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ORIGINAL ARTICLE

MATERNAL QUALITY OF LIFE DURING SOCIAL DISTANCING FROM THE COVID-19 PANDEMIC

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ABSTRACT

Objective: to assess maternal quality of life during the covid-19 pandemic. **Method**: Exploratory, quantitative, cross-sectional study with a sample defined with the virtual Snowball method. The collection took place between June and September 2021, online. A semi-structured form on socioeconomic issues and the World Health Organization's abbreviated quality of life assessment instrument were used. Data analysis included descriptive statistics, Pearson's Chi-Square, Fisher's Exact, and Multiple Logistic Regression tests. For all analyses, p-value <0.05 was considered. **Results**: 305 responses from women with a mean of 1.6 children. Gender inequality was present. There was statistical significance between race/brown color (58.3%; p=0.045) and income of up to one minimum wage (67.9%; p<0.001) and low quality of life. Higher probability of lower quality of life in mothers who did not share responsibilities for child care (OR 3.18) and for those who did not take care of mental health (OR 2.45). **Conclusion**: The emotional well-being and quality of life of mothers of children in social distance during the pandemic was low. The support network is a protective factor for the mental health and quality of life of this population. Gender discussions and assignments with children are necessary.

Keywords: Mothers. Quality of life. Covid-19. Gender equality.

INTRODUCTION

Due to the covid-19 pandemic, caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), humanity experienced a serious global health crisis, since the high transmissibility of covid-19 caused a number of deaths greater than the sum of the epidemics caused by the Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) and the Middle East Respiratory Syndrome Coronavirus (MERS-CoV)[1-2]. Because it is a respiratory transmission virus, prevention occurs through collective pacts such as the adoption of respiratory etiquette and the use of masks, as well as social distancing measures[3-4].

Although extremely effective in controlling the pandemic, social distancing measures result in the confinement of part of the population, generating several health impacts, being particularly significant in mental health, such as anxiety, depression, irritability, sleep disorders, fatigue and cognitive impairments[5-7].

In the pandemic context, women, especially mothers, experienced additional disadvantages compared to men. The relationship between work, gender and motherhood can generate personal and professional conflicts due to the sexual division of labor, in which women are socialized to be responsible almost exclusively for the care of the home and children[8-9].

In the context of women's health, the impacts of the pandemic ranged from domestic work overload and an increase in domestic violence to job loss and income reduction, exposing women to greater emotional and psychological stress, leading to anxiety crises and physical illness[8-10].

The situation of the COVID-19 pandemic, by itself, was a stressful event. Fear of falling ill and uncertainty about maintaining the source of income generated feelings of insecurity and anxiety, and made it difficult to focus on other aspects of life, such as work, studies and family relationships[11-12].

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The reality of the woman-mother is even more critical, since they had to make adaptations to ensure survival, with the intensification of working hours associated with the home office regime and the reduction of the support network due to the suspension of sending their children to schools and daycare centers, unfeasibility of rest time and accumulation of activities, resulting in exhaustion and psychological suffering[10-13].

Faced with so many changes and uncertainties arising from the pandemic scenario, families had to reorganize themselves, in an attempt to reconcile all the daily demands in the confinement scenario. However, the unequal division of responsibilities with the care of children and the home overloads and disrupts the routine and way of life of women mothers, leading them to exhausting situations that can affect the quality of life (QoL) of mothers of children, contributes to a potentially toxic environment, aggravates the negative effects of confinement, and especially in single-parent families and with a low socioeconomic profile[5,14-15], highlighting the need for studies that investigate the QoL of mothers of children in the face of the pandemic.

According to the World Health Organization's Quality of Life Group, The WHOQOL Group[16], QoL refers to the way a person perceives his position in life, taking into account his culture, values and expectations, standards and concerns. This is a complex concept because it considers physical and mental health, personal beliefs, social relationships, and the relationship of individuals with the environment.

Therefore, this study is justified due to the importance of reflecting on gender inequality and sexual division of labor, which exposes women-mothers to situations of vulnerability and may contribute to a decrease in their QoL. As well as the relevance of knowledge about maternal QoL for the direction of preventive actions and promotion of self-care and emotional well-being of mothers, directly influencing family well-being, including children health, by their positioning as the main caregivers and managers of the family environment and children.

