v. 4, n. 73, 2024

International Journal of Health Science

EVALUATION OF THE BIRTH EXPERIENCE IN CORRELATION WITH OBSTETRIC VIOLENCE AND FEAR OF COVID-19: INITIAL PERIOD OF THE PANDEMIC

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Abstract: Introduction: The changes brought about by the pandemic have decisively affected the health sector, including childbirth care. The lack of knowledge about the disease and the potential risks to the mother and baby after contamination with the COVID-19 virus permeated the population's imagination. Pregnant women were the last population to be included in general among those considered at risk for contracting the disease, and this fact occurred after the death of some pregnant and puerperal women. Among other facts, it was evidenced that the impediments to the presence of companions were impacted by racial bias, even though this is a right guaranteed by law. In this context, tools used to assess the birth experience, fear of COVID-19 and childbirth assistance were even more relevant. **Objectives:** The present study aimed to know the perception of postpartum women in the center of southern Bahia about the care received during childbirth in the first year of the COVID-19 pandemic. To this end, we sought to correlate the quality of the birth experience, the fear of covid and the quality of obstetric care received. **Methods:** Three instruments were used to evaluate care: the CEB2-BR, an assessment scale on the fear of COVID-19, and the Childbirth Violence Assessment Questionnaire. A descriptive and correlational analysis of Spearman's was performed and the Student's t-test was applied to verify significant variations between groups. **Results:** Significant correlations were found between some variables. General fear and anxiety; feeling threatened and general fear; negative memories of childbirth and general fear; general insecurity and fear; need for greater listening and general fear; satisfaction with the information received and less general fear; possibility of choosing analgesia and satisfaction with the birth experience; safety and satisfaction with the birth experience. **Conclusion:** The experience of childbirth needs to be a moment of protagonism of the mother-baby dyad, but this aspect was not prioritized by the care teams during the critical period of the 1st year of the pandemic. Self-confidence, self-control, emotional balance, security, and adequate support are directly related to positive birth experiences. More research investigating the type of care provided during childbirth, the experience of childbirth, and women's mental health, is notably needed.

Keywords: childbirth experience; pandemic; COVID-19; obstetric violence; fear of COVID-19

INTRODUCTION

Since 2020, a series of studies have focused on the impact of the pandemic in various contexts. In the context of perinatality, it was also no different. Studies and research, throughout the world, sought to determine the extent to which the virus could endanger women and their babies, before, during and after pregnancy (Rajewska et al., 2020; Rochelson et al.,2020). Can contracting the virus and developing the disease compromise the health of a woman who is trying to get pregnant? And when you are already pregnant, or have you already had your baby? Can the transmission of the disease occur vertically? And through breast milk? Some of these questions have already been partially answered and others are still under study. The fact is that the pandemic context was something extremely unexpected for most of us and this virus is still under investigation and being better known every day.

Childbirth care in the pandemic scenario was permeated in general by insecurity, uncertainty and fear. Some pregnant women were able to be cautious about their exposure and the maintenance of social isolation, however, unlike assistance to eventual care or elective surgeries, which allow for temporary

postponement, deliveries continued to take place throughout this period, in an exceptional way, in a pandemic context (Brasil, 2020). Unfortunately, here in the country, we had to face the loss of life by women who had just had their children (FSVC, 2020). The death of postpartum women turned on the alert in Brazil that COVID-19 could affect not only high-risk pregnant women (Collucci, 2020; Marques-Santos, 2021).

In this context, changes were also necessary at the time of delivery and postpartum, seeking greater safety for all those involved in the process. Ordinances and decrees provided guidance regarding the changes that needed to be adopted due to the new epidemiological scenario: restriction on the presence of companions, especially members of risk groups (the elderly, pregnant women, diabetics, and others with serious diseases); guarantee of elective care for high-risk pregnant women; suspension of activities/ courses/groups promoted by doulas, as well as their permanence in maternity hospitals; suspension of hospital visits and carrying out parental visits to Neonatal Intensive Care Units (UTIs-Neo) on an individualized ways (Brasil, 2020). In the face of a restrictive orientation, racial bias permeated the criterion of allowing or prohibiting the companion (Mittelbach & Souza, 2022; Goiabeira et al., 2022).

