findings of this research point to the increase in interventionist medical procedures in the face of suspected and confirmed cases of the disease, under the argument of avoiding complications, shortening the expulsion period and reducing the risk of contamination of newborns. However, it is

noteworthy that the practices identified in participants' statements are anchored in risk discourses, which diverge from official regulations and scientific evidence, as highlighted in other investigations[3,4,7-9,20,26].

From this perspective, it is noted that changes in hospital care for parturient women often prioritized practices without the strength of recommendation, as is the case with the indiscriminate performance of cesarean sections without clinical indication. In addition, procedures that require judicious use were routinely used, such as episiotomy, oxytocin infusion, neonatal airway aspiration and suspension of skin-to-skin contact. Furthermore, the adoption of proscribed practices was observed, such as the Kristeller maneuver and cervix reduction[13], which represent situations of obstetric violence and, therefore, represent violations of women's bodily integrity[21,26]. These findings suggest that the pandemic context intensified the process of medicalization of obstetric and neonatal care, thus threatening achievements regarding humanization, quality and safety[27,28], especially in low- and middle-income countries[6,9,16,20,26].

On the other hand, a study with 885 women, who had their children in hospitals in the United States of America from March to July 2020, revealed the prevalence of normal childbirth (70%), presence of a companion (97.5%), non-separation of newborns at birth (82.6%), breastfeeding in the first hour of life (74.6%) and staying in rooming-in (89.2%), regardless of serological status for COVID-19. Although these findings differ from the recommendations in force at the time, it is noted that most good practices in childbirth and birth care were maintained[15].

Even though the first guidelines for parturition care in times of COVID-19 were often divergent and included some of the behaviors identified in the present study, except those abolished, the gradual production of knowledge on the topic reinforced the relevance of good practices[16,20,26-28]. Thus, the power of nurse-midwives to develop care based on scientific evidence and aligned with protocols for safety in hospital care during parturition in the pandemic context, as shown by the results.

According to what was found in investigations that address the efforts undertaken by nurse-midwives to maintain good practices in childbirth during the pandemic[1,16], participants faced challenges in offering non-invasive care technologies to parturient women, defined as a set of knowledge, techniques, procedures and relational skills that materialize in intentional actions, which may or may not require the use of instruments, such as the nurses' body, companion, Swiss ball, birthing stool, shower, essential oils, massagers and other resources[17].

To act from this perspective, nurses needed to adapt their care process with these technologies, in light of sanitary measures, to reduce the occupational exposure of professionals, such as clothing and physical distancing, as well as to mitigate the risk of spreading SARS-CoV-2, expressed in the preference for personal protective equipment and environments (PPE) and in restricting the movement of people in collective spaces.

However, the use of PPE and maintaining a distance of one meter in care environments[3] interfered with the manifestation of health professionals' relational skills, such as body postures, facial expressions and gestures[6,29]. In the case of nurse-midwives, these skills are the basis of non-invasive care technologies, including demonstrations of affection, availability, support, empathy and closeness[17], which were hampered in the context of the pandemic, mainly due to the use of protective masks.

These, for instance, obscure important characteristics of non-verbal communication, making it difficult to perceive and interpret emotions, especially those that move the lower portion of the face, identity recognition, communication, in terms of understanding, interactions and interpretation as well as the ability to perceive social information[29,30].

About the strategies adopted by participants in relation to non-invasive technologies that usually require the use of the nurses' body, such as massage, or equipment, such as Swiss ball, birthing stool and stool, It is noted that their actions were aligned with the recommendations for controlling COVID-19, even with the inadequacies in the infrastructure of maternity wards, which prevented childbirth assistance in private spaces and with inputs for individual use[6].

In this way, they created demarcation resources,

avoiding crowds in collective care areas; cleaned and disinfected shared objects after each use[3]; safeguarded good practices in childbirth, manifested in non-invasive technologies that encouraged the progression of labor, through ambulation and the use of equipment; and promoted relaxation, comfort and well-being, with massage, warm bath and companion participation in care[1,16].

Thus, it is noted that, during the COVID-19 pandemic, nurse-midwives continued to offer non-invasive care technologies, with adaptations that contributed to controlling the disease in hospital childbirth care, ensuring parturient women's access to good practices.

Considering the findings of this study, it is recommended that, in future contexts of health crisis, investments be made in the work of these experts and in the development of continuing education actions that provide opportunities for discussion and problematization about professional protocols and practices, based on scientific evidence, public policy guidelines established in the scope of obstetric and neonatal care, as well as the rights of women and newborns to safe, qualified and respectful care.

Limitations of this research include the technique used to gather participants and the form of virtual interviews, which, respectively, may have resulted in participant homogeneity and harmed the perception of subjectivities, which are better identified in person.

