REVISTA DE LA FACULTAD
DE CIENCIAS DE LA SALUD
Vol. 27(2):177-186, August - November 2024
i-ISSN 0123-7047 e-ISSN 2382-4603

Original Article

Experiencing family care for premature newborns during the COVID-19 pandemic

Experiencia del cuidado familiar de recién nacidos prematuros durante la pandemia de COVID-19

Experiência de cuidados familiares a recém-nascidos pré-termo durante a pandemia de COVID-19

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ARTICLE INFORMATION:

Article received: November 16, 2023
Article accepted: November 30, 2024
DOI: https://doi.org/10.29375/01237047.4830

How to reference. Chagas-e Silva GN, Pino-Rivera PA, Martins-Ruthes VBTN, Azevedo-Mazza V, Weissheimer-Kaufmann G, Bueno-Guisso AC, et al. Experiencing family care for premature newborns during the COVID-19 pandemic. MedUNAB [Internet]. 2024;27(2):177-186. doi: https://doi.org/10.29375/01237047.4830

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GNCS. *conceptualization, methodology, validation, formal analysis, research, data collection, original article writing, revision and editing.* ***PAPR.*** *conceptualization, methodology, validation, formal analysis, research, data curation, revision and editing.* ***VBTNMR.*** *conceptualization, methodology, validation, formal analysis, research, data curation, revision and editing.* ***VAM.*** *conceptualization, methodology, validation, formal analysis, research, data curation, project supervision and administration, revision and editing.* ***GWK.*** *conceptualization, methodology, validation, formal analysis, research, revision and editing.* ***ACBG.*** *proofreading and editing.* ***MEBM.*** *proofreading and editing.*

ABSTRACT

Introduction. According to the United Nations, around 15 million premature babies are born worldwide every year. Our work aims to describe the experience of families in caring for premature newborns during the COVID-19 pandemic. **Methodology.** Our study is a qualitative, multiple-case study, conducted between September 2021 and March 2022, with family members of premature newborns who underwent outpatient childcare at a university hospital in southern Brazil that implemented the Kangaroo Method. We collected data through online interviews with a semi-structured instrument and thematic categorical analysis of the data. **Results.** The data analysis resulted in five categories: feelings and experiences; experience in the health service; repercussions of family income and work; family dynamics; and support network with a premature baby. **Discussion.** The experience of prematurity poses a challenge to family functioning and demands a care-centered approach from health professionals. **Conclusion.** Strengthening the family bond and promoting full child development emerge as elements that need to be reviewed and guaranteed, with strategies that seek to mitigate inherent risks and cultivate an environment conducive to the development of each child and their family.

Keywords:
Infant, Premature; COVID-19; Parenting; Child Health; Child Care

RESUMEN

Introducción. De acuerdo a las Naciones Unidas, alrededor de 15 millones de niños prematuros nacen en el mundo cada año. El presente trabajo pretende describir la experiencia de las familias en el cuidado de recién nacidos prematuros durante la pandemia de COVID-19. **Metodología.** Nuestro estudio es un estudio cualitativo de casos múltiples, realizado entre septiembre de 2021 y marzo de 2022, con familiares de recién nacidos prematuros atendidos ambulatoriamente en un hospital universitario del sur de Brasil que implementó el Método Canguro. Los datos fueron recolectados a través de entrevistas con un instrumento semiestructurado y análisis categórico temático de los datos. **Resultados.** El análisis de los datos resultó en cinco categorías: sentimientos y vivencias; experiencia en el servicio sanitario; repercusiones de los ingresos familiares y el trabajo; dinámica familiar; y red de apoyo con un bebé prematuro. **Discusión.** La experiencia de la prematuridad plantea un reto para el funcionamiento familiar y exige un enfoque centrado en los cuidados por parte de los profesionales sanitarios. **Conclusiones.** El fortalecimiento del vínculo familiar y la promoción del pleno desarrollo del niño surgen como elementos que necesitan ser revisados y garantizados, con estrategias que busquen mitigar riesgos inherentes y cultivar un ambiente propicio para el desarrollo de cada niño y su familia.