The first year of the pandemic between March 2020 and March 2021 can be considered a period of criticality, as it included the first two waves of concentration of infected people and the spread of the virus (Chagas et al, 2021). This also included the period in which Brazil became one of the epicenters of the epidemic (Barrucho, 2020), also putting at risk a health system on the verge of collapse (Lopes, 2020). The first year of the pandemic also corresponded to the interval that preceded the start of vaccination in Brazil, especially when pregnant and postpartum women were not yet covered (FEBRASGO, 2021).

In the face of this critical pandemic scenario, the evaluation of the birth experience proved to be an important tool in identifying the variables that positively or negatively impacted such experience (Santos et al., 2022). Instruments specific to assess fear related to COVID-19 (Barros et al., 2021) or that seek to assess culturally perpetrated phenomena, as in the case of obstetric violence (Palma & Donelli (2017), have proven useful. The present study aimed to know the perception of postpartum women in the center of southern Bahia about the care received during childbirth during the first year of the COVID-19 pandemic.

METHODS

EVALUATIVE RESOURCES

In this research, three instruments were used, two already validated for the Brazilian reality and one that had its validation possible with part of the data from this research. The Questionnaire on the Experience of Childbirth (CEQ-2BR) was originally developed by Dencker e cols. (2010). The swedish version comprised a closed instrument, consisting of 22 items, based on four main dimensions: Autonomy or Own Capacity, Perception of Safety, Professional Support, and Protagonism or Participation. The version used in this study comprised 33 items identified as relevant between the Spanish and American versions, and the version for validation had to suppress some of the items in its process of adaptation to the Brazilian reality, totaling 22 items. The questions investigate the perception of the puerperal women about their experience in relation to labor and delivery, satisfaction with professional follow-up, satisfaction with the place where the delivery took place, satisfaction with the type of delivery. The items were evaluated within the following possible answers: «I totally disagree; Disagree;

Agree; totally agree», and three items required self-assessment in relation to one's own safety, on the level of control perceived in relation to the birth and on the intensity of pain felt, on a scale of 0 to 10. High scores tend to indicate better birth experiences.

The second instrument was the Childbirth Violence Assessment Questionnaire (QAVP). Instrument developed and validated for Brazil by Palma & Donelli (2017), It consists of eight multiple-choice items and twelve items that need to be evaluated according to a scale of 0 to 10, on choices and/or impositions related to the type of delivery and the perception of the intensity of some behaviors that can be characterized as obstetric violence. In addition, there are also seven open items that allowed the women to complement information that was not covered by the closed questions.

The third was the COVID-19 Fear Scale in the Perinatal Period. Scale prepared by Ahorsu e cols. (2020), which was validated for the Brazilian version and adapted to the perinatal context by Barros e cols. (2021). Originally composed of seven assertions that seek to investigate how fear related to COVID-19 can affect individuals, two more items were added specifically aimed at the perinatal context. It is characterized by being a self-completed questionnaire and composed of nine assertions to be answered on a 5-point Likert scale, from «Strongly disagree; a «Strongly Agree». This scale was used in this research as an exploratory resource to assess the fear of COVID-19, by puerperal women, due to the critical period of interest to be studied.

ANALYSIS PROCEDURE

The result of each questionnaire was calculated by the total scores obtained, through the respective instructions. With the SPSS software, the descriptive analysis of the sample and frequency was performed through independent variables (race, age, date of delivery, place of delivery, type of delivery) and dependent variables (experience of childbirth, obstetric violence, fear of COVID). Through the JAMOVI software, a descriptive and correlational analysis of Spearman was performed and the Student's t-test was applied to verification of significant variations between two groups of women (those who had the right to a companion X those who did not).

Spearman's rank correlation coefficient or Spearman's rô is a non-parametric measure of rank correlation (statistical dependence between the classification of two variables). The coefficient evaluates how strongly the relationship between two variables can be described by the use of a monotone function. If there are no repeated data values, a perfect Spearman correlation of +1 or -1 occurs when each of the variables is a perfect monotonous function of the other. Spearman's coefficient is appropriate for both continuous variables and discrete variables, including ordinal variables. (Lehman et al, 2013). The sample of this study was non-parametric and can be analyzed by this coefficient.

