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IMMEDIATE PUERPERIUM DURING THE PANDEMIC: WOMEN'S ORAL HISTORY IN THE LIGHT OF OBSTETRIC CARE MODELS

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ABSTRACT

Objective: To describe the immediate puerperium experience of women during the COVID-19 pandemic in a public maternity hospital in Curitiba/PR in southern Brazil.
Method: A qualitative study, following the Thematic Oral History methodological framework. The setting was a high-risk maternity-school. Data collection took place through a semi-structured, audio-recorded, on-site interview, from October to December 2021, with analysis of results following the Thematic Oral History method, which comprises the phases of transcription, textualization and transcreation.
Results: Nine women in immediate puerperium participated, with varied professions and aged between 25 and 34 years. Relevant topics were: "Maternity in a context of risk", which deals with emotional aspects related to the pandemic, health care during the pandemic and care actions against COVID-19; "Physical and symbolic perceptions of breastfeeding", which involves feelings, manifestations in the body and the symbolic of breastfeeding; "Achieve: direct and indirect transitive verb", which talks about women's power of personal transformation; and "Nuances of care", which addresses the (in)delicacies of the care received.
Conclusion: The experience of immediate puerperium in hospital environments during the pandemic transversely went beyond aspects of pregnancy, childbirth and the puerperium, revealing elements not related to the pandemic and others, such as fear of contamination specific to the pandemic context. Talking about their experience is an opportunity to expose feelings and align thoughts about their reality. Characteristics of childbirth care models orbiting between technocratic and humanized were observed, demonstrating aspects to be overcome by health professionals and worked with women.

DESCRIPTORS: COVID-19. Women. Pandemics. Puerperium. SARS-CoV-2.

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PUERPÉRIO IMEDIATO NA PANDEMIA: HISTÓRIA ORAL DE MULHERES À LUZ DOS MODELOS DE ASSISTÊNCIA OBSTÉTRICA

RESUMO

Objetivo: descrever a experiência de puerpério imediato de mulheres na pandemia da COVID-19 em maternidade pública de Curitiba/PR, no Sul do Brasil.
Método: estudo qualitativo, seguindo referencial metodológico da História Oral Temática; o local foi uma maternidade-escola de alto risco; a coleta de dados deu-se por entrevista semiestruturada, audiogravada, presencial, de outubro a dezembro de 2021, com análise dos resultados seguindo o método História Oral Temática, que compreende as fases de transcrição, textualização e transcriação.
Resultados: participaram nove mulheres no puerpério imediato, com profissões variadas e idade entre 25 e 34 anos. Os Temas Relevantes foram: "Maternar em um contexto de risco", que versa sobre aspectos emocionais relativos à pandemia, assistência à saúde na pandemia e ações de cuidado contra COVID-19; "Percepções físicas e simbólicas do aleitamento materno", que envolve sentimentos, manifestações no corpo e o simbólico do amamentar; "Conseguir: verbo transitivo direto e indireto", que fala sobre o poder de transformação pessoal das mulheres; e "Nuances do cuidar", que aborda (in)delicadezas do cuidado recebido.
Conclusão: A experiência de puerpério imediato no ambiente hospitalar na pandemia perpassou transversalmente aspectos da gestação, parto e puerpério, revelando elementos não relacionados à pandemia e outros, como o medo da contaminação, específicos do contexto pandêmico. Falar sobre sua experiência é oportunidade de expor sentimentos e alinhar pensamentos sobre sua realidade. Foram observadas características dos modelos de assistência ao parto orbitando entre tecnocrático e humanizado, demonstrando aspectos a serem superados por profissionais de saúde e trabalhados com as mulheres.

DESCRITORES: COVID-19. Mulheres. Pandemias. Puerpério. SARS-CoV-2.

