



RESEARCH ARTICLE

Childbirth and the Pandemic in the Interior of Bahia: The impact in Healthcare of Sanitary Crisis

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ABSTRACT

Introduction: The practice of violence against women, which has a gender dimension, extends to the perinatal context and, in its various manifestations, has been termed obstetric violence. Between January and June of 2020, Brazil had the highest total number of deaths among pregnant and/or postpartum women in the world, reaching 124 deaths; progressively, the predominance of deaths due to COVID-19 contamination in the postpartum period was observed, compared to those that occurred during the gestational period, as well as in the manifestation of symptoms. The visibility given to the assistance offered throughout the pre- and postnatal period, as well as the birth experience itself, has potential as a tool for affirming and strengthening female protagonism. Intense negative feelings are indicative of postpartum distress and exploring women's perception of childbirth care is the first step.

Objectives: This article sought to understand how women who gave birth in municipalities in the south-central region of Bahia perceived the assistance they received during childbirth during the first year of the COVID-19 pandemic.

Methods: This was a cross-sectional study that included 89 postpartum women recruited through social networks who had their babies during the critical period of the pandemic (March 2020 to March 2021) in the Vitória da Conquista Health Region. The data transcribed and qualitatively analyzed here correspond to the responses provided during the completion of the open-ended questions in an electronic form that included the "Violence in Childbirth Questionnaire" (Palma & Donelli, 2017).

Results: The participants were primarily first-time mothers and had their deliveries in a hospital setting via cesarean section. A negative evaluation of the birth experience and the care received during and immediately after delivery was observed.

Conclusion: Even in a pandemic context where levels of insecurity, uncertainty, and uncontrollability were inherent, the care and support offered by healthcare teams proved insufficient in a hospital birth setting, despite being undeniably necessary and a priority. The applicability of humanization in perinatal care and its effective implementation were impacted by the naturalization of obstetric violence, minimization of needs, staff reduction, communication deficits among team members, and a lack of empathetic care. The care provided is still not related to female empowerment and the primacy of the mother-baby dyad.

Keywords: Childbirth care; COVID-19; cultural practice; Obstetric violence

1. Introduction

The perinatal period – encompassing pregnancy, childbirth, and the postpartum period – represents a unique stage in women’s lives, marked by intense physical, psychological, and social transformations. Even in normal contexts, these changes can generate various vulnerabilities, especially when adequate family and professional support is unavailable (Pio & Capel, 2015; Simas et al., 2013). This is a time when female empowerment should be guaranteed, ensuring that decisions about the body and childbirth will be based on autonomy and respect. However, in unfavorable contexts, this empowerment is frequently replaced by authoritarian and dehumanizing practices (Reis et al., 2017).

In Brazil, the struggle for the humanization of obstetric care consolidated itself from the 1980s onwards, accompanying the creation and expansion of the Sistema Único de Saúde (SUS). The expression “humanization” was only officially at part of public health politics with the **Programa de Humanização no Pré-Natal e Nascimento** (PHPN), instituted in the 2000s (Brazil, 2000). Since then, this movement has strengthened as an ethical, technical, and political strategy for improving maternal health care, guided by the principles of humanized childbirth and woman-centered care.

However, the persistence of violent practices and the denial of pregnant women’s autonomy reveal that humanization is not yet a universal reality. The so-called obstetric violence – a term encompassing physical, psychological, verbal, symbolic, or sexual conduct, as well as negligence and unnecessary interventions – expresses this contradiction (Brazil, 2016). It is estimated that **one in four Brazilian women** has experienced some type of violence during childbirth (Hamermüller & Uchoa, 2018). Although the term was banned from official documents in the 2010s, under the justification of conceptual inadequacy (Cancian, 2019), the phenomenon remains widely recognized by international organizations and social movements defending women’s rights.

The research “**Nascer no Brasil**” (Leal & Gama, 2014), conducted by Fiocruz, highlighted the magnitude of these practices: 53,5% of the women interviewed underwent episiotomy and 36% to the Kristeller maneuver — both contraindicated by the World Health Organization (WHO, 1996). These data reveal the persistence of a culture of intervention and control over the female body, sustained by institutional hierarchies and gender inequalities.

In the context of the COVID-19 pandemic, this situation was exacerbated. Social isolation, restrictions on health services, and the overload on professionals directly impacted the childbirth experience. Female vulnerability intensified, especially among women living in inland cities who faced territorial and structural limitations in accessing care. Therefore, the research presented here sought to understand how childbirth care was configured in the interior of Bahia state during the first year of the health crisis, giving voice to the women who experienced this process and contributing to reflection on obstetric practices in times of humanitarian emergency (Reichert et al., 2022; Stewart et al., 2017).