T-tests are hypothesis tests useful in statistics when it is necessary to compare means. By using this study, it was possible to compare a sample mean with a hypothetical value or with a target value using a t-test for the sample. We compared the means of two groups with a t-test for two samples. The t-value measures the size of the difference relative to the variation in your sample data. In other words, T is simply the calculated difference represented in units of standard error. The greater the magnitude of T, the greater the evidence against the null hypothesis (Normando et al., 2010).

JAMOVI 2.3.21 is a free software that is all translated into Portuguese, can be downloaded for free and has specifications and

features similar to SPSS. In it, it was possible to perform the correlations between the three instruments through Spearman's regression analysis, where all the correlations found were signaled. It was also possible to calculate the t-test for distinct and non-parametric groups according to the sample distribution of this study.

RESULTS

PARTICIPANTS AND SOCIODEMOGRAPHIC PROFILE

This research focused on the period from the first year of the pandemic (March 2020 to March 2021) and was approved to be carried out completely *online* (registration with CONEP under CAAE numbers: 32934720.3.0000.5556 and Opinion: 4.291.630). From the convocation of the participants through social networks to the effective selection of these (puerperal women who gave birth during the first year of the pandemic, in the health region of Vitória da Conquista). Out of a total of 104 women who consented to participate in the research and registered their data, in fact, 89 women could be included among the members of the final study, as they met the required criteria (cities where the delivery took place and the date of delivery during the pandemic period) and thus composed the sample. Of these 89 women, 49 (55%) were aged between 21 and 30 years on the date of collection. The second age group was concentrated between 31 and 38 years old, and 33 participants (37%) were included. A third age group was constituted between 41 and 44 years, which included six participants (7%). Most of these women identified themselves with the black race (brown + black), totaling 62% of the participants. Regarding education, 75% of the participants reported having a degree and/or subsequent training. In terms of income, 62% reported having a family income between 1 and 4 minimum wages. Regarding the emergency aid provided by the federal government, 20 of the participants requested and received it and 10 requested it, but did not receive it. More than half of the participants stated that they were in a stable union (68.5%).

The participants of this study are able to represent the national population proportionally in terms of ethnicity, however, the representation of schooling is higher than the national index. Income was directly impacted by the presence of emergency aid in all families that were able to access it (IBGE, 2021).

Race/skin color	**N (n%)**
Brown	49 (55%)
Black	6 (7%)
White	34 (38%)
Age group	**N (n%)**
18 to 20 years old	1 (1%)
21 to 30 years old	49 (55%)
31 to 38 years old	33 (37%)
41 to 44 years old	6 (7%)
Schooling	**N (n%)**
Up to High School or Technical Education	22 (25%)
Undergraduate and Graduate Studies	59 (66%)
Masters	6 (7%)
Doctorate	2 (2%)
Type of income	**Frequency**
Emergency Aid	20 received/10 requested and did not receive
1 to 4 MW	55 (62%)
More than 4 minimum wages	34 (38%)
Marital status	**N (n%)**
Single	3 (3%)
Married woman	61 (69%)
Divorced	1 (1%)
Lives in the same house	24 (27%)

Sociodemographic profile (Table 1)

PLANNING AND PLACE OF DELIVERY

The survey managed to concentrate a greater participation of primiparous women (58%), compared to multiparous women (42%). Regarding pregnancy planning, 58% reported that the current pregnancy was planned. Certainly, the pandemic was not included in the planning of these women, when they decided to become pregnant, or if they found themselves pregnant, during this period. Adapting pregnancy and childbirth when faced with a pandemic context is challenging, mainly due to the scarcity of information about a new disease, even competing, concomitantly, with *fake news* and little adaptation to the context of motherhood (Estrela et al., 2020).

Most of the participants had their deliveries in a hospital (97%) and most of the deliveries were by cesarean section (61%), which is higher than the national average (53.77%). Vitória da Conquista concentrated all the respondents, however, one participant gave birth in the municipality of Belo Campo. The municipality of Vitória da Conquista is the headquarters of the health region and it was already expected that there would be a predominance and preference for this location for childbirth, mainly due to the higher concentration of maternity hospitals and hospitals, compared to the other municipalities contemplated in this research. The data obtained in this survey are close to what is expected for the national profile in relation to hospital births in which there is a predominance of cesarean sections, reaching 83% of deliveries (ANS, 2019). There is evidence that surgical births negatively affect birth experiences more than any other operational vaginal birth (Henderson, 2013; Rowlands, 2012). However, we emphasize that in Brazil there is a culture of normalization of cesarean sections (Nakano et al., 2016), reaching a prevalence of 88% in the private sector (Leal & Gama, 2012).

