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COVID-19 threatens the progress of humanised childbirth: a qualitative study of giving birth during the pandemic in Brazil

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Abstract: *The stressful nature of the early months of the COVID-19 pandemic severely impacted the quality of maternity care. The purpose of this study was to understand and explore the labour and delivery experiences for women who were diagnosed with COVID-19 in Brazil during this time. Between July and October 2020, we conducted 28 semi-structured interviews with postpartum women who tested positive for COVID-19 prior to delivering at a tertiary hospital in Fortaleza, Brazil. Interview transcripts were coded, and we carried out a thematic analysis using three domains of the World Health Organization's model of intrapartum care for a positive childbirth experience as a framework. During labour and delivery, women experienced varying levels of respect, with many women reporting feeling mistreated by their healthcare team because of their COVID-19 diagnosis. Due to COVID-19 hospital protocols that denied companions or visitors, women reported feeling unsupported and isolated, especially during the mandatory quarantine. Women also experienced varying levels of effective communication, with some women citing they felt the staff were often fearful, and either avoidant or disrespectful. A minority of women reported that the staff appeared to be respectful and receptive to their needs. Our findings provide preliminary evidence that the strain of the COVID-19 pandemic on health professionals potentially results in ineffective communication and mistreatment during labour and delivery. Embedding respectful and humanised childbirth principles into emergency maternal healthcare protocols may improve the childbirth experience for women with COVID-19, as well as for women during future public health emergencies.* DOI: 10.1080/26410397.2022.2152548

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Introduction

The issues of disrespect and obstetric violence within health facilities during pregnancy and childbirth have gained international attention in recent decades.[1] This issue has entered the international agenda due to the adverse effects that it has not only on the advancement of women's rights, but also on reducing poor maternal and neonatal health outcomes globally.[1–6] In response, initiatives encouraging respectful maternity care have been increasing, especially in countries like Brazil where social movements such as the humanisation of childbirth are being incorporated into policies.[6–9] For example, the *Rede Cegonha,* which was implemented in 2011, is Brazil's current maternal national health policy

that aims to uphold the provision of quality and evidence-based maternal healthcare while also supporting women's rights and "humanised childbirth" principles.[10] To further guide initiatives and policies such as those in Brazil, the World Health Organization (WHO) has developed recommendations to improve intrapartum care management and encourage health facilities to provide a positive childbirth experience using a human rights-based approach.[6] These recommendations include a nine-domain model of intrapartum care, as well as guidelines for the postpartum period.[6]

However, the 2019 SARS-CoV-2 (COVID-19) pandemic has added a new layer of complexity to the sustained implementation of respectful maternity care practices. Due to limited hospital resources, the isolating nature of current clinical protocols, and the increased rates of psychological distress among healthcare workers, the pandemic has placed an immense strain on health systems across the globe, especially in Brazil, as it was the second largest COVID-19 hotspot at the start of our study (July 2020), with over two million cases and 74,000 deaths.[11–13] Moreover, this strain can be felt not only among the healthcare providers but also among vulnerable patients, such as pregnant women. Currently, pregnant and postpartum women who contract COVID-19 are at an increased risk of maternal morbidity and even mortality.[14,15] In Brazil, pregnant women had the highest risk of dying from COVID-19 in the Americas,[16–18] with one study estimating there was a 70% excess in maternal deaths in Brazil during the first 15 months of the pandemic.[19]

Given the magnitude of the crisis, there is increasing concern that the COVID-19 pandemic may undo progress towards respectful maternity care due to the strain the disease has placed on providers and the healthcare system; moreover, there is also concern that the principles of respectful care are not adequately embedded into hospital protocols during public health emergencies.[20,21] Therefore, the purpose of this study was to explore the labour and delivery experiences of women diagnosed with COVID-19 and who received facility-based care in Fortaleza, Brazil during the first wave of COVID-19 cases and deaths. Based on the perspectives of pregnant women, we also aimed to understand whether health professionals engaged in humanised childbirth practices while providing maternity care.

