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ORIGINAL ARTICLE

Caring and being cared for: Pregnant women in the COVID-19 pandemic

Cuidar-se e ser cuidada: gestantes na pandemia de covid-19

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ABSTRACT The health and social drama experienced during the COVID-19 pandemic impacted health services, work, household, and social life, generating harmful consequences for women's reproductive lives. This article presents the results of a qualitative study based on narrative interviews with 31 women who experienced pregnancies between 2020 and 2021. This work aimed to understand how the pandemic affected their experience of pregnancy and their care conditions. Although challenges regarding access and quality of assistance were expected, the atmosphere of fear and insecurity caused by misinformation and the irresponsibility of the federal government's actions had an indescribable deleterious impact on their lives. The outcomes on women's daily lives, sociability, and work resulted in overload, exhaustion, insecurity, loneliness, fear, and anguish, with immense physical and psycho-emotional repercussions.

KEYWORDS Reproductive health. Reproductive rights. Social inequity. COVID-19.

RESUMO *O drama sanitário e social vivenciado na pandemia de covid-19 teve impactos sobre serviços de saúde, trabalho, vida doméstica e social, gerando consequências nefastas para a vida reprodutiva das mulheres. Este artigo apresenta resultados de um estudo qualitativo realizado a partir de entrevistas narrativas com 31 mulheres, que viveram gestações entre 2020 e 2021. O objetivo foi compreender como a pandemia afetou sua vivência da gravidez e suas condições de cuidado. Embora fossem esperados desafios quanto ao acesso e à qualidade da assistência, a atmosfera de medo e insegurança provocada pela desinformação e pela irresponsabilidade das ações do governo federal tiveram um impacto deletério inefável em suas vidas. Os efeitos sobre a cotidianidade, a sociabilidade e o trabalho das mulheres se desdobraram em sobrecarga, exaustão, insegurança, solidão, medo e angústia, com imensas repercussões físicas e psicoemocionais.*

PALAVRAS-CHAVE *Saúde reprodutiva. Direitos sexuais e reprodutivos. Iniquidade social. Covid-19.*

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Introduction

In early 2020, the COVID-19 pandemic broke out, a health emergency that triggered a global health and social crisis. In March of that year, the Brazilian Ministry of Health (MoH) confirmed community transmission of the novel coronavirus in Brazil. From then on, protective measures, such as social distancing, bans on gatherings, and masks, were implemented to prevent contagion by the SARS-CoV-2 virus, which was previously unknown in Brazil and worldwide.

Contrary to the recommendations of national and international health authorities, the Brazilian federal government's responses to the pandemic were guided by scientific denialism, ideologization, and disqualification of protective measures[1–3]. Amid a chaotic and uncoordinated scenario, state and municipal governments managed the health crisis in their territories, whether aligned with the perspective of federal authorities or not, with many difficulties for the latter[1–3]. As a result, the country has recorded 23 million cases and 700 thousand deaths from COVID-19 in just under two pandemic years[4].

Shortly after the global health emergency was declared, the WHO recommended maintaining sexual and reproductive health services, which were considered essential[5]. Following international guidelines, the MoH included all pregnant and postpartum women in the risk group for the new coronavirus and, in June 2020, the Women's Health Coordination Office released a technical note to guide and guarantee the operation of sexual and reproductive services, including access to contraceptive methods and legal abortion[6]. However, the President of the Republic was against the measure, suspended the note, and the technicians responsible were dismissed[7,8]. Studies have shown that the consequences were disastrous for women's reproductive lives, with barriers to accessing prenatal, childbirth, and postpartum care and compromised quality of care offered during the most critical pandemic years[9–13].

Behind these statistics, we can glimpse nuances of the health and social drama experienced during the pandemic years. There was a dizzying increase in the maternal mortality rate in Brazil, from 55 maternal deaths per 100,000 live births in 2019 to 108 deaths in 2021[14]. There were 549 maternal deaths from COVID-19 in 2020 and 1,519 in 2021[14].