2. Methodology

Due to current social distancing measures, this is a quantitative-qualitative, descriptive, and exploratory study focused on analyzing the childbirth experience of women residing in the interior of Bahia state during the first year of the COVID-19 pandemic. The study was conducted between **march 2020 and march 2021**, a period considered the most critical of the health crisis. The research was advertised through social media and was linked to the project “Impactos psicossociais da assistência ao parto: período crítico da pandemia por COVID-19 na Bahia”, registered with Conselho Nacional de Ética em Pesquisa (CONEP) under numbers CAAE: 32934720.3.0000.5556 e Parecer: 4.291.630, em 22/09/2020.

Due to current social distancing measures, data collection was conducted entirely remotely, using a digital platform specifically developed for the

study. Participants were postpartum women who gave birth during this period and resided in municipalities within the Microregion of Health of Vitória da Conquista, located in south-central Bahia state. The choice of this territory is justified by the regional relevance of Vitória da Conquista, which stands out for having pioneering legislation focused on the humanization of childbirth — such as Law nbr. 2.277/2019, which ensures the right to the presence of a doula, and Law nbr. 2.228/2018, which establishes guidelines for the prevention of obstetric violence.

Primiparous and multiparous women were included, selected by convenience sampling, after accepting the **Informed Consent Form**. The questionnaire was made available in a virtual environment and contained, in addition to the **sociodemographic data**, three instruments validated for the Brazilian context:

1. **Questionário sobre a Experiência de Parto (CEQ-2BR)** – adapted and validated version for Brazil, built from this same database (Santos et al., 2022);
2. **Questionário de Avaliação de Violência no Parto (QAVP)** – Developed and validated by Palma and Donelli (2017), designed to identify practices of obstetric violence perceived by postpartum women;
3. **Escala de Medo da COVID-19 no Período Perinatal** – originally developed by Ahorsu et al. (2020) and subsequently validated and adapted for the Brazilian perinatal context by Barros et al. (2021).

The data collection allowed for the gathering of information on sociodemographic conditions, perceptions of fear and insecurity related to the pandemic, as well as experiences of support, respect, and empowerment during childbirth. The analysis of quantitative data was conducted using descriptive statistics, while open-ended responses were examined according to thematic content analysis principles, allowing for the capture of the narratives and meanings

attributed by the participants to their childbirth experience in a pandemic context.

This methodology made it possible not only to describe the impacts of the pandemic on obstetric care in the interior of Bahia, but also to highlight subjective and relational dimensions of care, which are fundamental for strengthening public policies of humanization and for recognizing women as protagonists of their labor and birth processes.

2. FROM FEAR TO RESILIENCE: STORIES SHARED BY THE PARTICIPANTS

The COVID-19 pandemic created a scenario of fear, uncertainty, and disorganization in health services, directly affecting women's childbirth experience. Under the guise of sanitary measures and safety protocols, several rights were suppressed, including the right to have a companion present during childbirth, guaranteed by Federal Law nbr. 11.108/2005. The narratives show that the absence of a companion was not due to strictly technical reasons, but to weaknesses in management and the lack of coherence in institutional protocols.

"I didn't have a companion because of the pandemic protocol; no hospital allowed it." (Mother, 36)

"My husband wasn't in the delivery room because of the pandemic." (Mother, 76)

"I was left alone in the hallway waiting for the pain relief, at the door of the operating room. I wanted my doula and my husband to be there while they cleaned the room, but I couldn't." (Mother 63)

The accounts reveal **loneliness, fear, and abandonment**, feelings amplified by the absence of a support network at a time of extreme vulnerability. The deprivation of the presence of significant people—partners, doulas, or family members—left the women helpless in the face of technical procedures dominated by a hierarchical and depersonalized logic. When the interventions ceased, many reported that companions were allowed to

enter, demonstrating inconsistency and arbitrariness in the institutional management of care.

3. Results - Content analysis and discussion

3.1 THE FRAGILITY OF HUMANIZATION AND THE RETURN OF CONTROL OVER THE FEMALE BODY.

The promise of a humanized practice, based on the autonomy and empowerment of women, proved to be far removed from the reality experienced by many participants. Decisions about the body and childbirth were frequently made without dialogue, revealing **a care model centered on the convenience of the team, and not on the needs of the woman.**

"They didn't let me choose which anesthesia would be used." (Mother 81)

"I wanted a natural birth without interventions, but during the pushing stage I ended up requesting pain relief... sometimes I still remember the moment of delivery and think that I wasn't strong enough." (Mother 08)

"I missed having a doula. I will always wonder if my son couldn't have been born naturally or if I prevented him from doing so by choosing a cesarean section." (Mother 64)

These narratives reveal the **subjective blaming** of women and the **symbolic control over the female body**, typical of an authoritarian obstetric culture. The ideal of "strength" and resistance becomes a moral criterion, while emotional support and respect for choice are neglected.