Methods

Overview

Between July and October 2020, we conducted an exploratory qualitative research study to understand the labour and delivery experiences of pregnant women who tested positive for SARS-CoV-2 in a tertiary care hospital. This study was approved by the Research Ethics Committee of the University of Fortaleza and the Ethics Committee of the General Hospital of Fortaleza in June 2020 (Reference Number/Número do Parecer: 4.099.331). Written informed consent was obtained from all study participants prior to data collection.

Study setting

This study took place at the General Hospital of Fortaleza, in Fortaleza, Brazil. This city is the capital of the state of Ceará which is located along the north-eastern coast of Brazil, and is the fifth largest city in the country, with over 2.7 million inhabitants.[22] The General Hospital of Fortaleza is considered one of the largest public teaching hospitals in the state. In terms of birth volume, the hospital has on average 400 births per month. In addition to its volume, this hospital was selected because it handles high-risk deliveries and was the primary referral point in the region if pregnant mothers contracted the SARS-CoV-2 virus during the prenatal period.

Recruitment and eligibility criteria

Our target population for this study was any woman who delivered and had tested positive for COVID-19 prior to delivery and was receiving care at the study hospital. At the time of the study, there was a statewide rule that all women coming to the hospital for prenatal care and/or delivery were tested for COVID-19. If a woman went to another hospital in the city of Fortaleza and tested positive for SARS-CoV-2 she was then transferred and admitted to the study facility, as this hospital was designated for all maternal COVID-19 cases and had an obstetric unit specifically for pregnant women with COVID-19. To recruit participants, posters inviting women to participate were hung on the walls of the post-birth recovery room in the COVID-19 obstetrics unit. The posters gave the name of one of the members of the research team, a nurse (CA) who also worked in the hospital. In addition to these posters, this member of the research team (CA) went to the recovery room and approached

women within 1–3 days after childbirth to see if they were interested in participating in the study. This ensured that their labour and delivery experiences were captured in a timely manner. Because these women were also diagnosed with COVID-19, they were subject to a mandatory 15-day quarantine regardless of disease severity, which allowed our team member (CA) to approach them during their time in this unit. Women were eligible to participate if they were ≥18 years old, did not have any neurological disorders, were pregnant, were delivering at the study hospital, and tested positive for SARS-CoV-2.

Data collection and analysis

As a research team, we developed an interview guide that sought to explore the labour, delivery, and early postpartum experiences of mothers who were being treated for COVID-19 at the study hospital. However, due to the COVID-19 protocols and limited personal protective equipment (PPE) available at the time of the study, interviews were only conducted by the nurse (CA) on our research team. To maintain participant privacy, interviews were conducted in private spaces while abiding by COVID-19 protocols. CA conducted these semi-structured interviews within one to three days postpartum. The interviews were audio recorded and accompanied by field notes. Interviews were transcribed verbatim and translated from Portuguese into English. With consent from our participants, information from patient records was also collected on the presence of COVID-19 symptoms, socio-demographic characteristics (such as age, education, marital status), complications in pregnancy, and birth outcomes. We anonymised these data and tabulated descriptive statistics using these characteristics (Table 1).

We utilised Braun and Clarke's method of thematic analysis to analyse the interviews.[23] This included familiarising ourselves with the data, developing initial codes, collating these codes to identify emerging themes, and then ensuring these themes connected to the data as well as the codes we extracted by creating a thematic map.[23] After refining our themes, we conducted the final analysis. As part of our final analysis, we relied on the WHO's model of intrapartum care for a positive childbirth experience as a framework to guide the organisation of our findings. We used three of the domains from the WHO's model: respectful labour and childbirth care; support from companion of choice; and effective communication by staff that we considered especially relevant to humanised delivery. These domains were selected because they embody Brazil's principles of humanised childbirth – which call for the elimination of unnecessary medical interventions during labour and the safeguarding

Table 1. Selected sociodemographic, clinical, and obstetric characteristics of study participants

