

Women's experiences in institutional childbirth care in times of the first and second waves of COVID in Mexico

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THEMATIC ARTICLE

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Abstract *This is a qualitative study that explores the perspectives and experiences of a group of Mexican women who experienced institutionalized childbirth care in the first and second waves of the COVID-19 pandemic. Through a semi-structured script, nine women who experienced childbirth care were interviewed between March and October 2020 in public and private hospitals in the city of San Luis Potosí, Mexico. Under the Grounded Theory analysis proposal, it was identified that the health strategies implemented during the pandemic brought with them a setback in the guarantee of humanized childbirth. Women described themselves as distrustful of the protocols that personnel followed to attend to their births in public sector hospitals and very confident in those implemented in the private sector. The intervention of cesarean sections without a clear justification emerged as a constant, as did early dyad separation. Healthcare personnel's and institutions' willingness and conviction to guarantee, protect and defend the right of women to experience childbirth free of violence remain fragile. Resistance persists to rethink childbirth care from a non-biomedicalizing paradigm.*

Key words *Pandemics, COVID-19, Delivery, Humanizing Delivery, Obstetric Violence*

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Introduction

Although at the beginning of the pandemic little was said about the risk of pregnant women from the SARS-CoV-2 virus, it was in August 2020 that the World Health Organization (WHO) made public the fact that pregnant women were more susceptible to developing severe forms of COVID, requiring admission to Intensive Care Units (ICU), and even despite this, to progress until death¹.

According to epidemiological monitoring reports from the Pan American Health Organization (PAHO), as of May 2021, in the Region of the Americas, 202,101 pregnant women positive for SARS-CoV-2 had been reported as well as 1,271 deaths (0.63%) associated with the disease in the same population group; figures that showed a substantial increase in relation to the number of confirmed cases in 2020 in at least 12 countries on this continent. The highest Maternal Death Ratio was reported for Mexico with 20.9 and Paraguay with 9.8, whereas the most alarming fatality rates were reported for Brazil with 7.22 and the Dominican Republic with 7.11².

In Mexico, the Department of Health reported that, as of August 2021, 73,785 pregnant/postpartum women with suspected COVID-19 had been monitored, confirming positivity to the infection in just over a quarter (27.6%). A total of 389 deaths with a cumulative fatality rate of 1.91% quickly placed COVID-19 as the first cause of Indirect Maternal Death in Mexican territory³.

The WHO and PAHO launched the epidemiological alert for COVID-19 during pregnancy on August 13, 2020, calling on the countries of the world to redouble their efforts to guarantee prenatal and natal care, but particularly to promote strategies to reduce morbidity associated with COVID-19 at all healthcare system levels. The recommendations issued included interventions focused on preventing new infections, but also those aimed at guaranteeing timely and quality care to avoid serious complications and/or deaths⁴. These organizations were also punctual in reiterating the right of all women, including those who are suspected or confirmed cases of COVID-19 infection, receiving quality care before, during and after childbirth, including prenatal, newborn and postnatal care, violence prevention and access to mental health programs⁵.

By May 2020, the United Nations Children's Fund (UNICEF) spoke out on the situation that new mothers and newborns would face during

the pandemic, aware of the overflow of health institutions, the shortage of equipment, supplies and qualified human resources. An important part of the available personnel was redirected to caring for patients infected with COVID, and this weakened general care services, including gynecology and obstetrics⁶. Concern also arose from the fact that protocols would be implemented based on very little scientific evidence given the lack of knowledge of the disease, but also in the certainty that we could return to implementing a biomedical care model, which in the last decade had worked intensely to eradicate⁷.

The COVID-19 pandemic repositioned, with more urgency than ever, the State's commitment to being a guarantor of the right to health by guaranteeing its essential elements, such as availability, accessibility, acceptability and adaptability⁸. These terms are described in Chart 1 and are essential to guarantee health as a right.

In the aforementioned context, this research aimed to assess institutionalized childbirth care during the so-called first wave of the SARS-CoV-2 pandemic based on the qualitative exploration of the four aforementioned indicators.

Methods

This is a qualitative study with a Grounded Theory design based on the proposal of Strauss and Corbin, who define it as an "inductive approach in which immersion in data serves as a starting point for the development of a theory about a phenomenon"⁹. This design was identified as relevant, since the interest was to reconstruct the experience of institutionalized childbirth care from women's narratives to identify its configuration, but also to trace the elements that lead to said configuration, in order to being in a position to prepare specific signs and recommendations.