Palabras clave:
Recien Nacido Prematuro; COVID-19; Responsabilidad Parental; Salud Infantil; Cuidado del Niño

RESUMO

Introdução. De acordo com as Nações Unidas, nascem anualmente cerca de 15 milhões de bebês prematuros em todo o mundo. Este artigo tem como objetivo descrever a experiência das famílias no cuidado de bebês prematuros durante a pandemia da COVID-19. **Metodologia.** Trata-se de um estudo qualitativo de casos múltiplos, realizado entre setembro de 2021 e março de 2022, com familiares de recém-nascidos pré-termo atendidos ambulatorialmente em um hospital universitário do sul do Brasil que implementou o Método Canguru. Os dados foram coletados por meio de entrevistas com instrumento semiestruturado e análise categorial temática dos dados. **Resultados.** A análise dos dados resultou em cinco categorias: sentimentos e vivências; experiência no serviço de saúde; impacto da renda familiar e do trabalho; dinâmica familiar; e rede de apoio com o bebê pré-termo. **Discussão.** A experiência da prematuridade constitui um desafio ao funcionamento familiar e requer uma abordagem centrada nos cuidados por parte dos profissionais de saúde. **Conclusões.** O fortalecimento do vínculo familiar e a promoção do desenvolvimento integral da criança surgem como elementos que devem ser revistos e assegurados, com estratégias que procurem mitigar os riscos inerentes e cultivar um ambiente propício ao desenvolvimento de cada criança e da sua família.

Palavras-chave:
Recém-Nascido Prematuro; COVID-19; Poder Familiar; Saúde da Criança; Cuidado da Criança

https://doi.org/10.29375/01237047.4830 Vol. 27(2):177-186, August - November 2024 Med UNAB ISSN 0123-7047 Impreso ISSN 2382-4603 Electrónico

Introduction

Premature birth is the leading cause of death in children under five years old (1). Premature newborns (PTNBs) are babies born before 37 weeks of gestation. Extremely premature infants are those born before 28 weeks, very premature infants between 28 and 31 weeks, and moderate or late premature infants between 32 and 36 weeks of gestation (2).

According to the United Nations, around 15 million premature babies are born worldwide every year (1). In Brazil, between 2012 and 2019, 23,059,611 live births were registered in the Live Birth Information System, of which 20,574 (0.09%) were extremely premature infants, 122,132 (0.53%) severely premature infants, and 2,188,723 (9.49%) moderate or late premature infants (3). According to data released by the National Alliance for Safe and Respectful Childbirth, in 2019, 300,000 premature births were registered in Brazil, leaving the country in 10th place in the world ranking of prematurity (4).

Although technological advances contribute to higher survival rates, these newborns (NB) have a high chance of developing long-term comorbidities. These comorbidities can have an impact on the family unit, in addition to high health costs for the country (5,6). Prematurity becomes a risk factor for neuropsychomotor, linguistic, cognitive, social and self-care development (7).

The development of a NB also involves its relationship with the context and environment in which they are inserted (8). The home environment is the main determining context in their development (9).

Parenting is an intrinsic factor in child development. It is defined as the set of activities that ensure a child's survival and development in a safe environment, in order to make them progressively more autonomous. Its determinants are the characteristics of the child, the parents, and the context in which they live (10).

Child development is stimulated when access to essential health care centered on the family's needs is provided (6). Specialized monitoring, especially in the first few years of life, is essential in order to check for risk factors that could have an impact on the child's development (5). Childcare consultation plays the role of monitoring the child's development to reduce the occurrence of complications and provide opportunities to achieve full growth and neurodevelopment (11).

The COVID-19 pandemic has brought changes to both the home environment and the health services that care for PTNBs. Health professionals and families then had to adapt to ensure that the child's care was not compromised (12).

The greatest difficulties faced during this period were learning and adapting to the pandemic scenario and the feeling of fear arising from exposure to the virus, as well as social isolation, responsible for intensifying the biological and social vulnerabilities present in the PTNB's family nucleus, which can interfere with their development (13).

Therefore, it is understood that finding a balance between stress and positive factors can help families recognize their potential for better functioning. This process is defined in the literature as the process of family resilience (14). In other words, all families have the potential for resilience if they have, or can identify, protective factors to help them cope and adapt, reinforcing the systemic aspects of families and positive growth (14).

Based on this, our aim was to describe how families experience caring for PTNBs during the COVID-19 pandemic.