Sociodemographic category	Number of participants (%)
Age range (years)	
18–29	18 (64%)
30–39	6 (21%)
40+	4 (14%)
Highest education attained	
Primary education	11 (39%)
Secondary education	10 (36%)
Higher education and beyond	7 (25%)
Marital status	
Single	8 (28%)
Stable union	14 (48%)
Married	5 (21%)
Divorced	1 (3%)
Municipality origin	
Fortaleza	5 (18%)
Other municipalities*	23 (82%)
Presence of COVID-19 symptoms	
Asymptomatic	2 (7%)
Symptomatic	26 (93%)
Birth outcomes	
Preterm	3 (11%)
Full-term	24 (86%)
Neonatal death	1 (3%)

*Other municipalities included: Caucaia ($N = 3$), Sobral ($N = 2$), Jaguaruana ($N = 2$), Pentecoste ($N = 2$), Tianguá ($N = 2$), São Gonçalo ($N = 1$), Parnaíba ($N = 1$), Quixadá ($N = 1$), Limoeiro do Norte ($N = 1$), Parajuru ($N = 1$), Messejana ($N = 1$), Crateús ($N = 1$), Itaitinga ($N = 1$), Beberibe ($N = 1$), Chorozinho ($N = 1$), Maranguape ($N = 1$), Fortin ($N = 1$).

of autonomy and respect for women – and because they also encompass the holistic attributes of quality maternity care, as these domains do not limit a positive childbirth experience to solely clinical and safety outcomes.[6–8] Furthermore, effective communication and having support during childbirth are some of the most critical components for ensuring the implementation of evidence-based and respectful maternity practices globally.[24,25]

Results

In total, 28 women participated. On average, participants were 27 years old (range 18–42 years) (Table 1). Over two-thirds lived with their partner either in a stable union or were married. A majority of participants also had a secondary education or beyond. Only six of the participants were from Fortaleza, while 22 were from other municipalities within the state of Ceará (e.g. Caucaia, Sobral, and Jaguaruana). One participant came from the state of Piauí. Regarding COVID-19 symptoms, two participants were asymptomatic. The remaining 26 participants described symptoms ranging from mild coughs, fatigue, and sore throat to high fever and severe shortness of breath. Regarding birth outcomes, three newborns were born prematurely; and one newborn died shortly after delivery. The remaining participants experienced no neonatal complications, and their newborns were full-term.

Using three domains (respectful labour and childbirth care, support from companion of choice, and effective communication by staff) from the WHO's model of intrapartum care for a positive childbirth experience as a guide for our thematic analysis, three major sub-themes emerged: levels of respect during intrapartum care varied, with many women reporting feeling mistreated; denial of companions led to loneliness and low support throughout their stay; and varying levels of effective communication with health professionals led to perceptions of avoidance or disrespect.

Respectful labour and childbirth care

Most study participants had successful deliveries despite having COVID-19. However, many mothers expressed that they felt mistreated or disrespected, sometimes in ways specifically related to being diagnosed with COVID-19. The perceived reasons for this treatment varied. For example, some mothers described feeling rushed during their delivery, while others described the staff mistreating or neglecting them.

"They didn't respect me. I felt very ashamed, and they did not help me with almost anything. They were concerned with acting and not with reassuring me. There was a feeling of urgency – of getting rid of the problem right away. I was the problem." (Mother 14)

"I think the [healthcare] teams should have more respect during this time of delivery and birth. My delivery was not normal, but I saw a lot of conversation that I didn't want to hear during the C-section … [I] heard a lot of ugly things … Respect was lacking." (Mother 20)

These experiences of mistreatment and disrespect were often accompanied by feelings of helplessness.

"I kept putting my hand over my mouth and nose to cover myself because they didn't have masks, and some were so rude to me when I said something – [they] told me to shut up … I felt very helpless. There was a time when I cried out in pain, and they scolded me." (Mother 10)

Referring to conversations a pregnant woman overheard from hospital staff, one woman stated:

"I was scared to death of the [ugly] conversations [I overheard], and they made mistakes because they were tense and at the same time did not focus on what they were doing. My life and my baby's were in their hands. Terrible feeling." (Mother 20)

The mothers who described these negative experiences also shared that it appeared as though their providers lacked empathy. For example, one participant's baby did not survive the delivery, and she went on to describe how no healthcare personnel checked on her after the child's death.