FINAL CONSIDERATIONS

Nurse-midwives reported that COVID-19 had implications for hospital childbirth care, since, in the first year of the pandemic, parturient women were admitted to maternity wards in advanced labor and had little information about the parturition process. Furthermore, they noted the increase in medical interventions during childbirth and birth, involving the indiscriminate adoption of behaviors that require clinical indications, being used judiciously or even proscribed. This scenario points to the erasure of good practices and the resurgence of medicalization, which may imply situations of obstetric, gender-based and violence against women as well as setbacks in maternal and neonatal health indicators.

On the other hand, the implications for the process of caring for nurse-midwives revealed the potential of these experts in respecting health measures to control COVID-19, scientific evidence and good practices in childbirth, since they maintained the offering of non-invasive care technologies, with adaptations that interfered with the manifestation of their relational skills, but preserved humanization in hospital care for parturient women.

IMPLICAÇÕES DA PANDEMIA DE COVID-19 SOBRE A ASSISTÊNCIA HOSPITALAR ÀS PARTURIENTES NA PERSPECTIVA DAS ENFERMEIRAS

RESUMO

Objetivo: conhecer as implicações da pandemia de COVID-19 sobre a assistência hospitalar às parturientes na perspectiva das enfermeiras. **Método:** estudo descritivo e qualitativo, com 20 enfermeiras obstétricas do estado do Rio de Janeiro. Os dados foram coletados de maio a julho de 2021, através de entrevista semiestruturada realizada por videoconferência, e submetidos à análise de conteúdo temática. **Resultados:** as implicações perpassaram por: parturientes foram admitidas nas maternidades em trabalho de parto avançado e pouco esclarecidas sobre a parturição; e incremento das intervenções médicas, expresso na adoção indiscriminada de práticas que requerem indicações clínicas, é de uso criterioso ou está proscrito. Por outro lado, as implicações sobre os cuidados das enfermeiras revelaram adaptações no oferecimento das tecnologias não invasivas diante dos protocolos de controle da COVID-19, no sentido de preservar a humanização e os direitos das mulheres no parto, ainda que tenham prejudicado a manifestação das habilidades relacionais. **Considerações finais:** pondera-se que a pandemia interferiu no acesso e na utilização das atividades educativas no pré-natal, e as medidas implementadas na assistência hospitalar às parturientes repercutiram no apagamento das boas práticas e recrudescimento da medicalização. Porém, evidenciam-se as potencialidades das enfermeiras obstétricas, que respeitaram as normativas sanitárias e proporcionaram cuidados seguros e respeitosos.

Palavras-chave: COVID-19. Parto. Assistência Perinatal. Cuidados de Enfermagem. Enfermagem Obstétrica.

CONSECUENCIAS DE LA PANDEMIA DE COVID-19 EN LA ASISTENCIA HOSPITALARIA A LAS PARTURIENTES DESDE LA PERSPECTIVA DE LAS ENFERMERAS

RESUMEN

Objetivo: conocer las consecuencias de la pandemia de COVID-19 sobre la asistencia hospitalaria a las parturientes desde la perspectiva de las enfermeras. **Método**: estudio descriptivo y cualitativo, con 20 enfermeras obstetras del estado de Rio de Janeiro/Brasil. Los datos fueron recopilados de mayo a julio de 2021, a través de entrevista semiestructurada realizada por videoconferencia, y sometidos al análisis de contenido temático. **Resultados**: las consecuencias incluyeron: parturientes admitidas en las maternidades en trabajo de parto avanzado y poco aclaradas sobre el parto; e incremento de las intervenciones médicas, expresado en la adopción indiscriminada de prácticas que requieren indicaciones clínicas, es de uso juicioso o está proscrito. Por otro lado, las implicaciones sobre los cuidados de las enfermeras revelaron adaptaciones en el ofrecimiento de las tecnologías no invasivas ante los protocolos de control de COVID-19, en el sentido de preservar la humanización y los derechos de las mujeres en el parto, aunque hayan perjudicado la manifestación de las habilidades relacionales. **Consideraciones finales**: se pondera que la pandemia interfirió en el acceso y la utilización de las actividades educativas en el prenatal, y las medidas implementadas en la asistencia hospitalaria a las parturientes repercutieron en la eliminación de las buenas prácticas y recrudecimiento de la medicalización. Sin embargo, se evidencian las potencialidades de las enfermeras obstetras, que respetaron las normativas sanitarias y proporcionaron cuidados seguros y respetuosos.

Palabras clave: COVID-19. Parto. Asistencia Perinatal. Atención de Enfermería. Enfermería Obstétrica.

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Corresponding author: Juliana Amaral Prata. Boulevard 28 de Setembro, 157, 7 andar. Vila Isabel. Rio de Janeiro. RJ. Cep: 20551-030, E-mail: juaprata@gmail.com, Telefone: (21) 991197178

Submitted: 16/01/2023
Accepted: 21/01/2024

Financial support

This study was financed in part by the Fundação de Amparo à Pesquisa do Estado do Rio de Janeiro - Brazil (FAPERJ). Notice n. 26/2021 – Basic Research Assistance in State Science and Technology Institutions UERJ, UENF e UEZO -2021.