For the theoretical reconstruction of the phenomenon and the articulation of the findings, decolonial feminism's contributions were used, particularly María Lagunes' contributions on the necessary demedicalization of women's bodies and the questioning of power asymmetries that, based on gender status, are deployed in therapeutic relationships that are built from the hegemonic medical model¹⁰.

Women who gave birth in an institutionalized manner in the public and/or private sector of the city of San Luis Potosí, with resolution of vaginal childbirth or cesarean section, with childbirth being induced or physiological, having full-term

Chart 1. Indicators of health guarantee as a human right.

Availability	Guarantee the sufficiency of facilities, mechanisms, procedures or any other means by which the right to health is materialized.
Accessibility	Economic and physical accessibility, access to information and non-discrimination in care.
Acceptability	Services are culturally appropriate, respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life cycle requirements, and designed to respect confidentiality.
Adaptability	Services must be aware of and accommodate the local context. In times of contingency, aspects of infrastructure, organization and care protocols are adapted.

Source: Authors based on indicators that Vázquez and Serrano⁸ propose to assess the guarantee of the right to health.

deliveries from March 2020 to October 2020, participated. To select participants, the theoretical sampling strategy was used, which involved starting with a starting sample, which originated from the assumptions of representation of participants and that after the preliminary analyzes increased until they did not express anything new regarding the object, which is called theoretical saturation¹¹. According to the emerging categories, more participants were identified for the consolidation and reconstruction of categories and thus reach theoretical saturation. This involved searching for participants with traits that emerged in each category.

To participate, participants had to voluntarily sign the Informed Consent Form; in the case of minors, Informed Assent Form was used. The interview was used with the purpose of obtaining data or information from participants through oral interaction. In this study, semi-structured interviews were used, based on planned questions that were adjusted to participants, with the possibility of motivating the interlocutor, clarifying terms, identifying ambiguities and reducing formalities¹². The interview guide was structured to explore the five criteria considered to assess the guarantee of the right to health, accessibility, availability, acceptability, adaptability and quality, and were carried out through virtual platforms (Zoom, Skype) due to social distancing measures derived from the pandemic. They lasted approximately 60 minutes with the possibility of having more than one meeting.

The interviews were audio-recorded, understanding this as the action of only recording the audio for the purpose of supporting the information, but not recording the faces of participants, so the cameras were kept off. Data analysis and

processing was carried out based on the proposal of Strauss and Corbin, through data coding in its three stages: open, axial and selective coding¹³.

Results

Participants' mean age was 28.1 years; eight were between 20 and 30 years old; and one was over 40 years old. The minimum age was 24 and the maximum was 42. Six reported living in marriage and three in a free union. In terms of education, seven had a bachelor's degree; one has a doctoral degree and another has a bachelor's degree; five said they worked in jobs related to their profession; three were dedicated to unpaid work at home; and one was a merchant.

Therefore, six gave birth in a private hospital and three in a public one. Of them, three said they had resorted to their savings or loans to pay for care; two had medical expenses insurance; and two used the health insurances established by the Mexican Social Security Institute with the private sector in the first wave of the contingency. Of the three who gave birth in the public sector, two did so through a social security program and one through a social health protection insurance in Mexico intended for people who do not have social security (INSABI).

Three categories emerged to explain the phenomenon, which we named "Distrust in public institutions and socially constructed certainties around private medicine", "Unnecessary caesarean sections as a resource to contain the risk" and "The return to solitary childbirth and dyad separation". The articulation of these led to the central category "Regression in the guarantee of the right to a humanized childbirth".

Regression in the guarantee of the right to a humanized childbirth

It emerges as a central category after accounting for the return to practices that had been visible prior to the pandemic as inadequate and violent, and which, based on scientific evidence, had been discarded from international and national childbirth care protocols. Below are some of the narratives that show actions associated with what has been called obstetric violence, since they imply actions or omissions that affect women's comfort or even put their lives at risk.

In the operating room, they pushed on my belly, as if to make the baby go down... I only felt that they were pressing and, despite the anesthesia, I felt pain. I told the doctor and the anesthesiologist and she said it was going to go away, and she ignored me (Nohemí, private hospital).

I told the nurse, "Excuse me, I asked for water and as far as I know I can drink water, and they didn't give me water and I would like to see if I could be given the opportunity to wet my lips because I feel very thirsty", and he told me that no and no (Jocelin, public hospital).

It was a shift change and there was a moment when, well, there was no one, some [doctors and/or nurses] arrived and then they left and I said, "What's going to happen?," because I felt like I was almost going to give birth and there was no one (Laura, public hospital).