Given the above, this study aimed to: evaluate the quality of life (QoL) of mothers of children during the covid-19 pandemic.

METHOD

This is a cross-sectional, exploratory study with a quantitative approach, which followed the recommendations of the STROBE checklist to guide the research. The study population was formed by mothers of children (considering "child" the person up to twelve years of age incomplete, according to the definition of the Statute of the Child and Adolescent - Law 8.069/1990), in social distance with their children, with a sample defined through the virtual Snowball method[17], using the temporality of three months of data collection to limit the n sample (n = 305).

The selection criteria for the sample of the target audience were: women over 18 years of age; literate; living with a child or children from 0 to 12 years of age (child). Those who were in work activity in the face-to-face modality (outside the domestic environment) were excluded.

The link with the invitation was published on the researchers' social media; it contained the specification of the selection criteria and access to the study form; it was also published at the research institution, participants referred to components of health care services, in addition to virtual groups of mothers, users of the unified health system, groups of schools and daycare centers and religious communities. As the sample was self-generated, and not probabilistic, the research had the collaboration of these initial and subsequent members in disseminating the research to other participants who met the established selection criteria and accepted to answer it. This process persisted until the metric, data collection deadline, was reached.

Data collection took place between June 15, 2021 and September 12, 2021. The following instruments were used: one to collect sociodemographic data (age, number of children, race/color, marital status, education, work, monthly income, division of responsibility for the care of the child (children), help from neighbors/family members in the care of the child (children), maternal health problem associated with limitation for the care of their children, and care for their mental health) and the abbreviated World Health Organization quality of life assessment instrument (WHOQOL-BREF), in the public domain and validated in Brazil, which contains 26 questions, two on general quality of life and the others encompassed in 4 domains: 1- Physical; 2- Psychological; 3- Social Relations and 4- Environment. The WHOQOL-BREF scores are

obtained by facets, from a Likert-type scale, with five points (1 to 5). Scores are measured in a positive direction, that is, the higher the score, the better the quality of life[18].

The collection was conducted online through the virtual tool Google Forms, with an estimated mean duration of 15 minutes, whose dissemination and recruitment took place through virtual social networks, such as email, WhatsApp and Instagram.

Data were tabulated from Excel 2013 and transferred for analysis in SPSS Statistics, using descriptive statistics, with measures of central tendency and dispersion; and inferential statistics, with Pearson's Chi-Square, Fisher's Exact and Multiple Logistic Regression tests. Fisher's exact test was used in situations where at least 20% of the cell values (cells) had a frequency of less than five.

The entry criterion of the variables in the multiple logistic regression model was established for $p<0.2$ in the bivariate analysis. Based on the median total score of the scale, low quality of life and, above this, high quality of life were defined. The hierarchical regression model was chosen, in which the variables with the highest p-value were gradually removed, keeping in the final model only those with $p<0.05$. It is noteworthy that, for all analyses, the 95% confidence interval and the significance level of 5% (p-value< 0.05) were used. It was possible to identify the main outcome of the study, in this case the correlation between social distancing due to the pandemic and the decrease in the quality of life of mothers of children.

The study was submitted to the Research Ethics Committee of the Health Sciences Center, Federal University of Paraíba, obeying the requirements of CNS Resolution 466/2012, and approved under CAAE 45856621.9.0000.5188 (Opinion: 4.740.107). Study participants agreed to the Informed Consent Form (ICF), which was at the beginning of the Google Forms form, and received a copy of the agreed term by email. The form did not require personal identification and all data were stored according to the regulations of research with human beings and the General Law for the Protection of Personal Data.

RESULTS

Based on the 305 completed forms, the mean age of the mothers was 34.7 years (SD ± 5.9), with a mean of 1.6 children, 48.5% were white, 82.5% were married, 56.1% had graduate degrees (complete and incomplete), 66.6% had paid work and 35.4% received an income between two and five minimum wages.