"I didn't see anything humanised [about my delivery]; I think the situation was lacking. There was no conversation … they told me it was the disease [COVID-19], and the baby did not survive. I cried softly because no one came to ask me anything, not even how I was. Everyone was covered [with protective gear], I just saw the eyes and nothing else." (Mother 8)

However, not all participant experiences were negative. Some mothers described quite positive

childbirth experiences at this same hospital. In contrast, the staff were described as kind and respectful.

"The [health] professionals treated me well despite the fact that they also felt scared, especially to touch me, but they were not disrespectful." (Mother 5)

"[The health professionals] were great, they explained a lot to me. I thought it was really good – they respected me a lot." (Mother 22)

These women did not describe as much duress compared to the women who felt they were mistreated. In fact, these positive experiences were often accompanied by descriptions of the staff appearing to be well-prepared and understanding.

"[The providers] were awesome, smart, and I only have compliments for the team. All very safe. I believe that they already had a lot of experience on [the delivery] service and for this reason, they were affectionate and humane. Thank God everything went well!" (Mother 27)

"I thought it was great they knew what had to be done and they gave me a lot of support when I despaired." (Mother 29)

Emotional support from companion of choice

Another major finding was that women overwhelmingly felt they were denied support due to being unable to be accompanied during the delivery. Because of the hospital's COVID-19 protocols, all study participants were denied companions both during delivery and in the first few days after the delivery.

"I knew I was entitled to a [companion], but they wouldn't let my husband in. They explained, but he was very angry and said he was going to complain to the hospital when a doctor answered him very rudely. It was kind of irritating; they can see that we are also people, and I didn't want to be alone. But then I saw that it wasn't just me. All the [COVID-19] patients were isolated in a single ward. And then I called him and told him about the situation, and my husband understood." (Mother 24)

"My relatives and family members could not stay with me, my partner could not attend the birth because the doctor did not want them to." (Mother 6)

Lack of permission to have family present to support women at the hospital led to recurring discussions of fear and loneliness.

"It was a very difficult moment, I was very afraid to enter the hospital … [It] was not what I expected for this moment. I felt very helpless with no family members around. I already knew that my partner did not want to see the birth and so I arranged for my mother or mother-in-law [to come] and then [found out that] they were not allowed to be with me. It was a feeling of loneliness at a time [when] we have so many expectations." (Mother 1)

As another woman stated:

"They told my partner to leave. And I really wanted to have my partner here, but the hospital wouldn't let him stay. This isolation is terrible." (Mother 7)

This recurring theme of loneliness became most pronounced when women were placed in the isolation sector of the hospital for a mandatory 15-day quarantine period. During quarantine, almost all the women expressed how much they missed their loved ones.

"I miss my children very much. They're [staying] at the neighbors' houses. I couldn't leave [all of them] together because it was too much for one house. My mother can only stay with three minors. Each neighbor has one. I get worried about them. I think it's working out this way, but I'm stuck for 15 days now. They say that as long as my pressure doesn't go down, they can't get me discharged from the hospital, [but] how [can I have] low pressure [without] get[ing] worried about them staying there?" (Mother 5)

"I miss home a lot. We are isolated here and do not feel that time has passed. They don't talk about when I'm leaving." (Mother 11)

"I feel very alone. I wish I had someone to talk to – my family. Everyone is away from me." (Mother 27)

These feelings of isolation and longing for family appeared to be more pronounced for mothers who were from far away.

"[I'm] looking forward to going home. Fifteen days here away from everything makes me very discouraged. I want to go back to my city. I don't know anyone here in Fortaleza, but no one can enter here either." (Mother 9)

"I'm fine in terms of COVID, but I don't think I'm fine in my heart. I miss my family and friends a lot. There, in the countryside we know everyone, and I miss that a lot." (Mother 15)

During these discussions, many women also voiced their desire to be discharged as soon as possible. However, amid these desires, they also shared trepidation about what might happen if they did leave the hospital early. Whether it was fear of spreading the virus to others or catching the disease again, many of the mothers could understand why this isolation was necessary.