SUPPORT NETWORK AND IMPACT FOR THE PANDEMIC

Most participants did not have follow-up for *Doula* during pregnancy until delivery (82%) and more than half of them did not participate in groups focused on pregnancy guidance (68.5%). It can be inferred that the pandemic context and the impositions resulting from health protocols, including social isolation, directly impacted this type of care. The minimum companion guaranteed by law was in some contexts prevented from being at the place of birth and this prohibition also extended to the *Doulas*. Regarding the relationship with the baby's father, the expressive majority said they had a happy relationship (83%). The existence of a support network (72%) was informed, which was mainly formed by family and friends (49%).

Regarding the impact of the pandemic throughout gestational monitoring, 73% reported **not having suffered** no type of impact, adverse outcome, even in the face of affirmative answers to items such as the diagnosis of COVID-19 during pregnancy or childbirth. Regarding having received the diagnosis of COVID-19 during pregnancy or after delivery, 22 participants (25%) answered affirmatively. The participants who had the disease, before or after childbirth, were close to the number of women who stated that they had suffered the impact of the pandemic during their gestational follow-up, which seems to show that only very close contact with the disease brought more direct consequences for the public studied. In a study that sought to compare stress in women during the third trimester of pregnancy and in the puerperium, 75% presented stress at the end of pregnancy, and 85% stated that they had experienced psychological stress. In the puerperium period, 63% stated that they had experienced this condition, and 83% reported psychological stress. There was

a positive correlation between stress levels and symptoms of postpartum depression (Rodrigues & Schiavo, 2011). Research carried out with pregnant women during their third trimester of pregnancy highlighted among the results, a negative expectation in relation to childbirth, permeated by feelings such as fear, pain and suffering, risks for the woman and the newborn, in addition to a lack of confidence to experience childbirth (Tostes & Seidl, 2016). In view of this information, in the next session, the main correlations found between the three instruments used in this study will be presented.

Place of childbirth	**Quantitative**
Public hospital	24 (27%)
Private hospital	62 (70%)
Residence	2 (2%)
Days of birth	**Quantitative**
Until 3 months of life	18 (20%)
From 4 to 7 months of life	37 (42%)
From 8 to 9 months of life	34 (38%)
City of childbirth	**Quantitative**
Vitória da Conquista	88 (99%)
Belo Campo	1 (1%)
Type of childbirth	Quantitative
Normal childbirth	35 (39%)
Cesarean childbirth	54 (61%)
Number of pregnancies	**Quantitative**
First pregnancy	52 (58%)
Non-primiparous	37 (42%)
Doula accompaniment until childbirth	**Quantitative**
Yes	8 (9%)
No	73 (82%)
Partially	8 (9%)
Participation in a mentoring group	**Quantitative**
Yes	23 (26%)
No	61(68,5%)
Partially	5 (6%)
Relationship with the baby's father	**Quantitative**
Happy	74 (83%)
Satisfactory	11 (12%)
Neutral	2 (2%)
Unsatisfactory	2 (2%)
Existence of a support network	**Quantitative**
Yes	64 (72%)
No	7 (8%)
Partially	18 (20%)
Composition of the support network	**Quantitative**
Family	36 (40%)
Friends	1 (1%)
Family and friends	44 (49%)
Other	8 (9%)
Pregnancy planning	**Quantitative**
Planned	52 (58%)
Not planned, but accepted	30 (34%)
Unplanned and delayed acceptance	6 (7%)
Unplanned and still in the process of acceptance	1 (1%)
Impact of the pandemic on prenatal care	**Quantitative**
Impact	24 (27%)
No Impact	65 (73%)

Diagnosis of covid-19 in pregnancy		**Diagnosis of covid-19 after childbirth**	
Yes: 9 (10%)	No: 80 (90%)	Yes: 13 (15%)	No: 76 (85%)

Information on pre – and postpartum (table 2)