PUERPERIO INMEDIATO EN LA PANDEMIA: HISTORIA ORAL DE MUJERES A LA LUZ DE MODELOS DE ATENCIÓN OBSTÉTRICA

RESUMEN

Objetivo: Describir la experiencia del posparto inmediato de mujeres durante la pandemia de COVID-19 en una maternidad pública de Curitiba/PR en el sur de Brasil.
Método: Estudio cualitativo, siguiendo el marco metodológico de la Historia Oral Temática. El escenario era una maternidad-escuela de alto riesgo. La recolección de datos se realizó a través de una entrevista semiestructurada, grabada en audio, cara a cara, de octubre a diciembre de 2021, con análisis de los resultados siguiendo el método de Historia Oral Temática, que comprende las fases de transcripción, textualización y transcreación.
Resultados: Participaron nueve mujeres en puerperio inmediato, con variadas profesiones y con edades entre 25 y 34 años. Los temas relevantes fueron: "Maternidad en contexto de riesgo", que trata aspectos emocionales relacionados con la pandemia, la atención a la salud en la pandemia y las acciones de atención frente al COVID-19; "Percepciones físicas y simbólicas de la lactancia materna", que involucra sentimientos, manifestaciones en el cuerpo y lo simbólico de la lactancia materna; "Conseguir: verbo transitivo directo e indirecto", que habla del poder de transformación personal de la mujer; y "Matices del cuidado", que aborda las (in)delicadezas del cuidado recibido.
Conclusión: La vivencia del puerperio inmediato en el ambiente hospitalario durante la pandemia permeó transversalmente aspectos del embarazo, parto y puerperio, revelando elementos no relacionados con la pandemia y otros, como el miedo a la contaminación, propios del contexto pandémico. Hablar de tu experiencia es una oportunidad para exponer sentimientos y alinear pensamientos sobre tu realidad. Se observaron características de modelos de atención al parto que orbitan entre tecnocráticos y humanizados, evidenciando aspectos a ser superados por profesionales de la salud y trabajados con mujeres.

DESCRIPTORES: COVID-19. Mujer. Pandemias. Puerperio. SARS-CoV-2.

INTRODUCTION

The COVID-19 pandemic has generated global changes in health care, affecting women, newborns, families and workers[1]. In maternal and neonatal care, restrictive practices were implemented that limited decisions and rights, changing care practice[1]. In institutions that adopted humanistic policies, during the pandemic, these practices were reversed in favor of the traditional medical model of obstetric care, which distances mothers, babies and families[2].

In April 2020, pregnant and postpartum women were part of the risk group for COVID-19, intensifying protective measures and developing institutional protocols that reorganized obstetric care[3]. In this context, the Brazilian reality was perceived in reduction in the offer of prenatal consultations, in new protocols related to hygiene, in implementation of telecare, in professional burden, in complications for mother and baby due to lack of prenatal care and increased perinatal and fetal mortality[4].

Maternal deaths from disease in Brazil were alarming and signaled the challenging scenario of care and guarantee of rights[3]. Broadly speaking, the consequences of the disease affected women more directly, through numerous inequities, affecting sexual and reproductive health and pregnancy-puerperal care[3]. In the pandemic context, the puerperium experience can also be influenced by women's fear and insecurity in participating in consultations and contracting the virus, receiving visits, the unknown, the chances of complications and death[5]. For women with the disease, misinformation about aspects of vertical transmission, about breastfeeding and the chance of negatively affecting the fetus, among others, generated fears and anxieties[5].

Immediate puerperium comprises women's stay in the maternity ward in cases of hospital childbirth, and can be understood as the period that comprises the involutive processes and the resumption of the female organism after pregnancy, and, although its delimitation is not precise, it can be defined as the period from the first to the tenth day after childbirth[6].

Faced with numerous challenges and based on the importance and need to record the experience of women in the puerperium, this study aimed to describe the experience of immediate puerperium of women during the COVID-19 pandemic in a public maternity hospital in Curitiba/PR, with the research question: How was the experience of women in immediate puerperium in the hospital during the COVID-19 pandemic?

METHOD

This is qualitative research using Thematic Oral History[7], having as a theoretical reference the childbirth care models[8]. The COnsolidated criteria for REporting Qualitative studies (COREQ) guide was followed.

Oral History is a resource to understand human behavior and sensitivity and the way the world is seen by individuals, what role people play in the world[7], through the narrative of their history. The Thematic Oral History genre was chosen, in which there is a central focus that justifies the interview related to the project. This genre cuts and leads to possible greater subjectivities, such as the meanings understood by participants in the experiences they lived, affirmations, contradictions, fantasies. Questions and answers are part of the process and seek to elucidate divergent issues of the topic[7].

For operationalization and consistency of research in the method, three hierarchical and interrelated concepts[7] are necessary, such as destination community, colony and network. Destination community is the initial reference concept, and involves a group of people who have a common bond and have lived a remarkable experience that reverberated in their life trajectory[7]. In the research, the target community comprised women who experienced immediate puerperium in hospital during the COVID-19 pandemic in Brazil.