There are two other relevant aspects to the issue of pregnancy and COVID-19. First, the racial biases in the way the pandemic affected women's reproductive health care. Black and brown pregnant women and women who had recently given birth with severe acute respiratory syndrome due to COVID-19 had less access to intensive care and a higher mortality rate than white women[15,16]. The second aspect is how the pandemic affected the mental health of pregnant women, compromising their care conditions[17,18].

This article presents the results of a study conducted with women who became pregnant from 2020 to 2021, covering different COVID-19 pandemic phases. The study aimed to understand how the health and social crisis – with its impacts on health services, work, domestic, and social life—affected the experiences and care conditions of these women during pregnancy.

The pandemic phases

The pandemic's epidemiological dynamics and its collective and individual impacts and challenges have changed over time. Based on the MonitoraCovid-19[19] system in Brazil, Barcellos and Xavier[20] proposed dividing the pandemic into five phases, by positivity of diagnostic tests, number of cases, deaths, and number of people with at least two vaccine doses.

From March and August 2020, the first phase was characterized by the expanded transmission from the capitals to the inland region, case underreporting, stricter confinement measures, an avalanche of misinformation, and hardly reliable knowledge about the impacts of COVID-19 on pregnant women and

fetuses[20,21]. In July 2020, Brazil accounted for 77% of deaths of pregnant or postpartum women due to COVID-19 in the world[22].

Stabilizing transmission indicators marked the second phase (September 2020 to January 2021) despite the high number of cases and deaths from the disease[20]. Months of poor public administration led to crises in local health systems, such as the one in Manaus[23].

The third phase (February to June/2021) started after the arrival of the vaccination against COVID-19 for the at-risk population, which only included pregnant women and postpartum women without comorbidities in May 2021[20]. The prevailing Gamma variant and the lack of healthcare were responsible for the pandemic's deadliest 'wave' in the country due to the disease itself and the chronic conditions neglected during this event[20].

Despite the federal government's attempts to discredit the vaccines, vaccination led to fewer hospitalizations and deaths, which marked the fourth phase (July to November/2021)[20]. During this period, it was already known that COVID-19 did not cause malformations, like Zika, nor did it affect breastfeeding[24].

The rapid spread of the Omicron variant caused an accelerated growth of cases and occupancy of ICU beds in the fifth phase (December 2021 to March 2022). However, lower mortality rates among people with at least two vaccine doses proved effective and relieved pregnant women, postpartum women, and the general population[20]. In April 2022, the MoH declared the end of the public health emergency in the country.

Methods

This qualitative study was developed with material from the research 'COVID-19 Pandemic and Women's Reproductive Practices in Brazil' conducted from 2021 to 2023 by the Gender, Reproduction and Justice Research Group (RepGen), a partnership between the Oswaldo Cruz Foundation (Fiocruz), the Federal University of Bahia (UFBA), and the Federal University of Rio de Janeiro (UFRJ). In the first stage of this research, an online questionnaire was distributed nationwide and answered by 8,313 women aged 18 or over from July to October 2021. Six hundred seventy-four of these women were pregnant at some point during the pandemic, and of these, 324 had given birth.

In the second phase, qualitative studies were conducted with subgroups of female respondents to understand their experiences of specific reproductive health situations. In this article, we present the results of a narrative study based on 31 in-depth interviews with pregnant women who gave birth at some point during the COVID-19 pandemic. The analysis of narratives allows us to understand collective aspects of the experience based on singular stories, reconstructing the events, interactions, and agency of the subjects, the social forces that conditioned the experiences, and the meanings produced by the people who lived them[25].

We aimed to consider several aspects to compose the study universe, including women who used public and private services, were pregnant during different pandemic phases, and lived in capitals and more peripheral or rural cities, besides ethnic-racial and age diversity. The interviews were guided by a thematic agenda covering issues such as reproductive intentions; women's and their families' reception of pregnancy; prenatal care and preparation for childbirth; care during childbirth and postpartum; domestic life and paid work during pregnancy.

After intensive readings of the interviews, thematic groups emerged and were grouped into two blocks of results, illustrated by excerpts in which women were identified with fictitious names and data on age range, ethnicity/skin color, and use of the private or public sector.