3.2 ABANDONMENT AND DENIAL OF CONNECTION: LONELINESS AFTER BIRTH

The absence of a companion, a doula, or a sensitive team produced a profound feeling of **emotional abandonment**, especially in the minutes following childbirth—a moment considered sacred and fundamental to the mother-baby relationship.

"I had no contact with my son when he was born." (Mother, 63)

"They didn't give me my baby to breastfeed right after the birth." (Mother 05)

"They didn't make skin-to-skin contact. They handed the baby to the father and didn't allow me to see the baby being born." (Mother 77)

"They tried to force me to give my baby formula in the hospital." (Mother 81)

"They didn't lower the sheet to see the baby coming out." (Mother 18)

These practices contradict established recommendations from the World Health Organization and the Ministry of Health, which advise skin-to-skin contact and encourage immediate breastfeeding, even in pandemic contexts, as long as hygiene and protection measures are respected (Oliveira et al., 2021). Literature shows that this early contact promotes hemodynamic and respiratory stabilization, strengthens the bond, and regulates the emotional state of the mother-baby dyad (Silva & Braga, 2019). Deprivation of this moment constitutes not only a technical failure but also a symbolic rupture in the experience of becoming a mother.

3.3 NORMALIZED VIOLENCE AND THE BODY AS A TERRITORY FOR INTERVENTION

The reports also reveal practices discouraged by the WHO since 1996, such as the routine use of episiotomy, excessive use of oxytocin, and the Kristeller maneuver — which involves pressing on the parturient's abdomen to accelerate the baby's delivery. These practices violate the principle of non-maleficence and demonstrate the persistence of **interventionist and violent models.**

"It prevented me from choosing the type of delivery." (Mother, 45)

"Episiotomy without my consent." (Mother, 53)

"I received a high dose of oxytocin, which the nurse commented on with surprise, as it wasn't normal." (Mother 36)

"I felt like a tube of toothpaste." (Mother 36)

"Pushing the baby with my arm to facilitate delivery." (Mother 85)

The vivid description of these experiences allows us to understand childbirth as **a field of symbolic and bodily disputes**, in which the woman's body is the object of intervention and not the subject of experience. By removing the power of decision, the team reinforces gender inequalities and legitimizes institutionalized control practices under the discourse of "technical assistance."

3.4 LACK OF PREPAREDNESS, INSENSITIVITY, AND MECHANIZATION OF CARE

The pandemic exacerbated the formative and relational weaknesses of healthcare teams. The women's accounts reveal **disorganization, haste, coldness, and a lack of empathy**, exposing the precarious working conditions and the ethical void in care.

"The on-call pediatrician at the hospital stood right in front of me, asking the obstetrician about my progress, as if she were rushing me." (Mother, 55)

"They cut my abdomen open before my companion even entered the room." (Mother, 78)

"I gave birth during the shift change... the staff were more concerned with the clock than with me." (Mother, 32)

"They brought my baby and I couldn't see because they had taken my glasses." (Mother, 56)

"Too many people in the room unnecessarily, just spectators." (Mother, 81)

These narratives starkly reveal the disconnect between the discourse of humanization and actual practice, highlighting the predominance of the technification of childbirth and the loss of the sense of care as a relationship. The lack of empathy and clear communication appears as one of the biggest

complaints, suggesting the urgency of rethinking the ethical and emotional training of healthcare professionals, based on the ethics of care (Gilligan, 1982; Silva et al., 2020).

The ethics of care proposes a reversal of perspective: recognizing the other as a subject and prioritizing connection, respect, and listening as the foundations of professional action. What the participants' accounts demonstrate is that, even in the face of fear and vulnerability, a resilient strength and a desire to give new meaning to their experiences emerged from them. By sharing their stories, these women transform pain into denunciation and silence into resistance.

3.5 FROM TRAUMA TO RESILIENCE: LESSONS LEARNED AND URGENT NEEDS

The experiences recounted by the postpartum women are not limited to the exposition of episodes of violence, but express **the power of memory and the capacity to process trauma**. Even months after childbirth, the memories remained vivid, indicating the profound emotional impact of obstetric experiences.