A representative portion of the first concept is the colony, which maintains the unique characteristics of the larger group, but, because it is a fraction of that, it makes the research executable and enables community understanding[7]. The research colony corresponds to women who experienced immediate hospital puerperium during the pandemic in the state of Paraná, Brazil. The network, in turn, comprises the smallest portion of the first concept and is a subdivision of the second[7]. In it, the given arguments that justify the lived phenomenon matter. In the research, women who experienced immediate hospital puerperium during the COVID-19 pandemic at a public health network university hospital, in the city of Curitiba, state of Paraná, Brazil, were used as a network.

The study site was a high-risk maternity hospital at a public university hospital in the city of Curitiba, state of Paraná, southern Brazil, due to these characteristics and because it is a reference for pregnant women with different gestational risks during the pandemic.

Participant inclusion criteria, named collaborators in the method, were to be women who had childbirth in the referred maternity hospital during the pandemic and who were within the 24 hours of immediate puerperium. Exclusion criteria were women in the immediate puerperium under 18 years old, who had a stillborn baby and/or a baby who needed intensive care, with cognitive limitations such as those related to memory and intellectual aspect and/or hearing limitation.

The data collection period was from October to December 2021. During this period, the presence of a companion was resumed, a test for COVID-19 was carried out upon admission, requiring the use of a face protection mask, and there was vaccination for pregnant women and puerperal women. For data collection, a semi-structured interview was used with a main topic ("Tell me about your post-childbirth/puerperium experience during the COVID-19 pandemic"), complementary topics (feelings, sensations, emotions felt, breastfeeding during the pandemic, support received, health actions that helped in the process during the pandemic, actions taken that could be implemented in future pandemics) and general information (initials, age, profession, religion, gestational age at the time of childbirth, month of childbirth, type of childbirth, number of previous pregnancies, companion present in pre-childbirth, childbirth and puerperium process, rooming-in, risk stratification). A pilot test[9] was carried out, with only readjustment of words, and the pilot included in the sample. There were no repeat interviews. The research's course was recorded in the field notebook[7].

Recruitment was by on-site verbal invitation, and the Collaborators included agreed to participate in the first contact, after presenting the researcher and the research. The interviews took place in a private room, individually and on-site, after reading and signing the Informed Consent Form (ICF) by women. Collection, from conception to methodological analysis, was carried out by a doctoral student, who is a scholar and main author and had previous experience in the method. The interviews were audio-recorded on two electronic devices, simultaneously. Women and babies' demands were respected. With the final version, the text was returned to each participant for reading and, upon agreement, signing the Assignment of Rights Agreement, method document[7]. All agreed with the final text. For the return, a new on-site and individual meeting was scheduled. The interviews lasted 104 minutes in total.

In the context of qualitative research, the sample was established, according to the purpose of the study, for convenience, seeking to find people with different experiences about a given event and, not necessarily, to assemble a representative sample[9]. In this approach, sample size is based on the need for information. This time, the principle of saturation was used, where participants' responses became recurrent, bringing elements similar to those already mentioned, not generating new ones[9] that would substantially contribute to the improvement of theoretical reflection, as it is understood that the constituted material made it possible to reach the proposed objective, sustaining analysis.

Interview analysis followed the method, comprising three phases[7]. In the absolute transcription phase, the passage from audio to writing occurred, in an equivalent, imitative text, according to what was said[7]. The VB audio voicemeeter® software was used, which unifies computer audio sources, together with a Microsoft Office 365 Word® document, which captures and quickly transcribes the sound into text automatically.

In the textualization phase, the text was read and reread, and questions removed to keep the text clearer[7]. The "vital tone", a phrase that guides the narrative, which gives the main meaning to the narration and from which the text is reordered, was listed[7]. Transcreation was the phase in which the final version of the text was prepared and, after authorization by the collaborator, it was the material used. This process allows, in addition to rationality, contact with subjective dimensions to better communicate the intention of what was told[7].

The method provides for the reports to be analyzed, crossed with both internal and external content, making it possible to perceive singularities, allowing them to be sustained and scaled from the individual experience to the social[7]. The analysis takes place with the constitution of the texts, where each one is exhaustively reread to list emerging topics and converging points that will be discussed with content concerning[7]. In this context, the analysis of the final version of the text was carried out by initial readings for greater approximation. After reading it in depth several times, in order to perceive present and converging minor points, relevant topics emerged. For instance: in the relevant topic "Maternity in a context of risk", there were minor points about fear of baby contamination and death, among others. Each relevant topic and minor points were flagged in simple colorimetry, in a Word® document, visually highlighting the content.