The research was approved by the National Research Ethics Committee, under CAAE 39133020.8.0000.5091 – Opinion Nº 4.695.062,

and ethical principles were followed per Resolution Nº 466/2012 of the National Health Council[26].

Self-care and being cared for: Pregnant women during the COVID-19 pandemic

The group studied comprised 54.8% of Black women and 45.2% of white women. Most were 30 or older (71%) and had completed higher education (71%). All but one were in stable relationships (married or common-law marriage). Four said they were 'housewives', five were students, eight were civil servants, seven had formal employment, four were 'self-employed', two were unemployed, and one was a businesswoman.

Pregnancy was not planned by most women in the study, a reproductive behavior that does not differ from the pre-pandemic period, when it was estimated that 55% of births in Brazil were not planned[27]. However, the discovery of pregnancy was considered a positive event, accepted and celebrated by women and their partners and families. Fear was a feeling cited in all interviews, manifested in several ways: fear of dying, of having an abortion, of the child being born sick or dying, of becoming infected and passing the disease on to others, and losing family members to COVID-19.

> *That was my biggest fear: that I would end up catching COVID and having the consequences, including miscarriage, death, or some severe complication.* (Paula, 18-24, brown, SUS).

The memory of the Zika epidemic (2015-2016) brought more apprehensions, as there were fears that the new coronavirus could also cause malformations. The news that COVID-19 did not affect fetal development brought relief.

> *When I found out I had* [COVID-19]*, I wasn't so scared, I was relieved. I was afraid it was Zika or Chikungunya.* (Gabriela, 30-39, white, SUS and private).

For those who experienced pregnancy during the third phase of the pandemic, when there was a higher number of deaths, including among pregnant women, the stress of confinement was added to their fears. Pregnant women who were already mothers felt physically and emotionally exhausted. Finding the time and energy to care for themselves, with other children and family members at home to care for, was a challenge.

> *I feel emotionally exhausted. How can I cope with this? Not because of the fear of the disease itself but because of this change in confinement, taking care of Beca* [my 5-year-old daughter]*, taking care of myself, and the lack of time to take care of myself.* (Gabriela, 30-39, white, SUS and private).

Despite fear and exhaustion, women sought health services and followed prenatal care routines. Data from our original survey indicated prenatal adequacy levels similar to pre-pandemic years, with 94% of follow-ups starting in the first trimester and 75% having more than seven visits[9].

There were reports of difficulty accessing health services among women living in inland or peripheral cities but not in large urban centers. Among the Unified Health System (SUS) clients, difficulties in scheduling appointments and tests, rescheduling and changing doctors, and care provided only by nurses were not seen as problems exclusive to the health situation. Some reported similar situations in previous pregnancies and related them to chronic deficiencies in public health services.

> *Then people will say that this is due to the pandemic, but it isn't, because I also could not do any tests through the SUS when I had my other daughter.* (Flávia, 30-39, brown, SUS).

As in another study[10], when women had to leave home for appointments and tests, it was stressful for them. The problem was not the location of the appointment but the risk of contamination on public transport, corridors, and elevators. Many were forced to seek care in places far from home, outside capitals and large centers.

In general, particularly in the first year, the women studied perceived that the quality of prenatal care had deteriorated due to preventive measures against COVID-19. The rush with which appointments were held to reduce the time spent in health services increased feelings of fear and insecurity.

> *It was a speedy, very rushed service. [...] Pregnant women have much on their minds and much fear. It even seemed somewhat inhumane.* (Marília, 30-39, brown, private).

Some respondents started prenatal care in the SUS due to the greater encouragement of vaginal birth and breastfeeding. However, they gave up due to the excess of people in public facilities, another example of the Brazilian health collapse[28]. Adherence to protective measures against COVID-19 was also controversial among SUS clients, with a greater perception of strictness before vaccination and in clinics but not afterward and in common areas.