As for child care, 86.6% of the participants received help from third parties, 41.6% from the child's father. In addition, 75.7% answered that they shared the responsibility for child care, considering a mean of 75.5 (SD ± 21.4) points for their own share of responsibility; 90.8% said they had access to the necessary food for themselves and their children and 79.4% of mothers denied having any health problems.

Regarding quality of life (QoL) results, 50.2% presented low overall QoL. As for the QoL facets, 56.7% presented low domain of social relationships, 56.1% low psychological domain, 54.8% low physical domain, 51.1% low domain of environment, as shown in Table 1.

Table 1. Frequency of information regarding quality of life (N=305). João Pessoa-PB, Brazil, 2021.

Variables	N (%)
Quality of Life Domains	
Physical Domain	
Low	167 (54.8)
High	138 (45.2)
Psychological Domain	
Low	171 (56.1)
High	134 (43.9)
Social Relations Domain	
Low	173 (56.7)
High	132 (43.3)
Environment Domain	
Low	156 (51.1)
High	149 (48.9)
Quality of life	
Low	153 (50.2)
High	152 (49.8)

Regarding the association of sociodemographic variables with quality of life (table 2), the variables that presented statistical significance were race/brown color (58.3%; p=0.045) and income of up to one minimum wage (67.9%; p<0.001), both with low QoL.

Table 2. Relationship between sociodemographic variables and quality of life of mothers (N=305). João Pessoa-PB, Brazil.

Variables	Quality of life	
	Low QoL n (%)	High QoL n (%)
Age		
20-29 years	33 (52.4)	30 (47.6)
30-39 years	95 (53.7)	82 (46.3)
40-49 years	24 (38.7)	38 (61.3)
Over 50 years	1 (33.3)	2 (66.7)
p-value	0.180**	
Race/skin color		
White	65 (43.9)	83 (56.1)
Brown	77 (58.3)	55 (41.7)
Black	11 (44.0)	14 (56.0)
p-value	0.045*	
Marital Status		
Single	13 (54.2)	11 (45.8)
Married/common-law marriage	121 (48.0)	131 (52.0)
Divorced/ Separated	17 (63.0)	10 (37.0)
Widow	2 (100.0)	0 (0.0)
p-value	0.229**	
Education		
Elementary School	2 (50.0)	2 (50.0)
High School	24 (60.0)	16 (40.0)
University Education	51 (56.7)	39 (43.3)
Graduate Education	76 (44.4)	95 (55.6)
p-value	0.135**	
Monthly Income		
Up to 1 MW	36 (67.9)	17 (32.1)
Between 2 and 5 MW	69 (63.9)	39 (36.1)
Above 5 MW	48 (33.3)	96 (66.7)
p-value	<0.001*	

Note: * Pearson's Chi-Square Test; ** Fisher's Exact Test.

In the analysis of quality of life and aspects of child care, it was observed that low quality of life was present in mothers who had a child (53.3%) and who did not receive help in care (65.9%). Regarding the support network, those who received help from family members (53.1%) and who did not have help from the parent (55.1%), spouse (54.5%), babysitter (52.3%), friends/neighbors (50.8%), school (49.8%), who did not share responsibility for the care of the child (71.6%) and who had children with health problems (58.3%) also had a low quality of life index. Of these variables, there was significance for the absence of help in care (p=0.031), absence of support network from the parent (p=0.043) and spouse/partner (p=0.036), and absence of division of responsibilities (p<0.001).

Regarding the analysis between the emotional and physical variables of mothers with quality of life, most presented low quality of life in the presence of some health problem (76.2%), which led to limitation in the care of their own children (60.3%), demonstrating the "terrible" feeling in the last week (88.5%), without taking care of mental health (61.4%), and using medication for some psychological issue (66.1%). All variables were statistically significant (p<0.001; p=0.006).

Table 3 shows the Multiple Logistic Regression Model of quality of life, which expresses that there was a 3.18 times greater probability of having a poor quality of life for women who did not share responsibilities for child care; 14.34 times for those who did not receive help from neighbors/family members; 5.19 times for those who believed that having a health problem limited the care of their own children; and 2.45 times for those who did not do something to take care of mental health.

Table 3. Variables associated with quality of life through adjusted logistic regression. João Pessoa-PB, Brazil, 2021.