In the data analysis, there was a triangulation of researchers, carried out in a way to minimize biases arising from a single analysis view, aiming to validate the investigative process, enrich and complement knowledge[10]. Two qualified researchers, with no previous contact with the interviews, read them and identified important points that, confronted with each other and convergent, originated the relevant topics.

From the perspective of models, human culture needs a system of fundamental values and beliefs as a basis, a model of vision that allows individuals to understand the world[11]. Cultures in which these systems are based on human superiority over nature are challenged to understand the powerful natural and supernatural experiences in which birth is integrated, as they manifest that this system is inadequate[11].

With regard to childbirth care, there are three predominant models, namely: technocratic, which promotes the separation between mind and body, understanding the latter as a faulty machine; humanistic, which encourages the connection between mind and body, understanding the latter as an organism; and holistic, which emphasizes the unity of body, mind and spirit and conceptualizes the body as an energy field that interacts by exchanging energy with other fields[8]. Practitioners who addressed elements of all of them in their practice would create "the most effective obstetric system ever known"[8:s5].

The research was carried out based on current ethical norms, with data collection initiated after approval by the Research Ethics Committee at the research site. For coding collaborators' names, as they did not choose another one to replace it and tried to do it anyway, the names of Brazilian writers of poetry, short stories, etc. were chosen. The choice is based on esteem for poetic writings, a relevant resource in the main author's recovery from post-COVID-19 dyslexia. In this way, maintaining anonymity, fictitious nomination takes the term "collaborator" and the writer's name.

RESULTS

Nine women in immediate puerperium participated in the research. Age was between 25 and 34 years. As for profession, three were homewives, the others were accountants, farmers, pharmacy assistants, bartenders, civil servants and self-employed. Gestational age at childbirth was between 37 and 41 weeks, seven women had had one or more previous pregnancies. There were two histories of previous abortion and, as for the current pregnancy, there was one of high risk and the others of usual risk. As for the presence of a companion, seven of them were accompanied by relatives, usually husband/partner with alternating labor (LB), childbirth and puerperium. They all maintained rooming-in. None had COVID-19 during the current pregnancy and/or childbirth.

The four relevant topics that emerged from the analysis are expressed as: Maternity in a context of risk; Physical and symbolic perceptions about breastfeeding; Achieve: direct and indirect transitive verb; and Nuances of care. It was revealed that collaborators' experience goes through the pregnancy-puerperal cycle.

Maternity in a context of risk

Emotional aspects related to the pandemic, maternal health care, presence of a companion and care actions against COVID-19 were brought up. With regard to emotional content, there was concern and fear about contamination by the coronavirus and about the vaccine:

[...] *I was very afraid of picking it up and hurting her* (Collaborator Thays).

So, until then I didn't know I had this variant anymore, now I'm more worried than I already was about COVID. Even in itself because he [referring to the newborn son] *is tiny, he doesn't have immunity, he doesn't have anything yet* [...] *then, it's losing my son* [...] *because of what the disease does, the damage it can cause.* (Collaborator Conceição).

Well, it's worrying, because it's a high-risk pregnancy, and COVID is another risk factor (Collaborator Cora).

I was afraid of taking the COVID vaccine, because [...] I saw some contexts that made me very concerned (Collaborator Adélia).

Changes in maternal health care during the pandemic reverberated in the unknown and distance from the childbirth location, in changes in protocols, such as not receiving visits during hospitalization, lack of physical contact and use of face protection masks. The reports highlight the changes in the hospital routine. Women's perceptions, feelings and sensations in relation to these changes were diverse:

[...] *it was very challenging like that* [...] *even concerned about the childbirth itself, not knowing how it would be* [...] *now, it's a little more liberated* (Collaborator Lygia).

The difference now is that we are not receiving visitors, it's just the companion [...] *and the masks, right? That you can't get out of your face* (Collaborator Carolina Maria).

The presence of a companion was brought as a resource of emotional support and help with babies during hospitalization:

[...] *I was already a bit desperate, having to be alone because I think their support is important, even to be able to go to the bathroom calmly and emotional support too* (Collaborator Lygia).

It helps a lot [...] *having someone to watch* [the baby], *especially* [...] s*o you can take a shower,* [...] *go to the bathroom, so you can eat* (Collaborator Adélia).

The actions implemented in the maternity ward, such as testing for the detection of SARS-CoV-2, hygiene aspects, face protection masks and not receiving visitors, brought safety:

[...] *they took the* [COVID-19] *exam, and I didn't have it* [...] *so that makes us more confident* (Collaborator Thays).