I saw the nurse very calm, as if she had a lot of time to do things and I already felt like pushing, until the baby started to come out that they started to move, but before that, it was as if they did not want to assist to you, as if they were afraid, as if you were going to infect them with something, yes, as if I saw them with a lot of insecurity (Alexa, public hospital).

Distrust in public institutions and socially constructed certainties around private medicine

The pandemic redoubled citizens' distrust in public healthcare services, and on the other hand, increased the socially constructed certainties around private medicine. All participants said they had wanted their childbirth care to be in a private institution, although not all had the conditions to make this wish come true. The interesting thing about this finding has to do with the fact that what moved women and their families to seek private care was the fear of being infected within public institutions, a fear that led them

to overlook other issues, associated with quality in maternal care, such as the strategies that are implemented to promote attachment and breast-feeding, and respect for childbirth with a companion. The way in which the fear of contagion prevailed can be read in the following narratives.

We talked to the gynecologist and she told us that hospital "X" had more cases of COVID, that it was very saturated with patients, so we said, "Okay, this is the one that has the least patients with COVID, let's go to that one" (Nohemí, 25 years, private hospital).

The thing is that we had already seen several hospitals but the majority that we liked were like no because there is a COVID area and it did scare us (Martha, 27 years, private hospital).

It happened to me in the middle of a pandemic, in the hospitals, in the insurance there were people infected and so on, and I said, I prefer... well, together with my husband, we made the decision to be safe in a private one (Daniela, 28 years, private hospital).

They told us that it was a non-COVID hospital, i.e., that they do not receive patients with COVID, that, at the end of the day, you know that knowing if it was COVID or not is very difficult, right? But being alone in a room (Vanessa, 29 years, private hospital).

The decision about where to give birth was due not only to the false certainties that the neoliberal discourse constructs about the benefits of private medicine, but fundamentally to the discredit that public hospitals that are part of a dismantled health system have gained.

I think that if I went to a public place, the attention would not be the same. I decided to go for a private one to have better attention and to be safer for both my daughter and I (Vanessa, 29 years, private hospital).

It is sad to hear, but it is a reality, the public health sector does not have sufficient resources from the government, but beneficiaries' attention and treatment has always been something that has left much to be desired, now imagine in times of COVID (Arely, 26 years, private hospital).

The three women who delivered in a public hospital described as one of the main disadvantages the delays in accessing care and the risks of contagion, which from their perception increased with said delay. Their stay in obstetric screening and tocosurgery rooms was framed by experiences of stress and anguish due to the possibility of being infected.

I didn't have pain, but there were people who did have pain and they weren't treated. They had

fluid leaking out, and they weren't treated... there we were all together, when isolation was at its maximum, we didn't have security, we had to help to a [woman] that was sitting and her water had broken [sic] and she was even bleeding (Alexa, 25 years, public hospital).

Unnecessary caesarean sections as a resource to contain the risk

In private hospitals, regardless of whether care derived from a health insurance or medical expense insurance, it was reported that care was much more agile and even immediate. We are concerned about having identified the practice of unnecessary cesarean sections, scheduled surgeries with the argument of shortening length of stay of women in clinics, and/or anticipating births given the prognosis in the virus' epidemiological behavior. Caesarean section was seen as a resource that involved risks and in that sense was not entirely desirable. It was reconfigured into a positive option highly linked to the idea of reducing the risk of contagion within the hospital.

I arrived at 05:30 a.m., it was already scheduled, they asked me for my IFE and who was responsible for me for any situation, I filled out my admission papers, they assigned us the room but they took me directly to the operating room preparation area for the same reason that they did the cesarean section, so that I wouldn't have to spend hours giving birth (Karla, 42 years, private hospital).

I had heard about humanized childbirth and I did want my baby to be with me for the first few minutes, breastfeeding and so on, but they told me, "No, that is a long time, it takes a long time, because of the pandemic the most practical thing is a cesarean section and a fast one" (Daniela, 28 years, private hospital).

It was scheduled, it was brought forward a week, you tell [your doctor], "Hey, I'm going to schedule a cesarean section for that date", you see the availability of the operating room and they tell you yes or no, it's already arranged, it's scheduled, everything quickly (Karla, 42 years, private hospital).

The return to a solitary childbirth and dyad separation

The right to birth in company and early attachment was violated in public and private sector institutions, under the argument that the healthy distance policy made the couple's presence in the

operating room or contact with their newborns unfeasible. The denial of these rights was much more evident for women who had a history of previous births and had had the opportunity to experience these with support and with the promotion of early attachment to their children.