"This isolation without being able to receive a visit is very bad. They said if I go home, I could pass the disease on to others. I even said that I wasn't going to leave the house and I wasn't going to be visited, but people will want to know about me at home and then I'm afraid I won't have the courage to send people away." (Mother 4)

"I'm fine, but I really want to leave this hospital. I'm afraid to catch COVID again and [it will] make it harder to leave." (Mother 12)

"I wanted to sign for my discharge, but I'm afraid of having to come back [to the hospital] and then it would be worse. I will wait with great faith in God that everything will work out." (Mother 19)

Although almost all the mothers expressed some degree of fear or loneliness during their quarantine, a few mothers shared that they were fine with the isolation.

"Thank goodness I am very well. [My baby] is here with me and everything went well." (Mother 23)

These mothers explained they were feeling content either because they had other means of communicating with their loved ones or because they felt that the worst of their childbirth experience was over.

"I'm glad I have the cell phone to kill the [time]. I always talk to [my family]." (Mother 21)

Effective communication by staff

Descriptions of verbal communication with the hospital staff varied significantly from mother to mother. Some mothers expressed that they felt the staff was rude. One woman explained, "*Ave Maria – [my delivery] was terrible. I felt like a leper. [The staff] are very closed off."* Such mothers described the treatment they felt they received in relation to the fear of COVID-19.

"As soon as I arrived, all the [staff] were that far away. The nurse introduced herself and told me to stay away from them and told my mother to leave the room. And it was pretty [rude] – saying [she] couldn't stay because there were a lot of people in the room there. But there was only me, my mother, a gentleman who I think was the doctor and someone else. It was just an excuse for my mom to leave. She cried a lot when she knew I was going to be alone. Then I couldn't take it and cried too." (Mother 4)

"I almost asked them not to be afraid of me – that I was no monster. It felt like I was an ET. They mistreated me in a way because they were harsh." (Mother 13)

Other mothers expressed that while some staff communicated rudely, they somewhat excused this behaviour since they understood that the staff needed to follow COVID-19 protocols or because they believed the staff were afraid of contracting the virus.

"I think [the staff was] afraid of becoming infected, right? But they were cordial. There was only one that I don't know if she was a doctor or a nurse who was so rude to my husband, but it must be her way." (Mother 7)

A few women shared that they did not communicate with the staff because they kept their distance from the patients.

"I think they were more concerned with saving our lives, and so they didn't talk and didn't come close and didn't touch us, but I think they did the right thing." (Mother 4)

"You can't be human without a touch. I was afraid that they would not want to hold my baby and drop it." (Mother 14)

For the handful of women who had more positive labour and delivery experiences, they shared a common sentiment that the staff were much more communicative and receptive to their needs. Whether it was providing updates or taking the time to explain what was happening, these actions seemed to put the mothers at ease.

"The [staff] were nice and gave me a lot of very good guidance and information." (Mother 16)

"[H]ere the staff seemed to be more prepared. I felt better here [and] they explained everything very well to me." (Mother 22)

"I thought they were going to leave me without news, but from time to time someone would ask

for my family's phone number and then bring me some news. I think they were even worried about me and my baby, and so I think [the staff] treated me humanely." (Mother 26)

Discussion

In the context of this exploration of the labour and delivery experiences of women diagnosed with COVID-19 in a tertiary hospital in Brazil, our analysis suggested that care varied widely. Fear and loneliness were reported by almost all women and were often experienced in conjunction with a perception that the staff feared them. Part of the isolation was attributed to the hospital's COVID-19 protocols, which prohibited companions or visitors during the hospital stay for women who tested positive. Many women reported having largely negative maternal healthcare experiences, which they attributed to both physical and emotional distancing (including infrequent communication) from healthcare providers and from loved ones. This was also reinforced by their recollections of mistreatment and disrespect by providers. Despite these negative experiences clearly deviating from the concepts of humanised childbirth and the WHO's recommendations for a positive intrapartum and childbirth experience, many women justified the mistreatment in the end, as long as their baby was alive and healthy.[6–8] For the handful of women who did report positive hospital experiences, their positive perceptions were largely shaped by how their healthcare providers communicated and engaged with them, such as providing reassurance, answering questions, and displaying empathy during a particularly stressful time. These actions are in line with respectful and humanised childbirth principles, even if the COVID-19 protocols at the time of the study did not allow for certain rights (e.g. having a companion).[6,7]