Variables	OR	CI	p-value*
Division of caregiving responsibility for the child (children)?			
Yes	1.00	-	-
No	3.18	[1.73 – 5.85]	<0.001
Help from neighbors/family in caring for the child (children)?			
Yes	1.00	-	-
No	14.34	[1.27 – 161.46]	0.031
Maternal health problem brings some limitation to the care of your child (children)			
Did not answer	1.00	-	-
Yes	5.19	[2.65 - 10.15]	<0.001
No	4.45	[1.36 – 14.54]	0.013
Do you take care of your mental health?			
Yes	1.00	-	-
No	2.45	[1.47 - 4.07]	0.001

Note: Adjusted R^2: 0.261; OR = Odds Ratio; CI = Confidence Interval; * Test significance.

DISCUSSION

Quality of life can be affected by several structural axes of society, such as racial and income inequalities, due to the restriction of opportunities and access to legal rights. With the pandemic, these inequities were potentiated, leading socially disadvantaged groups, such as non-white and low-income women, to even more vulnerable situations [19-20], corroborating the results of the significant associations between low QoL and mixed race/color and income of up to a minimum wage. It is conjectured that if the sample of this study was composed of a high number of brown and black mothers with low income, an even more expressive frequency of low QoL could be found.

In addition to racial and economic issues, women also deal with the consequences of social construction based on gender, in which men are socialized for life outside the home and to be providers, and women to take care of children and the home as an obligation, devotion, manifestation of love, instinct or natural consequence of the choice for reproduction [13,21], which may be related to the high share of responsibility of mothers in cases where they claimed to share responsibility for child care.

Thus, even when there is a companion, there is no guarantee of a fair division of household tasks. Investigations[22-23] show that even when fathers increase their involvement with housework and childcare, mothers also increase such involvement, following an unequal division of responsibilities.

It is important to note that the pandemic heterogeneously affected people of different genders, with an impact especially among women, exposing their social vulnerabilities. The role of women as caregivers brought greater risks, both of contracting covid-19 and of physical and emotional overload, with impacts on mental health. In addition to social distancing, situations of violence increase, as the home is an unsafe place for many women and children[8-10].

Allied to these dynamics, the absence of a support network for mothers of children resulted in the accumulation of functions and a negative impact on the lives of these women. This fact, in the context of the pandemic, was called "The COVID motherhood penalty"[9].

In addition to the overlapping functions being directly related to the development of suffering and mental disorders in mothers, the pandemic is an aggravating factor for mental health, due to increased anxiety, stress, frustration and boredom, loneliness, irritability, sadness and various fears (of contamination, lack of supplies and decreased income)[5,8,11,24-25], which justifies the results about the "terrible" feeling reported by mothers and lack of care for maternal mental health.

The presence of these stressors leads to changes in physical health, social well-being, and excessive consumption of alcohol and other drugs, including medications such as psychotropics, directly influencing quality of life[5,11,24].

The influence of mental health on the quality of life of mothers, in a patriarchal system, is related to the centralization of child care in the maternal figure and the social imposition of an ideal motherhood, and it is up to women to take care of and take responsibility for their children despite the situation,

even in the face of their own illness[13,26-27]. In this context, the regression results of our study showed that not receiving social support, especially from family members and neighbors, is associated with 14.34 times more chances of low maternal QoL. Thus, receiving support from people in social life is a mediating and moderating factor of parental stress and life satisfaction, which corroborates studies [28-30] on social support.

In view of the results about the absence of a support network, it is suggested that society reflect on the role and operationalization of social support in the face of maternal needs, including in pandemic contexts such as covid-19, in which many mothers needed to reconcile home office and child care without external support.

Knowledge about the quality of life of mothers of children during social distancing from the pandemic by covid-19 contributes to the planning of health and nursing care in view of the impacts of emotional well-being on the basic human needs of the woman-mother as well as contributing to the direction of public policies that promote the improvement of the quality of life of this public.