> *I went to places where people wore masks on their chins and were crowded in the waiting room. [...] I liked prenatal care through the SUS, but I didn't continue with it because of that, as I felt unprotected against the pandemic.* (Gabriela, 30-39, white, SUS and private).

Brazilian and international studies have shown setbacks in prenatal care from 2020 to 2021, with fewer appointments, late start of follow-up, difficulties in running tests, and barriers for companions[11-13,29,30]. The respondents also mentioned these barriers in the public system and the early pandemic stages. In private services, the barriers were occasional for tests.

> *The only really annoying thing was that I had to do everything alone, everywhere: at the health center and the private health service.* (Larissa, 30-39, brown, SUS, and private).

Rights were curtailed under the pretext of preventing exposure to the virus, leaving women helpless[9]. Private service clients realized that the pandemic was yet another subterfuge for doctors to pressure them to perform cesarean sections.

> *I think the pandemic only served to make doctors terrorize mothers a little more, forcing a cesarean section.* (Glória, 18-24, white, private).

In the SUS and private sectors, healthcare professionals' role in informing and guiding women on specific issues related to pregnancy during the pandemic was, at best, timid. In 2020, a survey of pregnant and postpartum women from all regions showed that 31% did not receive professional guidance on the risks of COVID-19 and preventive care during pregnancy, 56% did not feel well-informed about the risk of contagion for the newborn, and 41% felt they were not well-informed about the specific risks for pregnancy[31].

Only five women interviewed reported receiving specific information from the health team during prenatal, childbirth, and postpartum care. As a result, the primary sources of information cited were internet pages, especially social networks of prominent media outlets, research institutes, governments, international organizations, and profiles of doctors and other health professionals, including denialists such as Dr. Nise Yamaguchi.

The spread of false or contradictory news and the excessive catastrophic information at the onset of the pandemic caused fear and insecurity among the entire Brazilian population[32]. As a result, some women in the study stopped watching the news and seeking information.

Lack of knowledge about the disease, conflicting information, and misinformation marked this period in history, affecting the physical and mental health of pregnant women and the population as a whole[17,18].

> *I tried not to watch too much news because I didn't want to be more scared than I already was. [...] I had seen stories about pregnant women dying and having severe complications during pregnancy due to COVID. That scared me a lot and made me stay even more confined at home.* (Elza, 30-39 years, Black, private).

The lack of reliable information and the regime of emergencies and priorities established at the beginning of the pandemic could justify the poor role of health professionals. However, even women who became pregnant later in life, when there was already consolidated information about the disease and its pregnancy risks, did not receive appropriate instructions.

> *I asked my doctor, 'Doctor, what's up with this pandemic and stuff?'. He didn't have any information either. It wasn't his fault either, as it was new to everyone. However, he didn't reassure me at all in that situation. So, it was all a nightmare.* (Inês, 25-29 years, brown, SUS).

On the other hand, the start of vaccination against COVID-19 brought relief and hope to most Brazilians and women in the study, who reported trust and used it as soon as it was allowed. Only one highly educated woman followed at a private service did not get vaccinated during pregnancy, exemplifying the effect of misinformation. She considered the vaccine experimental; her attending physician advised against it, and she also followed anti-vaccine doctors on social media, such as the aforementioned Nise Yamaguchi.

> *At my age, I prefer to choose the risk of COVID. If I were 60, I don't know what to balance, and maybe I would have another* [position]. (Bruna, 25-29, brown, private).

Two other situations of contraindication to vaccination existed in the private system but not in the public system. The women were vaccinated, assuming sole responsibility for their care.

> *It was at my own risk. If I wanted, I could take the vaccine, but she didn't recommend it because there wasn't enough data for pregnant women to say whether it was effective.* (Marília, 30-39, brown, private).

According to data from the Brazilian Obstetric Observatory, in March 2022, only 40.3% of pregnant and postpartum women were fully vaccinated against COVID-19[33]. A review of international literature[34] found that having a health professional as the primary source of information was associated with favorable opinions and attitudes of pregnant women regarding the vaccine. Despite the little professional guidance, adherence to the vaccine in the group studied was high.