Before you were supposed to have a partner during your birth and now we were completely alone, they had me almost until the last one, I even felt forgotten because there was a moment in which I felt that my baby was no longer moving and I started to get scared, and then the pain, and then the breathing, i.e., like at that moment I forgot how to breathe, many things came together (Jocelin, 27 years, public hospital).

Because of the risk of contagion, they told us that it was going to have to be a solo birth, no one would be able to accompany me other than the necessary medical personnel... they did not let my husband enter (Arely, 26 years, private hospital).

That they didn't let my husband pass was dreadful, because it is a moment that you say is two, there couldn't have been many people in the operating room. We also didn't know if it was true that the Ministry of Health was going to close them down, we never knew, but I'm not going to put myself there and risk them being closed down for putting myself there with my rebellion (Daniela, 28 years, private hospital).

You see that, in private ones, they give you the opportunity for your husband to attend the birth, so, for example, we had already contacted several hospitals, but there were some who told us that the husband could not come in and that the baby was not taken to the room to avoid any type of risk (Vanessa, 29 years, private hospital).

They reported that premature separation from their babies affected their bond and the establishment of breastfeeding.

They told me, "No, it's just that the baby usually stays in the nursery, we will just give him to you when it is time to eat" and because of COVID, it was not rooming-in. Because I am a nutritionist, so it was like "beat it" and they scolded me (Martha, 27 years, private hospital).

I couldn't breastfeed her while a nurse was there and said to me, "Do you want to see your baby?", but I only stayed for about five minutes because they told me, "We have to take her away, excuse me, but I have to take her now", supposedly as a protocol of how they are doing due to COVID, they did not allow the mothers and babies to have it together (Nohemí, 25 years, private hospital).

They took her to me that day for just an hour, I got better at three in the afternoon, she was there

in that little capsule for about forty minutes, afterwards the nurse told me, "Say goodbye because she's going to nurseries", he just showed her to me from afar and changed her... (Daniela, 28 years, private hospital).

These decisions not to bring newborns closer to their mothers or to deny dyad entry to the delivery room make more sense if one considers that, within the institutions in which their birth took place, no adjustments were implemented regarding the restriction on healthcare personnel entry and circulation, which resulted in non-compliance with the measures dictated by national policy to mitigate COVID-19 transmission. Added to the high flow of institutional actors within the tocosurgery areas, it is important to consider that adjustments were not made regarding the infrastructure conditions of this type of services, which, as other authors have pointed out in advance, are designed to care for births from a maquila and/or serial logic, where little respect is given to the privacy and intimacy of birth.

Living their birth experiences within unknown spaces, without sources of family support and within a space represented not only as something unknown but also dangerous, influenced them to live their experience in situations of anxiety and stress when they thought they were exposed to possible contagion.

In the observation [labor] area, there were about twenty or more of us in a single room... we were in the hallway, some were in the cubicle that belonged to them as stretchers, but no, for others, we were in front of them, as if we were at their feet but in the hallway, right there in that same room (Alexa, 25 years, public hospital).

This saturation of spaces was not experienced in private clinics, mainly because the infrastructure has elements that allocate spaces of privacy and intimacy for users.

Discussion

This research aimed to assess institutionalized birth care during the first and second waves of the SARS-CoV-2 pandemic based on qualitative exploration of the indicators that Social Protection Human Rights has established to guarantee access to health as a human right.

According to participants' experience, hospital care returned to practices that detract from humanization of childbirth, constituting a setback in terms of women's human rights and particularly in terms of reproductive rights. The

above is extremely worrying in a country like Mexico, in which obstetric violence has been recognized as a form of violence against women in the legal frameworks of 24 of the 32 federal entities, and in six it has been classified as a crime¹⁴.

The perception of risk led women to decide alternative trajectories of obstetric care, which has also been reported in studies that precede ours¹⁵. In our study, given the participants' socio-demographic conditions, they decided to follow a privatized medical service. Other studies carried out in rural and marginalized populations have indicated that seeking care is directed towards obstetricians and midwives^{16,17}.

Although the choice of alternative trajectories of obstetric care is a citizen right of women and their families, it is necessary to highlight that, in this case, care trajectory modification occurred due to the infodemic that framed the phenomenon throughout the world, but particularly in Latin America, where it has been noted that governments showed indolence in the face of the generation and spread of false, inaccurate or misleading information about the disease behavior, the measures to contain it, and they were not convincing regarding the effectiveness of the protocols implemented in the institutions¹⁸.