[...] *we feel very safe to see the whole team with zeal in alcohol, with a mask* [face protection]*, and everything* (Collaborator Hilda).

The fact that they had just cleaned the room, sanitized everything, washed the stretcher, dismantled everything, I thought it was really cool (Collaborator Adélia).

I'm liking that I can't have visitors (Collaborator Aline).

Physical and symbolic perceptions about breastfeeding

It involves the feelings of breastfeeding, the manifestations in the body and the symbolism of the act, revealing own aspects of practice.

We have another challenge which is breastfeeding. I have one of the breasts where the spout is inverted, so it has already cracked, it's hurting, but it's part of the process, everything works out fine (Collaborator Hilda).

I'm very happy [...] *to be able to breastfeed her, which was my wish* [...] *it's a very good thing, you feel that way more, more important! Ah, it is an immense joy! The nurse who assisted me* [...] *taught me exactly, that I thought I had to pick it up with these two fingers* [shows the thumb and middle finger] *and we have to pick it up with C so that helped me a lot* [referring to how to use the fingers to position the breast for breastfeeding] (Collaborator Thays).

It hurts a lot, because it's sensitive [...] *but at the same time it hurts, it's nice to see that you're feeding. Being able to pass the nutrients on to her, knowing it's you! That you have what she needs! Very good. The source of nutrition* (Collaborator Clarice).

The feelings involved in breastfeeding (BF) were positive, even when seen as a challenge. Body sensations were sensitivity and pain in the nipples, with occurrence of fissure. The symbolism of BF involves the desire to do so, the perception of feeling important, valued, as the only source of nutrients. The possibility of not BF was also presented:

[...] *we are trying to do this* [...] *very complicated too* [...] *I'm not worried about it, if I need to interrupt. Today there is no such thing as "Oh, you have to suck on your mother's breast", no, not at all* (Collaborator Aline).

Achieve: direct and indirect transitive verb

The word "achieve" emerged from the narratives and stood out in the analysis, signaling as if childbirth and puerperium were a struggle. Transitive verbs are those that need some complement to make full sense. "Achieve" cannot be alone, it needs "what", "who". When a transitive verb is direct, the complement does not need a preposition and, when indirect, it needs a preposition. Achieve to move in both possibilities. Reveals about personal transformation and success achieved. The excerpts say:

A mother is also born (Collaborator Lygia).

A new woman [...] *was born* (Collaborator Conceição).

It was a struggle, but he had a cesarean section (Collaborator Hilda).

I thought I was going to die and that I couldn't take it, that I wasn't going to be able to get her out of me, that I wasn't going to have that strength, and I did! It's a victory (Collaborator Thays).

It was very difficult, I thought I wasn't going to make it, that I wasn't going to have the strength [...], *but there ended up being a strength from I don't know where* [...] *a very, very, very, very, very great strength, and then* [...] *comes the little human being. But it's not easy* (Collaborator Clarice).

The responsibility that comes with it is too great (Collaborator Aline).

Nuances of care

The topic is composed of (in)delicacies of care. The nuance of delicacy emerged from the satisfaction involved with professional care and the relaxation of precautionary measures against COVID-19:

[...] *it was super good, it was surprising actually* [...] *I already expected it like, "Oh my God, you can't do anything, nobody can stay with me". And now, as it is a little more liberated, the experience was very good* (Collaborator Lygia)

They took care of me very well, they put us in a room alone, where I could go without a mask, it was great [...] *I felt very comfortable, very welcomed, the doctor was wonderful, the people who took care of me until today morning to help me bathe.* [...] *the doctor who assisted me was wonderful, she let me hold her hand, I screamed, I asked her for help, she said "I'll help you, I'm here* [...] *she* [the doctor] *would look at me and say, "I'm here, you'll make it". The doctor and my husband said, "You'll make it"* [...] *the nurse who assisted me, even that was wonderful. She helped me take a shower, taught me how to do it* (Collaborator Thays)

Always, every time I needed to come here, I was very well assisted [...] *this already brings a little more comfort* [...] *the doctors also cleared all my doubts, it was really a very humanized service, as I say.* (Collaborator Aline)

Collaborators felt "welcome", "cared for", "comfortable". Delicacy was also revealed in subtle situations of encouragement, touching the hand and informational issues, and practices such as guidance on BF, clarification of doubts, help with bathing.