CORRELATIONS FOUND BETWEEN THE QUALITY OF THE BIRTH EXPERIENCE, FEAR OF COVID AND THE QUALITY OF CARE RECEIVED

Among the results obtained in the correlation between the three instruments, some results were highlighted and will be analyzed below. One third of the participants did not feel happy during their labor and delivery, and a portion similar to this one varied less or more in relation to their dissatisfaction. This portion includes those who did not feel treated with respect (15%), who identified that they needed more presence from the team (31%), greater encouragement (33%), who did not feel capable (27%), who did not feel strong

or happy (30%), who had negative memories of childbirth (27%), or who the memories made them depressed (25%), who felt frustrated (31%), that they did not deal well with the situation (25%), that they would have liked to have had greater participation in decisions about childbirth (29%), that they could not choose between pain relief resources (36%) or between the most comfortable position (39%) and, above all, did not feel prepared for changes in delivery planning (31%), and this experience did not correspond to what they had dreamed of (31%). From these results, it is possible to understand that this public included women who did not deal well with the changes in childbirth planning and who were possibly not adequately prepared for this process or the need for change throughout the evolution. As a result, this experience directly impacted the memories they have about their births.

In addition to the portion that most frequently reported negative experiences during childbirth, it is worth highlighting aspects pointed out by more than half of the participants who reported feeling afraid (69%), having felt anxious (58%), in addition to having reported feeling more pain during childbirth (63%). In other words, although a large portion of the participants were able to positively bond with the team (83%) and reported a happy birth experience (78%), these aspects do not exclude the occurrence of negative feelings and experiences permeated by pain and fear

In the comparison between groups, statistical significance was found for happiness and for a better evaluation of care among women who had the right to a companion, either partially or full-time. The women who were happier and more satisfied with the evaluation of childbirth were those who had the right to a companion. This finding reinforces the need to guarantee the right to a companion, regardless of the circumstance in which the birth is experienced. Childbirth accompaniment is a right and as such, it must be guaranteed in all contexts.

The greater satisfaction with the care received was directly correlated with aspects related to female protagonism. The women who were most satisfied with the care received were those who also had: greater possibility of making choices regarding pain relief resources (anaesthesia), those who had the freedom to choose the most comfortable position, those who were satisfied with the information received and those who were able to actively participate in the decision-making process related to care and interventions.

There was a significant correlation with the supply of information and the level of satisfaction with the care provided. The women who were most satisfied with the amount of information provided by the teams were also those who were most satisfied with the care provided, corroborating the results in which dissatisfaction with the care was associated with insecurity, fear and frustration. In the literature, satisfaction with the information received was also related to a good perception of the care team (Domingues, 2004). Lack of knowledge and lack of information are directly associated with negative feelings such as fear and frustration.

There was a positive correlation between women's participation in decisions and choices regarding care and interventions, with satisfaction with the care received. Again, it is a correlation that points to the level of trust and freedom, established with the team. Women who were freer and had a greater right to choose a comfortable position, when deciding what was best for them, throughout the evolution of their deliveries, made a better evaluation in relation to the care received by the health teams. This data is again confirmed by finding a correlation between the choice to

		Statistics	Gl	p
CEQ-Happiness	t for Student	-3.24 the	87.0	0.002
Evaluation of assistance	t for Student	-5.53 the	87.0	<.001

Note. H_a $\mu_0 \neq \mu_1$

a Levene's test is significant ($p < 0.05$), suggesting a violation of the assumption of homogeneity of variances

Group Descriptions

	Group	N	Average	Median	Standard deviation	Standard error
CEQ-Happiness	0	15	2.67	3.00	1.18	0.303
	1	74	3.50	4.00	0.848	0.0986
Evaluation of assistance	0	15	5.87	5.00	2.72	0.703
	1	74	8.84	10.00	1.696	0.1972

I) T-test for independent samples

		Evaluation of assistance	CEQ-Analgesia	CEQ-Decision Making	CEQ-Information received	CEQ-Choose Position
CEQ-Analgesia	Rho de Spearman	0.349 ***	—			
	p-value	<.001	—			
CEQ-Decision Making	Rho de Spearman	0.562 ***	0.440 ***	—		
	p-value	<.001	<.001	—		
CEQ-Information received	Rho de Spearman	0.586 ***	0.415 ***	0.631 ***	—	
	p-value	<.001	<.001	<.001	—	
CEQ-Choose Position	Rho de Spearman	0.302 **	0.384 ***	0.610 ***	0.464 ***	—
	p-value	0.004	<.001	<.001	<.001	—