In the context of research, recalling these episodes represents an act of **symbolic reappropriation** — a gesture of reconstructing one's own narrative and reaffirming the right to dignified care. Just as the collective response to the pandemic demanded adaptation and learning, so too do childbirth assistance services need to **learn from these experiences** so that future health crises find teams that are better prepared, sensitive, and committed to the principles of humanization and women's rights.

4. Results

4.1 PROFILE AND CONTEXT OF BIRTHS

Most participants gave birth in a hospital setting (97%), predominantly **cesarean way section (61%)**, a proportion higher than the national average of 53.77%. The municipality of **Vitória da Conquista**, the headquarters of the health macro-region and a maternal and child health referral center, concentrated

all respondents, with the exception of one participant whose delivery occurred in the municipality of Belo Campo. This predominance was expected, since Vitória da Conquista has a higher concentration of maternity wards and hospital infrastructure compared to neighboring municipalities.

The results reflect the national panorama in which hospital births are hegemonic, and cesarean sections are often **normalized as the standard choice**. In 2022, the National Supplementary Health Agency (ANS) recorded rates of up to 82% of cesarean sections in hospital births, reaching **88% in the private sector** (Leal & Gama, 2012). This trend expresses the phenomenon of the **“cesarean culture”** (Nakano et al., 2016), which, although socially legitimized, has been associated with subjectively more negative experiences and a feeling of loss of control (Henderson & Redshaw, 2013).

4.2 EMPOWERMENT AND SATISFACTION WITH THE ASSISTANCE

Satisfaction with the care received showed a direct correlation with **the preservation of female autonomy** during childbirth. The women who

reported greater satisfaction with the care were those who were able to make **conscious choices**: they opted for pain relief resources (such as analgesia), decided on the most **comfortable position**, received adequate information, and actively participated in decisions regarding interventions and care.

These findings confirm that **autonomy is a positive determinant of the birth experience**. Women who experienced a participatory, informative, and respectful environment gave higher ratings to the care provided, while those whose choices were restricted reported feelings of insecurity, fear, and frustration.

In general, the literature confirms this association: **satisfaction with care** is closely linked to the **quality of information provided and the feeling of control over the process** (Domingues, 2004). In the present study, a significant correlation was observed between the satisfaction indicators and the dimensions of the **Childbirth Experience Questionnaire (CEQ-2BR)**, as demonstrated by Spearman's correlation analysis:

| Variables | CEQ- Pain management | CEQ- Decision making | CEQ- Information received | CEQ- Choice of position |
|-----------------|----------------------|----------------------|---------------------------|-------------------------|
| Rho de Spearman | 0.349*** | 0.562*** | 0.586*** | 0.302** |
| p-value | < .001 | < .001 | < .001 | 0.004 |

Nota. $p < .05$, $p < .01$, $p < .001$

These results show statistically significant correlations between the **quality of communication and the level of satisfaction**, reinforcing that autonomy and dialogue are central variables for a positive birth experience.

4.3 INFORMATION, LISTENING, AND SHARED DECISION-MAKING

The provision of **clear and timely information** proved to be one of the most decisive aspects in the

perception of care. Women who reported greater access to information were also those who rated the care more highly. This correlation suggests that **effective communication is a protective factor against fear and insecurity**—feelings intensified during the pandemic context.

The availability of understandable information and the opportunity to engage in dialogue with the team act as mechanisms for **reducing anxiety** and

strengthening trust, constituting fundamental elements of humanizing childbirth. This finding corroborates the **guidelines of the “Nascer no Brasil”** survey (Leal, 2018), which emphasizes the importance of active listening and shared decision-making as pillars for improving maternal and neonatal health indicators.

4.4 BODY AUTONOMY AND PERCEPTION OF CARE

Participants who had the freedom to choose their birthing position and decide on the use of analgesia showed **higher levels of satisfaction** with the care received. This data reinforces the principle of **bodily autonomy** and the right to **active participation** in the birth process.

These dimensions of choice and freedom, as pointed out by Leal (2018) and Dodou et al. (2014), directly influence the perception of safety, the bond with the team, and the construction of **positive memories** about childbirth. When the woman's protagonism is respected, care tends to become an empowering experience rather than one of submission.

On the other hand, when the imposition of behaviors and control over the female body prevail, the experience becomes negative, compromising emotional well-being and the beginning of the mother-baby relationship.