The nuance of indelicacy emerged in the sense of characterizing aspects that were not very sensitive to women's comprehensiveness, appearing in non-welcoming, non-listening and restriction of choice. About non-welcoming, it was stated:

[...] *I had pre-eclampsia, the placenta had detached, so I was afraid of losing him. And when I came back from anesthesia, I didn't see him, so for me it was pretty scary. I thought I had lost him and they hadn't told me anything. The fear was already in my head, of having lost him, so I cried everything I had to cry yesterday. When I saw him, everything calmed down* [...] *I went to the classroom at eleven o'clock, when I woke up it was already three-fifteen* [in the afternoon]. *I don't remember anything, nothing* (Collaborator Conceição)

About not listening:

[...] *the team was very good, but I felt that I suffered from this, that I had to insist a lot to be able to evolve there and really discover that the baby face's was turned and then he could not turn around* (Collaborator Hilda)

The reports showed issues involving vaccination, doubts, fear and pressure. Fears and pressures appear in different ways, mediating choices and reflecting on experiences:

[...] *I took the vaccine even after the seventh month, because my doctor said, "No, now it's all formed* [the fetus], *it's just gaining weight, so now it's ideal to take it". I was kind of like this... and I even received a call from the health center asking why I hadn't taken it; I felt a bit pressured and ended up taking it.* (Collaborator Adélia)

[...] *because of my problem, doctors always said that I shouldn't get pregnant, and because of my age, he* [the obstetrician who follows her] *said, "Oh, there is a possibility, but there are risks and if you want it, it's time, because of age". I said, "Ah, I'll try"* [...] *I tried and it worked.* (Collaborator Cora).

I was very afraid of not being able to breastfeed, because I had surgery on my chest and [...] *my doctor was sure I couldn't breastfeed* [...] *they are letting me breathe so I can have this moment with my daughter* [...] (Collaborator Thays).

DISCUSSION

Experiencing the puerperium in a hospital environment during the pandemic included changes in practices, protocols and forms of care. The feelings involved in BF include pleasure, satisfaction, happiness, a feeling of worth. There is also insecurity, tiredness, guilt and perception of being defiant, disgusted, stressful[12]. About BF, the experience encompassed feelings, bodily manifestations and symbology. Women understand BF as a divine gift, of feminine nature, seen as something that goes beyond the biological characteristic[12].

Nipple trauma, such as the cracks mentioned in the narratives, are one of the main barriers in BF[12]. However, actions that only aim to take care of biological aspects, representative of the technocratic model, do not fully respond to the needs of women who are experiencing a transition and, sometimes, need to be listened to carefully, have doubts clarified and anguish alleviated[13].

The possibility of not breastfeeding was mentioned, and here it is relevant to realize that BF takes on an institutional and disciplinary aspect naturalized both by professionals in relation to mothers and by mothers themselves, something like a requirement for hospital discharge and that, in a way, "qualifies" mothers to perform this function outside this environment[14]. Here, it is pointed out the respect for encouraging practice for women who breastfeed or not, as there is a risk that, in not breastfeeding, it represents an aspect of the technocratic model that the female body is defective and incapable, and women blame themselves or be blamed for not breastfeeding.

The experience revealed direct points of connection with the pandemic, such as fear and concern. The pandemic itself has generated and heightened the fear connected to the unknown and the unexpected that childbirth encompasses, added to being exposed, insecure and subject to choiceless protocols, the feeling of loss of control and uncertainties of the future[15]. Concern about the effect of the disease on themselves and their babies, as in our research, was reported by other women with 91% and 99%, respectively[16], demonstrating concern about this. Contamination and the possibility of babies being affected were feared by women, in addition to the affectation of not having a companion, reported as traumatizing[5]. Welcoming, dialoguing, binding and respecting the will and desires are essential for the childbirth and birth to have a favorable outcome[5].

Fear of COVID-19 vaccine was also cited. Systematic review with meta-analysis identified that acceptance of this vaccine among pregnant women was around 53.46%, lower compared to the general population[17]. Furthermore, acceptance has shown to be increasing, which may have been attributed to communication strategies, signaling that the recommendation of obstetricians can strongly influence the decision to vaccinate[17].

During the pandemic, some conducts implemented with little evidence affected pregnant women and couples, being potentially harmful to the health and rights of pregnant women, especially those that curtailed emotional support during LB[18]. In the face of new situations, such as the pandemic, previous patterns are immediately resumed, which is not safe for the health and well-being of women and babies, as they are aimed at intervention, contrary to quality evidence, exposing themselves to the risk of applying actions of institutional and routine focus again, often excluding people's physical, psychological, spiritual, social and cultural dimensions[1].