Note. *p<.05, **p<.01, ***p<.001

II) Satisfaction with care and evidence of female protagonism

		Evaluation of assistance	CEQ-Strength	CEQ-Positive Memories	CEQ-Happiness	CEQ-Security
CEQ-Strength	Rho de Spearman	0.435 ***	—			
	p-value	<.001	—			
CEQ-Positive Memories	Rho de Spearman	0.525 ***	0.582 ***	—		
	p-value	<.001	<.001	—		
CEQ-Happiness	Rho de Spearman	0.506 ***	0.446 ***	0.716 ***	—	
	p-value	<.001	<.001	<.001	—	
CEQ-Security	Rho de Spearman	0.543 ***	0.647 ***	0.601 ***	0.561 ***	—
	p-value	<.001	<.001	<.001	<.001	—

Note. *p<.05, **p<.01, ***p<.001

III) Satisfaction with care and positive perceptions

use analgesia and the evaluation of the care providedThese data corroborate the paths defended by the most recent research, which was motivated by the results of the «Nascer no Brasil» survey, which provided a more concerned look at the woman, the baby and the prioritization of strategies congruent with scientific evidence and better health indices (Leal, 2018).

The findings found in the literature, considering that the rates of greater satisfaction of women in childbirth are directly linked to variables such as speed of delivery, little suffering, presence of a companion, access to information and treatment provided by the health team (Domingues et al., 2004; Pinheiro & Bittar, 2012). The data on speed of delivery was not necessarily investigated in this study, however, the lack of information and the inadequate treatment offered by the team were aspects pointed out by the women who had more negative experiences in this context.

Corroborating the findings on protagonism, positive feelings of happiness, good memories related to childbirth, perception of safety and of having been strong, were correlated with evaluations of satisfaction with the care received. In this evaluation, the importance of the team's performance in a cohesive way and prioritizing the woman's potential and a safe environment for the mother and baby is evidenced. A number of factors can contribute to ensuring safety, including the presence of a family companion (Dodou et al., 2014; Souza et al., 2016). The bond established becomes a two-way street: offering quality care and having the guarantee of satisfaction, as well as its opposite.

Everyone has to gain, just as everyone has to lose, and the smartest thing is to opt for the common good. It is enough to take this perspective to a micro and short- and medium-term analysis. A postpartum woman who is not satisfied with her birth experience may develop an illness during the puerperium and is much more likely to have an impact on her general health, on the establishment of bonding and care for the baby, adaptations to the new routine, etc. (Guerra et al, 2014). A conjunction of risk factors in which consequence can lead to another, like a snowball. The struggle for the quality of care provided during childbirth is already an old struggle (Steen & Steen, 2014) and its guarantee should not be restricted to this period. Addressing and disseminating information that guarantees good health practices, such as psychoeducation projects, need to be a priority for every professional who works in this area, as well as content to be acquired by future pregnant women and their support network.

Negative correlations were found between the evaluation of care and a greater need for team participation. The women who felt a greater need to be encouraged, a greater need to have been listened to more and who would need a greater presence of the teams, were the ones who evaluated the care provided less positively. As previously discussed, the bond established between professionals and patients is decisive for satisfaction with care. In cases where care was offered in a deficient way in relation to the greater need for listening, the need for greater encouragement and a greater presence of the team, satisfaction was lower. In a study that sought to investigate the role of the team in care and comfort during labor and delivery, responsibilities were listed that were not only technical, but that contributed to the process of women appropriating their own bodies and knowing their limits (Carraro et al., 2008). In summary, it is evident that the closer, stronger and more reliable the relationship with the team, the higher the satisfaction rates with the birth experience.