However, it is important to note, all the women in our study were interviewed 1–3 days after childbirth, which is a period of intense emotion. For example, expressing feelings of gratitude is common after giving birth, especially if their babies are born alive and well. Thus, even if there had been adverse experiences, the birth of their child may have outshone any negative experiences they might have had, which could bias their responses towards having a more positive perception of their labour and delivery experiences despite objective statements that suggest otherwise. Therefore, we caution against interpreting these results without taking this context into account, as the diversity of perceptions of these experiences should not excuse nor justify any deviations from respectful maternity care.

While there have been several qualitative studies that have explored the experiences of pregnant women and postpartum women during the COVID-19 pandemic,[26–35] few have specifically captured the intrapartum care experiences of pregnant women diagnosed with COVID-19.[36] Also, to our knowledge, only one other study has focused on pregnant women diagnosed with COVID-19 in Brazil. This study from Southeast Brazil, in contrast to ours, included women interviewed in various stages of pregnancy and focused on perceptions of COVID-19 diagnosis, treatment, and adherence to public health recommendations.[36] As such, labour and delivery care was only mentioned briefly in three cases for which hospitalisation and premature birth were imminent.[36] Our study, on the other hand, focused exclusively on intrapartum care experiences of pregnant women who were also diagnosed with COVID-19.

Despite the limited literature on these experiences, our findings reinforce many negative aspects that COVID-19 has had on healthcare experiences of pregnant women. In several studies in the US, Canada, UK, Australia, and Iran, the potential lack of support by a companion was a salient source of duress for many pregnant women, especially during prenatal care visits.[26–29,34,35] Outside of the COVID-19 pandemic, it is well documented that the support of a companion is associated with helping women have a more positive childbirth experience, particularly in Brazil.[37–39] However, little research has centred on the consequences of this lack of support during the intrapartum period for women with COVID-19. In a Canadian study on women's childbirth experiences during the pandemic, while fear and loneliness were common among the participants, they were not infected with the virus, thus they were at least allowed one support person during labour and delivery.[34] In our study, the women were not allowed any support persons throughout the entire duration of their hospital stay. This denial of support likely exacerbated feelings of fear and isolation, especially during the quarantine period.

In prior studies, fear and loneliness expressed by pregnant women have often been reported in the context of lockdowns or isolation within

one's own home or due to social distancing from loved ones who did not quarantine with the nuclear family.[29–31,33,36] For the women who expressed similar sentiments in this study, their feelings arose from being completely isolated from their loved ones or partners while they were staying in the hospital. Nevertheless, commonalities reinforce previous studies suggesting that COVID-19 isolation protocols can have a negative emotional and psychological impact on pregnant and birthing people.[29–31,33,36]

Finally, respectful maternity care in the context of COVID-19 appears to vary widely among healthcare settings, even within the same country. For example, in a study conducted in the UK during the COVID-19 pandemic, when obstetrics patients felt rushed or uncared for, they interpreted these interactions as their providers lacking empathy and disrespecting them.[26] However, in another study in England that captured a few intrapartum experiences, the healthcare professionals were described as kind and comforting.[35] Interestingly, in the study from Southeast Brazil, most negative perceptions about maternal healthcare experiences stemmed from the personal and internalised stigma and fear associated with diagnosis of COVID-19,[36] whereas the negative experiences we reported in our study were in response to treatment by the healthcare team. However, when healthcare providers were discussed in the study from Southeast Brazil, these women expressed that healthcare teams were more respectful and supportive compared to most of our interviewees.[36] Of note, most of the interviewees in that study who had positive perceptions of their healthcare team had telemedicine visits. A similar positive sentiment following telemedicine visits was also expressed by pregnant women in Turkey.[30] In settings where disrespect in maternal healthcare was reported, such as ours, these experiences were in-person.[26,34] This distinction is significant because it highlights a unique issue with adherence to respectful and humanising childbirth principles when the pregnant person is engaged with in-person services. Moreover, the context of the women diagnosed with COVID-19 in our study when seeking prenatal care or at emergency services at the time of delivery during the first wave of the pandemic, may have created an added pressure on providers, leading to poorer treatment.