In the pandemic context, health care for pregnant women, mothers and babies demanded care in order to preserve good obstetric practices and avoid viral contamination[15]. It was essential to balance actions with quality evidence and those related to the virus, articulating maternal care and COVID-19 with effective, compassionate actions that respected the rights of women and babies, given the unforeseen consequences of actions not based on evidence of effectiveness[1].

In the experience, collaborators manifested themselves about the presence of a companion. For women, it is traumatizing to be alone, to take care of their baby without the help of a companion, inferring that this presence safeguards their opinion and desires[5]. During the pandemic, there were regulations limiting the companion, however, in the data collection at the study site, the right to the companion was allowed. In another study, even outside the pandemic, the companion was not authorized, sometimes it could only be female and, in others, women chose the person; in the first two situations, the determinations opposed the women's desires[19]. To avoid contamination, practices that valued women's protagonism were neglected, which caused suffering to parturients, family members and professionals. These observed that isolation and the fact of preventing the presence of a companion produced intense suffering in women[4].

From the feeling of security brought by the collaborators in adopting conducts such as the COVID test, it is inferred that it is also related to the negative result. In another study, verification of respiratory symptoms on hospital admission, hand hygiene, use of face protection mask by professionals and companions in LB and childbirth and prohibition of visits are cited as preventive measures[20].

Based on the report of the benefit of non-visitation, other women reported greater intimacy and more time for themselves and their babies due to hospital calmness due to less capacity, and perceived professionals to be more relaxed because they treated only patients[21]. Congruent with this, the quietness in hospitalization due to the absence of visitors and the support of professionals represented a protective factor for puerperal women's mental health[22]. From another point of view, non-visitation was an ambivalent experience, for not sharing that moment[20].

From the narratives, the nuance of delicacy of care emerged, representing a characteristic of the humanistic model, which takes the connection between body and mind, sees women as a subject and not an object, having as its essence the bond of care between women and those who provide care and the connection of patients with the various aspects of themselves, family and social[8]. This model demands connection and relationship and insists on the deep humanity of those involved. It stresses the importance of touch, care and opens up a discussion on care options, guiding values to be shared, considering woman participation and empathy by professionals[8].

Positive aspects of nursing care in immediate puerperium were identified in attentive behavior and alertness to body signals, teaching practical aspects of care, solving doubts and having more time available in relation to doctors[23]. Demonstrating patience, availability, concern, handling emotional and verbal reactions in LB, clarifying doubts and verbalizing care were points of good professional service perceived by women[14].

Providing a private environment that made it possible not to use a face mask during LB revealed attention and care. The use of a mask was a barrier in the relationship between women and health professionals, as reported by pregnant women or women who gave birth during the pandemic. For them, the mask hindered the communication aspect, the recognition of professionals and dissociated the experience of childbirth[21].

In terms of indelicacy, non-welcoming and mother-child separation after cesarean section were noticed. Separation is the basic principle underlying the technocratic model, in which there is separation soon after birth, as it is considered that babies are the desired product, a new social member belonging to society and not to women[8]. Women, in turn, is seen as an object, a secondary product, and their experience is rarely of interest to professionals, who are alienated from them, and exempt themselves from the responsibility of interventions on their body and the impact of this on women's mind and spirit[8].

Post-cesarean distancing caused discomfort for women who experienced it, causing a negative experience and dissatisfaction with the care received[24]. Care (less) in immediate puerperium was

seen in the non-fulfillment of women's needs, in the lack of important guidance and distinct attention and care, and in the focus on technical care issues to the detriment of puerperal women's needs[23].

Not listening is part of indelicacy. In other experiences, non-listening occurred in the disrespect for women's autonomy in LB and childbirth, and related to their desires, with a denotion of passivity due to medical attitude[19]. Professionals expect parturient behavior of obedience, passivity, docility so that they observe the instructions given, submitting the woman to the authority of technical knowledge[25].

Women develop passive behavior, as they are more affected by social characteristics that create power structures, generating asymmetry between individuals[25]. Gender norms shape behavior, attributes and social roles that restrict female autonomy and support[25], which may reflect on decisions about pregnancy, childbirth and the puerperium. They can strengthen the technocratic aspect of segregating women into components and the parturition experience of the flow of life, freeing professionals from the responsibility of caring for the mind and spirit of women and keeping them away from them, as they understand there is no need for involvement[8]. Even knowing the power of touch and affection, professionals do not do it for self-protection[8].