The highest frustration indexes, of women who had more negative memories about

		Evaluation of assistance	CEQ-Maior Escuta	CEQ-Greater Encouragement	CEQ-Greater team presence
Evaluation of assistance	Rho de Spearman	—			
	p-value	—			
CEQ-Maior Escuta	Rho de Spearman	-0.725 ***	—		
	p-value	<.001	—		
CEQ-Greater Encouragement	Rho de Spearman	-0.505 ***	0.703 ***	—	
	p-value	<.001	<.001	—	
CEQ-Greater team presence	Rho de Spearman	-0.536 ***	0.745 ***	0.818 ***	—
	p-value	<.001	<.001	<.001	—

Note. *p<.05, **p<.01, ***p<.001

IV) Insatisfaction and deficits in the care offered

		Evaluation of assistance	CEQ- Depressed memories	CEQ-Frustration	CEQ-Negative Memories
Evaluation of assistance	Rho de Spearman	—			
	p-value	—			
CEQ- Depressed memories	Rho de Spearman	-0.640 ***	—		
	p-value	<.001	—		
CEQ-Frustration	Rho de Spearman	-0.437 ***	0.606 ***	—	
	p-value	<.001	<.001	—	
CEQ-Negative Memories	Rho de Spearman	-0.679 ***	0.750 ***	0.625 ***	—
	p-value	<.001	<.001	<.001	—

Note. *p<.05, **p<.01, ***p<.001

V) Insatisfaction with care and negative feelings/thoughts

		Evaluation of assistance	V.O-Vulnerability	V.O-Threat	V.O-No response
Evaluation of assistance	Rho de Spearman	—			
	p-value	—			
V.O-Vulnerability	Rho de Spearman	-0.656 ***	—		
	p-value	<.001	—		
V.O-Threat	Rho de Spearman	-0.571 ***	0.674 ***	—	
	p-value	<.001	<.001	—	
V.O-No response	Rho de Spearman	-0.563 ***	0.641 ***	0.724 ***	—
	p-value	<.001	<.001	<.001	—

Note. *p<.05, **p<.01, ***p<.001

VI) Insatisfaction with care and situations of obstetric violence

childbirth and with a higher number of memories related to childbirth that made them depressed, were correlated with low evaluations in relation to satisfaction with childbirth care. According to Preste & Ferreira (2021), the COVID-19 pandemic further exacerbated negative feelings such as fear, loss of control, and insecurity at the time of delivery. Negative experiences and the level of stress can be associated with stressful events typical of the gestational or puerperal phase, as well as fears about childbirth, fear that the fetus will die, financial and marital concerns, lack of support network, doubts about the body, among several other different reasons for each pregnant woman, mainly, in the case of the first pregnancy (Rodrigues & Schiavo, 2011). As the predominant audience of this research was primiparous, this is revealing information.

Women who experienced more vulnerability, experienced some situation of threat by members of the care team and were ignored when making requests, evaluated the care received during childbirth less positively. These experiences can be configured in situations of obstetric violence, since childbirth itself is already classified as a moment of vulnerability. At a time of pandemic permeated by insecurity and uncertainty, the intensity of these negative experiences is even more amplified. Among the negative feelings reported by the participants, feelings of inferiority, vulnerability and insecurity were highlighted, being mentioned by 29% of the participants. The feeling of threat by women in relation to the speech of some professionals was highlighted (22.5%). Childbirth should be a unique experience for each woman (Gutman, 2021), however, in addition to not being able to mark the particular experience, in some cases it was also permeated by obstetric violence.

A very relevant piece of data correlated the evaluation of the care received with the absence of the companion, together with the perception of the absence of privacy. Complaints related to the permission of companions were not uncommon in this study, and this fact was associated with racial bias in some locations in the country (Mittelbach & Souza, 2022; Goiabeira et al., 2022). Even though it is a right guaranteed by law, (Law No. 11,108 of 2005), it was not adequately insured during the pandemic. The Ministry of Health made powers and disclosed criteria regarding the presence of companions, but did not disclose any prohibitive position (Brasil, 2020). Such conducts adopted by the care teams need to be questioned in terms of validity, especially so as not to become a reference in future parturiation conditions.