Documenting the role of COVID-19 on women's birthing experiences in the context of labour and delivery care is necessary given the potential for changing policies to better serve pregnant women. It is also important given that Brazil has been one of the countries most impacted by COVID-19, having the third highest COVID-19 death toll in the world.[40] Our findings highlight an issue important for gender rights and quality healthcare in a region where obstetric violence was already prevalent prior to the pandemic.[3,7,8] Although respectful maternity care practices have been successfully promoted in some parts of Brazil, they have been delayed in other areas due to implementation challenges.[7,8] Thus, the pandemic likely exacerbates these infrastructural weaknesses, especially in Northeast Brazil where socio-economic inequalities are prominent.[41]

Overall, our findings provide preliminary evidence that the stress of the COVID-19 pandemic may be diminishing Brazil's progress in implementing respectful and humanised childbirth practices. This is significant because deviations from recommended practices could undermine progress in the advancement of women's rights and could also exacerbate poor infant and maternal health outcomes at a time when birthing people are already vulnerable to these consequences of COVID-19, especially in Brazil.[15–18,42] This issue is also salient because of the context of how maternal healthcare will be handled in future public health emergencies. At the time of this study, COVID-19 was the most pressing public health emergency but due to coordinated, global vaccination campaigns, as well as more time and understanding of the SARS-CoV-2 virus, healthcare systems have begun to adapt to the new realities this pandemic has brought, as exhibited by decreasing cases and the relaxing of COVID-19 protocols. However, given the current climate crisis as well as other social and political crises (such as armed conflicts and renewed assaults on women's rights globally), public health emergencies are likely to continue. Therefore, it is important that the lessons from studies such as ours are applied to future public health emergency preparedness protocols, especially considering the social and biological factors that make pregnant women, mothers, and newborns particularly vulnerable during these crises.[43–45] It is not enough that women and newborns survive childbirth during these times of crisis, they should also be able to have respectful, safe, and positive experiences. In order for these principles to be upheld however, healthcare systems need to be held accountable to provide care that has human rights embedded into their emergency protocols.

Strengths and limitations

Some study strengths include utilising a qualitative approach to explore women's experiences in depth. The semi-structured interviews allowed for rapport building with the interviewer and space to share their narratives freely.[46] Furthermore, inductive and thematic analyses allowed for the sub-themes to organically emerge from the data.[23] Lastly, utilising the WHO model as a framework aided our ability to highlight specific areas within these women's maternal healthcare experiences, which could serve as targeted points of intervention for future quality improvement initiatives in maternal healthcare.

This study also has limitations. Due to the logistical constraints of the COVID-19 pandemic at the time of study, we were restricted to a single tertiary hospital in Fortaleza. Moreover, the timing of the interviews, which was during a vulnerable and emotional period (1–3 days after delivery), may have biased our participants' perceptions of their experiences in either positive or negative ways. However, it should be reiterated that this potential for emotional bias does not excuse nor justify any disrespect or mistreatment these women experienced. Furthermore, although the hospital's referral system resulted in participants originating from a variety of municipalities, we do not know how transferrable their experiences may be to the general population of women. Therefore, future studies should expand upon this work in other populations of pregnant and birthing women. Future research should also be coupled with quality improvement initiatives and respectful maternity care-based interventions that aim to enhance the quality and delivery of in-person maternal healthcare services for women diagnosed with COVID-19 as well as with similar illnesses during future public health emergencies.

Conclusion

This study represents the first qualitative investigation into the labour and delivery experiences of mothers who are also receiving facility-based treatment for COVID-19 in Fortaleza, Brazil. Our findings suggest that negative maternal healthcare experiences while being treated for COVID-19 largely stem from perceived mistreatment, disrespect, denial of companions and support throughout stay, and poor communication with healthcare providers. Given the ways in which public health emergencies place an immense strain on healthcare systems, it is paramount that pregnant and birthing women receive respect and are able to have a positive childbirth experience despite these structural factors.