The results of this study align with the literature on care conditions in pregnancy and childbirth during the pandemic[9-18,29-31,34-37]. For the respondents who had experienced pre-pandemic pregnancies, concerns and fears regarding the health of the fetus were expected in caring for themselves and being cared for, and challenges regarding access to and quality of care, particularly in public services. However, the atmosphere of fear and insecurity caused by the irresponsible actions of the federal government and the dissemination of fake news, combined with misinformation by health professionals, had an ineffably harmful impact on the lives of these women.

Daily life, sociability, and work of pregnant women during the COVID-19 pandemic

Social distancing measures and restrictions on movement were stricter at the beginning of the pandemic, and little was known about

the disease's risks for pregnant women and their fetuses[21]. Social and family events were suspended, public gatherings were prohibited, and, most importantly, people in risk groups were advised to stay at home.

The respondents who could choose strict isolation to avoid infecting themselves and others, such as older parents, did so. Some had to live with their extended family, subject to the rules of the house where they lived, sometimes in environments that did not respect the protection protocols.

> *I was worried about catching COVID, and there was a little more pressure from my family not to isolate myself completely. [...] However, I couldn't deny it since I was at my mother's house. I couldn't stop it.* (Paula, 18-24, brown, SUS).

Being separated from family and friends and not being able to socialize with work peers, religious communities, and other pregnant women were reasons for the women's grief, who lamented the loss of social rituals: sharing the pregnancy with the family, baby showers, photo sessions, and visits to the newborn.

> *The pregnancy was lonely; the birth was lonely. [...] From the layette to the birth in the maternity ward, without support, without visits, without the celebration we used to have.* (Helena, 40+, white, private).

Regardless of the household and family arrangement, loneliness was a recurring theme. Women felt isolated without the possibility of face-to-face interaction. Some turned to virtual communication to mitigate loneliness and have space to talk about themselves, their pregnancy, fears, and desires at this stage of life. They participated in pregnancy groups, yoga classes, physical exercise classes, and even online religious services.

> *Since I learned I was pregnant, I have started participating in Facebook groups and apps. [...] Seeing other women and mothers in the same situation is good for me.* (Nízia, 30-39, white, private).

Besides individual adaptations to restrictions, the impact of the pandemic on the experience of pregnancy varied by social marker of difference. The health crisis exposed the fragility and partiality of women's rights and racial, class, and gender injustice[9,18]. One respondent's statement highlights how being a Black woman was an additional stressor in the experience of pregnancy amid a pandemic.

> *Whenever I arrive at places, the first thing that comes to mind is that I am Black, and then the other information. So, for us, the situation of vulnerability ends up being more significant. Then, we have that care issue in that we are not as cared for as white women are.* (Amanda, 25-29, Black, SUS).

Unemployment, domestic overload, violence, and psycho-emotional disorders were also more frequent among Black and peripheral women, burdening the impact of the pandemic on previously vulnerable groups[15,16,30,32,36,37]. Furthermore, national research has indicated low schooling levels and dwelling places as factors associated with the worse evolution of COVID-19[36,37]. Municipalities with fewer health and economic resources had higher rates of incidence and mortality from the disease among pregnant women[38], corroborating the narratives of women in this research living in cities in the inland region or outskirts about problems with access and quality of care received during the pandemic.

In Brazil and abroad, women became more unemployed and suffered more significant income loss due to the pandemic[29,36]. In this study, the respondents' partners maintained or increased their income, while most maintained or lost it due to the health crisis. Given the uncertainties of this period, the fear of unemployment was a constant feeling even for those who continued to work remotely and did not lose income.

> *I was already stressed out. Because many things happened. [...] I was afraid that something would happen to the pregnancy, afraid that my other son would get it before he was vaccinated, and afraid of being unemployed.* (Cecília, 40+, Black, SUS).

In this sense, social inequalities became apparent among women. The most privileged, in terms of employment and income, enjoyed the possibility of remote work, flexible working hours, reduced commuting stress, and, in short, the prerogative to take better care of themselves and prepare.