The women who felt the most fear in general were also the ones who felt the most anxiety. At the same time, those who felt more fear were those who had less perception of having been strong and having felt capable. The historical, cultural, and social moment caused by the pandemic and the directions given (or lack thereof) to resolve it played an essential role in the management of fear. What was evidenced by the results is that the fear experienced associated with the invalidation of oneself. Fear, in principle, has a biologically protective function for the life of the species. It is in the history of life, which can contemplate traumas and which involves education and culture, that some fears can become excessive (André, 2007). From a biological point of view, having some level of fear in relation to COVID-19 was what made the initial measures to restrict the movement of people effective for some time, when most of the population remained in their homes. This phenomenon can be explained by Skinner:

		Evaluation of assistance	Companion Rights	V.O-Companion absent	V.O-Privacy
Evaluation of assistance	Rho de Spearman	—			
	p-value	—			
Companion Rights	Rho de Spearman	-0.421 ***	—		
	p-value	<.001	—		
V.O-Companion absent	Rho de Spearman	-0.401 ***	0.793 ***	—	
	p-value	<.001	<.001	—	
V.O-Privacy	Rho de Spearman	-0.485 ***	0.292 **	0.433 ***	—
	p-value	<.001	0.006	<.001	—

Note. *p<.05, **p<.01, ***p<.001

VII) Insatisfaction with the assistance and absence of the companion

		General Fear	CEQ-Anxiety	CEQ-Strength	CEQ-Capacity
General Fear	Rho de Spearman	—			
	p-value	—			
CEQ-Anxiety	Rho de Spearman	0.377 ***	—		
	p-value	<.001	—		
CEQ-Strength	Rho de Spearman	-0.500 ***	-0.320 **	—	
	p-value	<.001	0.002	—	
CEQ-Capacity	Rho de Spearman	-0.455 ***	-0.374 ***	0.859 ***	—
	p-value	<.001	<.001	<.001	—

Note. *p<.05, **p<.01, ***p<.001

VIII) Fear and self-perception

> «What is good for the species is what helps it survive. What is good for the individual is that which promotes his well-being. What is good for culture is what allows it to solve its problems. There are other types of values, but they eventually occupy a secondary place in terms of survival. (...) Humanity, slowly and erratically, has created environments in which people behave more effectively and undoubtedly experience the sensations that accompany successful behavior. It is a process that continues.» (Skinner, pp. 175-176).

The direct possibility of contamination or even the potential risk (indirect risk) need to be considered when referring to COVID-19. The fear investigated in this research predominantly included the observation of self-preservation. When considering the little accumulated knowledge about the disease, at that moment, this fear in question, culturally speaking, would be contemplated in the fear related to the unknown or little known, in other words, inherently and predominantly a circumstantial fear, due to the moment experienced. Kovács (1992) states that fear is the most common response to death and affects all human beings, regardless of age, gender, socioeconomic level and religious belief. In view of this information, it is evident that feeling fear in the context in question was consistent with the contingencies experienced.

CONCLUSION

The correlations found in this study point to two clearly distinct groups: women who were able to guarantee the presence of companions and those who did not have this guarantee the need for improvement in childbirth care. The women who evaluated the care provided and their childbirth experience more positively were the ones who had the greatest possibility

of exercising their protagonism. They were able to make more choices regarding the resources for pain relief, the position of greater comfort and were satisfied with the information received. They had more positive feelings such as perceived security, happiness, strength, and built more positive memories about childbirth.

The participants who negatively evaluated their birth experience felt a greater need for the presence of the teams, so that they were more listened to and encouraged. These women were more frustrated, depressed, and built more sad memories about childbirth. They were also the ones who felt most vulnerable and suffered violence through threats or were ignored in the face of their demands. The absence of companions was also directly related to the lack of guarantee of privacy. General fear was directly related to anxiety and negatively related to feelings of strength and perceived ability.

In short, in order to find high levels of satisfaction with childbirth care and experience, it is necessary to reduce the feeling of fear and favor a welcoming environment of preparation for childbirth. The more secure, the stronger and more aware of their possibilities of choices, the more satisfied these women will be with the care and the better memories and positive feelings they will have in relation to their birth experiences.

The data collection for this work took place entirely online, so that it may have failed to access a portion of the population that does not have access to quality internet. This collection model, which proved to be convenient during the pandemic period, may have brought some limitations about the generalization of the results.

The instruments used in this study proved to be adequate and useful for the constructs evaluated. The correlations found are in accordance with the scientific evidence in the literature. Research investigating childbirth care, childbirth experience, and women's mental health in more cities and regions of the country is necessary in order to better understand the phenomenon of obstetric violence in the country, in a pandemic context or outside it. The pandemic alone was not the most preponderant factor in terms of the impact on the evaluation of the assistance provided. Elements such as the possibility of exercising protagonism and making choices throughout the evolution of the birth experience had a greater weight in the results found in this study.

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