Methodology

We conducted a qualitative multiple case study, based on YIN's methodological framework. The proposed case study is presented as a methodological outline that seeks to understand the nature of a social phenomenon in its real-world context (15).

Our study was conducted between September 2021 and March 2022, with family members of premature infants who were undergoing childcare monitoring at a university hospital in southern Brazil that has implemented the Kangaroo Method Policy as a care strategy for PTNBs and Low Birth Weight Newborns (LBWN) (<2,500 grams).

The Kangaroo Method is a Brazilian Health Ministry policy defined as: a model of humanized care, with qualified professionals, which includes biopsychosocial intervention strategies that seek the well-being of the newborn, promoting the active participation of parents and family in early neonatal care. It is divided into three stages: 1) it begins in prenatal care for pregnant women who required specialized care during labor/birth, followed by the newborn's admission to the Neonatal Intensive Care Unit (NICU) or the Conventional Neonatal Intermediate Care Unit; 2) all the care processes started in the first stage continue in the Kangaroo Neonatal Intermediate Care Unit (KNICU). The NB remains continuously with its mother; 3) includes clinical follow-up and support for families by the hospital team and primary care until the NB reaches a weight of 2,500 g. From then on, the PTNB or LBWN is

discharged from the Kangaroo Method and then monitored by primary care or specialized outpatient clinics (16).

The inclusion criteria were: being a family member of a PTNB who weighed 2,500 grams and was monitored in the childcare clinic at this hospital, and whose PTNB was discharged from the NICU at least one month before data collection; and families with at least one electronic device with internet access to participate in the online research. The exclusion criteria were PTNBs with a diagnosis of severe respiratory, orthopedic, or neurological disease at the time of hospital discharge; PTNBs with atypical neuropsychomotor development or home use of medical devices; and family members under the age of 18 at the time of the interview or who had communication difficulties due to foreign language or biological issues.

The strategy for recruiting participants was to invite family members of PTNBs to the childcare clinic with information about the study and scheduling of an online interview.

We used the snowball sampling technique, in which participants could suggest that other family members take part in the study (17). The research was mediated by sample saturation, which consisted of suspending the inclusion of new participants when the data obtained showed repetition (18).

Family members who voluntarily agreed to take part in the research and met the inclusion criteria completed the online Informed Consent Form and were considered research participants. We conducted an audio-recorded interview, lasting approximately one hour, using the online applications WhatsApp® and Google Meet®. The interview was guided by a semi-structured instrument with questions related to our objective.

The interviews were transcribed in Microsoft Word® and returned to the participants for revision and correction if deemed necessary. The interviews were analyzed after the participants' modifications. Family members were identified numerically and subsequently in order to maintain the anonymity and confidentiality of the data.

Data analysis consisted of examining, categorizing, and tabulating the data (15). Each family was considered a case, so the unit of analysis was the family. We chose to use the strategy "treating your data from scratch", in which theoretical propositions are not considered, allowing the researcher to explore the data based on the identified insights and "developing the case description" (15), which facilitates the understanding of the evidence from each family through thematic categories (15). We used Web Qualitative Data Analysis - WebQDA® software to organize the data (19).

The initial coding carried out in the software resulted in 254 references, which were marked with 31 initial codes. These codes were then grouped and reorganized into a hierarchical structure and five thematic categories.

During the preparation and execution of the study, we followed the recommendations of the CheckList - Consolidated criteria for reporting qualitative research - COREQ19. This research was approved by the Research Ethics Committee under opinion No. 4,691,210/2021 and CAAE No. 45468121,8,0000,0096, on May 4, 2021.

Results

Ten PTNBs mothers took part in the study, aged between 21 and 36. Three (30%) had up to 8 years of schooling, five (50%) had up to 11 years of schooling, and two (20%) had more than 11 years of schooling. As for marital status, six (60%) were in a stable union, three (30%) were single, and one (10%) was married. Regarding family income, according to the national minimum wage for the year 2021 (R$1,100.00), one (10%) received less than one minimum wage, nine (90%) received between two and four times the minimum wage, and four (40%) were unemployed.

As for the newborns, one (9%) was very premature and ten (91%) were late premature. One of the families had a twin pregnancy. All the PTNBs had low birth weights.

From the interpretation of the data, five thematic categories emerged: feelings and experiences; experience in the health service; repercussions of income and work; family dynamics and prematurity; and support network.