Disclosure statement

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Résumé

Le caractère angoissant des premiers mois de la pandémie de COVID-19 a eu de graves répercussions sur la qualité des soins de maternité. L'objet de cette étude était de comprendre et d'explorer l'expérience du travail et de l'accouchement vécue par des femmes chez qui la COVID-19 avait été diagnostiquée au Brésil pendant cette période. Entre juillet et octobre 2020, nous

Resumen

La estresante naturaleza de los primeros meses de la pandemia de COVID-19 tuvo un grave impacto en la calidad de la atención materna. El propósito de este estudio era entender y explorar las experiencias de trabajo de parto y de parto de las mujeres que fueron diagnosticadas con COVID-19 en Brasil durante este tiempo. Entre julio y octubre de 2020, realizamos 28 entrevistas

avons mené 28 entretiens semi-structurés avec des femmes en postpartum qui avaient été testées positives à la COVID-19 avant d'accoucher dans un hôpital tertiaire de Fortaleza, Brésil. Les transcriptions des entretiens ont été codées et nous avons réalisé une analyse thématique avec pour cadre trois domaines du modèle de soins intrapartum pour une expérience positive de l'accouchement de l'Organisation mondiale de la santé. Pendant le travail et l'accouchement, les femmes ont rencontré divers niveaux de respect, beaucoup de femmes indiquant qu'elles s'étaient senties maltraitées par leur équipe de soins en raison du diagnostic de COVID-19. Du fait des protocoles de l'hôpital en matière de COVID-19 qui interdisait la présence de compagnons ou de visiteurs, les femmes ont rapporté qu'elles se sont trouvées isolées et insuffisamment soutenues, particulièrement pendant la quarantaine obligatoire. Les femmes ont aussi éprouvé différents niveaux d'efficacité de la communication, certaines femmes affirmant qu'elles avaient l'impression que le personnel était souvent inquiet, et soit évitant soit irrespectueux. Une minorité de femmes ont relaté que le personnel semblait respectueux et réceptif à leurs besoins. Nos résultats fournissent des données préliminaires montrant que les tensions exercées par la pandémie de COVID-19 sur les professionnels de santé aboutissent potentiellement à une communication inefficace et un traitement inadapté pendant le travail et l'accouchement. Intégrer des principes de respect et d'humanité dans les protocoles de soins de santé maternelle d'urgence peut améliorer l'expérience de l'accouchement pour les femmes infectées par la COVID-19, de même que pour les femmes lors de futures situations d'urgence sanitaire.

semiestructuradas con mujeres posparto que dieron positivo en la prueba de COVID-19 antes de dar a luz en un hospital terciario en Fortaleza, Brasil. Codificamos las transcripciones de las entrevistas y realizamos un análisis temático utilizando tres elementos del modelo de atención intraparto de la Organización Mundial de la Salud para una experiencia de parto positiva como marco. Durante el trabajo de parto y el parto, las mujeres experimentaron diversos niveles de respeto; muchas mujeres informaron sentirse maltratadas por el personal de salud a causa de su diagnóstico de COVID-19. Debido a los protocolos hospitalarios relativos a COVID-19 que prohibían acompañantes o visita, las mujeres se sentían sin apoyo y aisladas, especialmente durante la cuarentena obligatoria. Además, experimentaron diversos niveles de comunicación eficaz: algunas citaron percibir que el personal a menudo era temeroso y evasivo o irrespetuoso. La minoría de las mujeres dijeron que el personal parecía ser respetuoso y atento a sus necesidades. Nuestros hallazgos proporcionan evidencia preliminar de que la tensión que produjo la pandemia de COVID-19 sobre los profesionales de salud tenía el potencial de propiciar comunicación ineficaz y maltrato durante el trabajo de parto y el parto. Incorporar los principios de parto respetuoso y humanizado en los protocolos de atención materna de urgencia podría mejorar la experiencia de parto para las mujeres con COVID-19, así como para las mujeres durante futuras urgencias de salud pública.