> *I had the opportunity to spend the entire pregnancy period working from home, so I had much more flexibility regarding my schedule. I could attend my appointments, do physiotherapy, and prepare myself.* (Rosa, 30-39, brown, private).

The closure of daycare centers and schools at the beginning of the pandemic meant that children and young people lost social interaction in these spaces and had to do schoolwork at home.[38] Aligned with national and international literature[30,38-42], our respondents struggled with the care work 'overload', represented by accumulated household chores and childcare.

> *The pandemic also taught us this lesson. Children suffered a lot, and mothers were overwhelmed as well.* (Cátia, 30-39, white, private).

The pandemic has widened and exacerbated inequalities in the sexual division of labor. While male partners were responsible for shopping and activities outside the home, women assumed predominantly domestic responsibilities, besides tasks arising from the pandemic context, such as children's school support and extra hygiene care, leading to a reduced time dedicated to paid work, professional development, and leisure[38-42].

> *My husband could have been more supportive. We get along well, and I thank God for our perfect marriage, but he could have been more supportive.* (Cecília, 40+, Black, SUS).

Many women felt supported by others, such as mothers, mothers-in-law, and domestic workers. However, especially in the first phase of the pandemic, they did not receive this support, as restricted movement meant that many families had to dispense with outsourced help for domestic care and reduce their support network.

> *Because nobody would come. We didn't receive anyone at home because anyone who came to help came by bus.* (Helena, 40+, white, private).

The sudden and prolonged increase in couples and families living together at home has created tensions, leaving some women with no breathing space. Crises in marital relationships, initiated or intensified by circumstances, have brought additional tensions to the experience of pregnancy, which is already full of fear, anxiety, and exhaustion.

> *I had no more escape. You know that little moment of escape? I didn't have it anymore. Because it was just inside the house, my husband, my children, and I.* (Cecília, 40+, Black, SUS).

> *I could say that my marriage was in crisis during this period. However, I can't even call it a crisis because that's what it is: the pandemic affecting the marriage. So, to what extent is a marriage in crisis and the pandemic?* (Gabriela, 30-39, white, SUS and private).

The effects of the COVID-19 pandemic on women's daily lives, sociability, and work have resulted in overload, exhaustion, insecurity, loneliness, fear, and anguish, with immense physical and psycho-emotional repercussions for pregnant women. Black, poor, and peripheral women have suffered from deteriorated pre-existing vulnerabilities.

Final considerations

The body of knowledge about the experience of pregnancy, childbirth, and postpartum in Brazil during the COVID-19 pandemic, including the conditions provided for women to take care of themselves and the care received by health services, is still under construction. Between collective health, social, economic, cultural, and political impact, and private, personal, and subjective impact, multiple aspects shaped women's experiences and gave them heterogeneity.

This study contributes to this knowledge by shedding light on how the care conditions of pregnant women were affected under the pandemic's epidemiological dynamics in its several stages; by the chaotic government responses to the health crisis; by the lack of or inaccurate information provided by health professionals and the federal government; by the different access to care, by the use of public or private health services and residence in capitals and large centers or inland and rural areas; and, finally, by gender, class, and race inequalities.

Now, when the National Care Policy[43] was approved, expanding the understanding that in order to overcome crises and face emergencies that lurk on our horizons – health, climate, economic, and social – it is necessary to value care work and share it in all its dimensions, it becomes imperative to delve into the knowledge of what was perhaps the greatest common challenge humanity has experienced in recent centuries – the COVID-19 pandemic – and extract from it clues on how we can reorganize the social reproduction of life.

Collaborators

Yamamoto TS (0000-0002-1816-2898)* contributed to the work's conception, data collection, analysis, and interpretation, the article's writing and critical review, and the final approval of the version to be published. Bonan C (0000-0001-8695-6828)*, Fonseca VM (0000-0002-5452-7081)*, Rodrigues AP (0000-0002-1873-5828)*, and Reis AP (0000-0002-6750-0187)* contributed equally to the work's conception, collection, data analysis and interpretation, the article's critical review, and the final approval of the version to be published. ■

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