4.5 FEELINGS, FRUSTRATIONS, AND EMOTIONAL IMPACTS

The reports revealed strong correlations between positive feelings (**happiness, strength, and security**) and **satisfactory evaluations of the care received**. The presence of a cohesive team, a safe environment, and respect for women's potential were factors associated with the creation of positive childbirth memories.

The presence of a family companion has also been identified as a **protective factor** for women's emotional health and their perception of humanized care (Dodou et al., 2014; Souza et al., 2016). The

bond established between the woman and the team forms a two-way street: the higher the quality of care, the greater the satisfaction—and reciprocally.

Conversely, **the highest levels of frustration and negative memories** were related to low satisfaction with the care received and a lack of agency. Some participants reported **memories associated with pain, loneliness, and feelings of inferiority**, demonstrating the persistent psychological impact of traumatic childbirth experiences.

These results are consistent with the study by Preste & Ferreira (2021), which identified, during the COVID-19 pandemic, an **exacerbation of feelings of fear, loss of control, and insecurity** among pregnant and postpartum women. According to Rodrigues & Schiavo (2011), these emotional states can be aggravated by factors such as fear of fetal death, lack of a support network, financial and marital concerns, and uncertainties about one's own body— aspects that are especially sensitive among **first-time mothers**, the predominant group in this study.

In this scenario, **29% of women** reported feelings of vulnerability and insecurity, and **22.5%** described **feeling threatened** by the attitude of healthcare professionals. These findings confirm the need to consolidate practices based on empathy, listening, and ethical care, especially during periods of health crisis.

As Gutman (2021) points out, childbirth should be a unique, singular, and affirmative experience for each woman. However, in the pandemic context, this uniqueness has, in many cases, been replaced by experiences of fear, loneliness, and violation of rights—experiences that challenge the fundamental principles of humanization and reveal the **persistent tensions between technique and sensitivity in contemporary obstetric care**.

5. Conclusion

The results of this research offer valuable insights into the childbirth experiences of women residing in the south-central region of Bahia, especially within

the critical context of the COVID-19 pandemic. The evidence reveals that **female empowerment in childbirth** — a central element of humanized care—remains an ideal far removed from reality, marked by asymmetrical practices and the persistence of authoritarian and interventionist approaches.

Although the **right to have a companion present** is guaranteed by **Law nbr. 11.108/2005**, many participants reported experiencing childbirth alone, under justifications linked to inconsistent health protocols. While the Ministry of Health, at the time, published **non-prohibitive technical guidelines** on the presence of companions, the accounts point to restrictive and arbitrary interpretations by some teams and institutions. Such conduct needs to be widely debated so that it does not become established precedents in future health crises.

Fear, a central element in women's experiences, was predominantly related to **self-preservation and uncertainty in the face of the unknown**. In a scenario of scarce information and invisible risk, fear did not emerge as a pathological trait, but as a human response to a collective threat. Even so, the findings suggest that **insecurity and the absence of emotional support** amplified this feeling, directly affecting the perception of acceptance and quality of care.

Correlational analysis demonstrated that **satisfaction with childbirth is closely associated with the possibility of choice, effective communication, and a sense of control over one's own body**. Women who felt heard and respected rated the care received significantly more positively. Conversely, restrictions on autonomy and the imposition of medical procedures increased the incidence of negative memories and feelings of frustration. These results are consistent with national and international literature, reaffirming that **female empowerment is a protective factor for emotional health and a positive childbirth experience**.

The combined use of the applied instruments — **CEQ-2BR, QAVP, and the Escala de Medo da**

COVID-19 no Período Perinatal — proved adequate and sensitive in detecting the proposed constructs, allowing for the capture of both quantitative and subjective nuances of the birth experience. The observed correlations reinforce the validity of these instruments for future studies, including in intercultural or interregional contexts.

Although the pandemic created a **context of exceptionality and vulnerability**, it did not prove to be the main determining factor in dissatisfaction with care. What proved to be more preponderant was the **presence (or absence) of practices based on humanization**, such as the right to choose, respect for the body's time, and an empathetic bond with the healthcare team. Thus, it can be stated that **the greatest challenge is not only in dealing with health emergencies, but in consolidating ethical and relational structures that support care in any circumstance**.

In summary, **reducing fear and increasing women's empowerment** emerge as central strategies for improving the childbirth experience. Informed, confident women who actively participate in the process tend to develop **positive memories and greater satisfaction** with the care received. The results of this research, by illuminating the intersections between gender, territory, and the pandemic, reaffirm the **need for ongoing investments in the ethical and technical training of healthcare teams, in guaranteeing reproductive rights, and in promoting care that recognizes childbirth as a human, social, and emotionally significant event**.

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