It is necessary to recognize the intrinsic limitations of the study design, as it is a data collection carried out online through a form filled out by the participants themselves and disseminated, in general, among people with similar demographic characteristics. Thus, the study did not include people without internet access, without computer skills and with no level of education that would allow reading and interpretation of text. In addition, because the study is cross-sectional, causality cannot be inferred.

CONCLUSION

The results expose the vulnerabilities regarding the repercussions on the quality of life of women mothers of children during the covid-19 pandemic and indicate that emotional well-being and QoL was low, especially among those with mixed race/color and income of up to a minimum wage and lack of social support, with the domains of social relationships and the psychological being the most affected.

Mothers report assuming unequal loads of attributions with their children, a fact that exposes the consequences of social construction based on gender. Knowing that the existence of a support network acts as a protective factor for the mental health and QoL of mothers of children, the results of this study can be used as theoretical support for preventive actions. Further studies focusing on the analysis of maternal burden are recommended.

QUALIDADE DE VIDA MATERNA DURANTE DISTANCIAMENTO SOCIAL DA PANDEMIA DA COVID-19

RESUMO

Objetivo: avaliar a qualidade de vida materna durante a pandemia da covid-19. **Método**: estudo transversal exploratório, quantitativo, com amostra definida com o método de Bola de Neve virtual. A coleta ocorreu de modo on-line entre junho e setembro de 2021. Utilizou-se um formulário semiestruturado sobre questões socioeconômicas e o instrumento abreviado de avaliação de qualidade de vida da Organização Mundial da Saúde. A análise de dados incluiu estatística descritiva, testes de Qui-Quadrado de *Pearson*, Exato de *Fisher* e Regressão Logística Múltipla. Para todas as análises, considerou-se p-valor <0,05. **Resultados**: 305 respostas de mulheres com média de 1,6 crianças. A inequidade de gênero esteve presente. Houve significância estatística entre raça/cor parda (58,3%; p=0,045), renda de até um salário-mínimo (67,9%; p<0,001) e baixa qualidade de vida. Maior probabilidade de baixa qualidade de vida em mães que não dividiam responsabilidades sobre os cuidados dos filhos (OR 3,18) e para as que não cuidavam da saúde mental (OR 2,45). **Conclusão**: o bem-estar emocional e a qualidade de vida das mães de crianças, em distanciamento social, durante a pandemia, foram baixos. A rede de apoio é fator protetor da saúde mental e qualidade de vida dessa população. Discussões sobre gênero e atribuições com os filhos se fazem necessárias.

Palavras-chave: Mães. Qualidade de vida. Covid-19. Equidade de gênero.

CALIDAD DE VIDA MATERNA DURANTE EL DISTANCIAMIENTO SOCIAL DE LA PANDEMIA DE COVID-1

RESUMEN

Objetivo: evaluar la calidad de vida materna durante la pandemia de Covid-19. **Método**: estudio transversal exploratorio, cuantitativo, con muestreo por el método de Bola de Nieve virtual. La recolección se realizó de forma *online* entre junio y septiembre de 2021. Se utilizó un formulario semiestructurado sobre cuestiones

socioeconómicas y el Instrumento para la Medición de la Calidad de Vida de la Organización Mundial de la Salud. El análisis de datos incluyó estadística descriptiva, pruebas de Chi-Cuadrado de Pearson, Exacto de Fisher y Regresión Logística Múltiple. Para todos los análisis, se consideró p-valor <0,05. **Resultados**: 305 respuestas de mujeres con un promedio de 1,6 niños. La desigualdad de género estuvo presente. Hubo significación estadística entre raza/color pardo (58,3%; p=0,045), ingresos de hasta un salario mínimo (67,9%; p<0,001) y baja calidad de vida. Mayor probabilidad de baja calidad de vida en madres que no compartían responsabilidades sobre el cuidado de los hijos (OR 3,18) y para las que no cuidaban la salud mental (OR 2,45). **Conclusión**: el bienestar emocional y la calidad de vida de las madres de niños, en distanciamiento social, durante la pandemia, fueron bajos. La red de apoyo es factor protector de la salud mental y calidad de vida de esta población. Las discusiones sobre género y asignaciones con los hijos se hacen necesarias.

Palabras clave: Madres. Calidad de vida. Covid-19. Equidad de género.

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