We consider the fact that fear has framed decision-making regarding care to be worrying, not only because psychoneuroimmunology speaks of the potential that this emotion has to affect the immune response¹⁹, but also and mainly because fear affects the establishment of priorities in an unrealistic way, in this case, in the search to avoid contagion. Women accepted unnecessary conditions and procedures that not only did not reduce their risk, but also led to other equally relevant risks, such as the practice of cesarean sections or premature dyad separation; these practices compromise the early introduction of breastfeeding, since it is documented that starting breastfeeding within the first 30 minutes of life enhances breastfeeding success and significantly reduces the risk of perinatal and infant death.

Authors who have documented the negative impact of birth and newborn care protocols during the pandemic have been emphatic in pointing out that the way breastfeeding is being affected can cause serious repercussions in an increase in the risk of childhood diseases that have been contained thanks to breastfeeding practice, particularly in the most marginalized and impoverished regions²⁰.

We also identified that, in the urgent need to provide themselves with certainty of immunity in

the midst of a chaos of information and mistrust, women opted to follow medical advice. Derived from this, they considered elective cesarean section as a valid resource to reduce or control the risk, even when international protocols were insistent on discouraging the performance of elective cesarean sections for the purposes of risk reduction, even in women confirmed as positive for COVID, since any possibility of vertical transmission has been ruled out²¹.

Despite the above, other investigations were identified in which, during the pandemic, a significant increase in the number of newborns obtained by cesarean section was documented without identifying convincing reasons for its performance²².

On the other hand, the return to the experience of giving birth alone was evident. This was also documented in research generated in other countries, such as the United States, Spain, Portugal, Brazil and Argentina^{15,23,24}. However, the isolation reported by participants in this study was more dramatic than that reported in previous studies, and even that which had been documented in Mexico in the pre-pandemic, since during the pandemic, isolation was not limited to denying the companion of a family member or significant other, but also implied a closer relationship between healthcare personnel and users. This situation to date has not been reported in another study, since although Viera documents that in countries such as Brazil and Portugal they suspended the presence of doulas and visitors in delivery rooms. They did not document any modification or distancing in doctor-user and nurse-user therapeutic relationships, as identified in the narratives of participants in this study¹⁵.

Although denying companion might seem like a minor issue, it becomes relevant, since it has been documented that this practice places women in a greater position of vulnerability, both physically and emotionally¹⁷, and that in times of pandemic, it behaves as a doubly stressful variable since fear of an unknown space no longer prevails only, but now it is configured in the imagination as potentially contaminated²⁵. Sandler has also been punctual in pointing out that the absence of meaningful companion increases the chances that women will be pressured to accept unnecessary obstetric practices and interventions²².

Dyad separation was another practice that women report having experienced in their childbirth experiences, despite the fact that, early in the pandemic, international organizations recognized that promoting skin-to-skin contact early would have a positive impact on the immunological performance of children and their adaptation to the extrauterine environment, which would also reduce the need for procedures and techniques that require close contact with healthcare personnel²⁶. On the other hand, it was evident that the absence or delay in implementing adjustments in the organization of services to contain the risk coincides with what other studies have reported regarding the fact that the health units involved did not make any effort to make adjustments in accordance with national and international recommendations with a view to minimizing the exponential spread of the disease, reducing health system burden and preventing the spread of the pandemic^{27,28}.

Final considerations

In this investigation, it was possible to document how, within the framework of the COVID-19 pandemic, the right of women and their children to experience humanized childbirths supported by scientific protocols was violated. The performance of unnecessary cesarean sections, early dyad separation and the imposition of isolation make clear healthcare personnel's and institutions' fragile disposition and conviction to guarantee, protect and defend the right of women to live this life experience free of violence and change the biomedicalizing paradigm on which their practice is based.

It is urgent to strengthen, after the pandemic, the activism that fights for new ways of contemplating bodies and the processes of reproduction and birth, recognizing these experiences as important rituals that signify life itself, where bodies are a means of vindication of human existence and not means of manipulating subjects. The way of being born lays the pillars for good living and a dignified life, because, in terms of decolonial feminism's contributions, giving new meaning to the way in which we conceive the body and its processes gives new meanings to the ways in which we relate through them.

Collaborations

KD Ríos González: protocol construction, data collection and analysis. YY Rangel-Flores: original idea, advice on protocol construction, advice on data collection and analysis, article writing.

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