In this regard, a very relevant component is communication, which takes place in different ways, depending on the characters and roles involved. It enables the exchange of information, ideas and feelings, providing data, solving doubts and listening to complaints from women in the puerperium, which increases safety and welcoming[3].

Allusive to the nuance of choice, there was the action of health professionals on the vaccine, pregnancy and BF. Although the content of choice extends from pregnancy to the puerperium, the literature is predominantly about childbirth. In this sense, in health practices, power relations obstruct the role of women in childbirth, reaffirm the oppression of the female body and naturalize inappropriate practices[24]. The positive experience of childbirth is provided when women take the center of care and participate in care decisions with qualified and empathetic professionals in a safe environment, with the educational role of health professionals focused on informed choice and decision-making being fruitful[25].

Regarding the route of childbirth, the choice, in addition to desire, is subordinated to prenatal information access and includes aspects related to family and culture[26]. Sometimes, the offer of information by doctors is elaborated as a scenario of clinical necessity of cesarean section, with the purpose of convincing those involved – woman, companion and nurse-midwife – that the only way out is the one presented by them[26]. However, a relationship between professional and patient, based on respect and trust, highlighting women's subjectivity and unique needs, is essential for care, as legitimizing the choices allows her to take a critical position when receiving information[26].

Professional asymmetry, where women depend on the doctor's information, makes them feel unable to choose and defend their desires in the face of the technical issue posed by professionals, which, together with misinformation, makes it difficult to have a safer and more self-determined childbirth experience[27]. These power relations in obstetrics are supported by the hegemonic model of care and interventionist practices that lack scientific evidence and humanized care, relationships outlined by professional power over parturition and female role[28]. Legitimizing women's choices, granting them autonomy to be and act in the whole of this experience, becomes essential[26].

The topic "Achieve" was about personal transformation and success. Pregnancy and childbirth are natural events of immense moral and emotional relevance; transformative, unforgettable experiences[29]. Pregnancy points to transformation, generating in women a feeling of loss of control, image reformulation, increased responsibility and personal growth, revealed by collaborators and growth connected to becoming a mother, the deepest and incomparable experience[30].

Birth is a unique experiential element. Childbirth is understood as a transitional portal, and women who go through it feel strong, capable, in tune with themselves and fulfilled [30]. So intense and valuable is it that traumatic childbirths created difficulties in the mother-baby relationship, as the initiatory passage of maternity was forbidden[30].

The collaborators did not believe they had enough strength, revealing an aspect of the technocratic model of self-doubt. In this model, women believe that natural female functions are defective and dangerous; they inculcate the idea that the body is neither normal nor predictable and, naturally, is a faulty machine; and they proclaim that pregnancy and childbirth leave the body-machine at continuous risk of functioning improperly or failing entirely, viewing birth as a mechanical process[8]. This weakens women's confidence and ability to choose and experience her process. For women to exercise autonomy, an environment free of violence is needed, with the guarantee of human rights and access to what is necessary to promote gender equality[25].

As research limitations, there is a single collection site and the design does not allow generalizations, although it reveals participants' experience without harming the quality of the findings and discussion. The experience of other individuals was not investigated as well as the late puerperium, which may be researched in the future.

CONCLUSION

The immediate hospital puerperium experience during the pandemic went beyond aspects of pregnancy, childbirth and the puerperium, and revealed certain aspects of pregnancy, delivery and puerperium process that go beyond other events. It also pointed out the fear of contamination by the new coronavirus and the uncertainty of flow changes in the maternity ward. Participants' memory rescued their trajectory along this path. Thus, talking about their experience is an opportunity to expose feelings and align thoughts about what they are experiencing. Oral history allowed access to women's intimate, deep and sacred content at a time when distance was imperative, denoting the willingness to contribute with their experience. The characteristics of childbirth care models orbit between technocratic and humanized, demonstrating points to be reflected and developed.

It is expected that the results reinforce the need for comprehensive care provided in the puerperium, mainly by nursing professionals. It is content that can be used as support in conduct elaboration in future health events.

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NOTES

ORIGIN OF THE ARTICLE

Extracted from the thesis -E*xperiências de puerpério hospitalar imediato na pandemia de covid-19: histórias contadas pelas mulheres*", to be presented to the Graduate Program in Nursing, *Universidade Federal do Paraná*, in 2023.

CONTRIBUTION OF AUTHORITY

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Discussion of results: Prandini NR, Resende ACAP.
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CONFLICT OF INTEREST

There is no conflict of interest.

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