Category 1: Feelings and experiences

This category describes the experiences and feelings of family members faced with challenges due to the pandemic period. The negative experience of separating the mother-child binomial during hospitalization, due to the mother having COVID-19, was evidenced in the statements, as seen below:

> *When she was born, she went straight to the NICU, and I went to the hospital room because I still had COVID, and after 4 or 5 days I was able to see her. (Family 1)*

> *The first time I was able to hold her, she was five days old, so I didn't even have that first touch. (Family 6)*

Family 3 feels remorse about not being able to breastfeed due to their child's premature birth:

> *At the hospital, I had a lot of milk, and I said I wanted to breastfeed, and the doctors said she [the baby] wasn't*

https://doi.org/10.29375/01237047.4830 Vol. 27(2):177-186, August - November 2024 Med UNAB ISSN 0123-7047 Impreso ISSN 2382-4603 Electrónico

breastfeeding yet and was in isolation. With everything that happened, my milk dried up when we got home and I couldn't breastfeed [...], but I feel regret, there's a bond that can be formed through breastfeeding. (Family 3)

The pandemic awakened a sense of fear in families, as evidenced in the following statement:

Life had a new meaning, brought by the overcoming of challenges experienced during this pandemic period, as evidenced by family 2:

I learned from everything that happened. It was a life lesson. It was an experience that I, my husband, and our family needed to go through to grow as people [...]. We now know how to value life, to see it through different eyes (Family 2)

Category 2: Experience in health services

In this category, the families addressed their experiences regarding access to, organization, and satisfaction with the health services responsible for their PTNBs' consultations during the pandemic.

In family 4's statements, there was a negative perception about the organization of the primary health care that monitored the newborn. At the time, patients with respiratory symptoms were not kept separated from other patients, which led to the interruption of the child's follow-up at the health unit.

I said I'm not going to keep bringing them in because everyone is kept in the same place. They haven't even separated the COVID-19 testing ward from the others. Everyone is kept together. So I didn't go to the UBS anymore. (Family 4)

The following statement show the monitoring of the PTNB focusing on the different specialties of childcare and expressing access to these services, even with the adverse scenario of the moment:

In addition to the hospital, she goes to the pediatric department, the infectious disease unit, and has appointments with a neurologist and a cardiologist. She's already been discharged from the ophthalmologist. The only thing missing is the ENT specialist, who hasn't been called yet. (Family 6)

The following indicate that there was a priority in care within the health services due to the fact that the baby was premature:

It was good, it's difficult to book an appointment in these services. Many people say that they tried to get a consultation, and it wasn't possible, but I did, because he was premature. (Family 7).

In general, the families were satisfied with the care and speed of the health services:

We didn't have any trouble accessing health services. I was actually surprised by the doctors, in six months she's seen them all [...] she went through all the appointments very quickly. (Family 6)

Category 3: Impact of income and work

This category addresses the impact of the pandemic on the family's work and income, and how this has influenced the care of premature babies, as shown below:

It impacted mostly our work, because we deal with people, and we found ourselves unable to work for a month. The money we had had already been spent; there was no money coming in [...]. (Family 8)

Family 6 reports that income has had a direct impact on childcare:

Of course, not having enough income affects my daughter's care. Now, for example, she no longer has her formula. She needs her formula but I can no longer afford to buy it for her, so she drinks normal milk. (Family 6)

Category 4: Family dynamics and prematurity

In this category, we listed the changes in the family routine to meet the demands of their child's hospitalization, during the pandemic:

We went there every morning, afternoon, and evening. Then, when she went to the nursery, I stayed with her from 8 a.m. until 8 p.m. (Family 7)

The development of protective factors is a major factor in changing the routine and, consequently, family dynamics, as shown in the following statements:

We don't go out much, only when she has an appointment, and when we go, we are very careful. I usually take the baby carrier and keep her in it most of the time, then I use hand sanitizer [...] when my husband can take me, or usually we go by Uber [...] but we avoid the bus. I've never taken the bus with her. (Family 1)

I didn't have visitors, I didn't tell anyone when I left the hospital, I didn't post anything. We just locked ourselves in the house, only two people came over. (Family 8)

There was also an impact on leisure activities, as shown in the following statement:

> *We were bohemian [...] but H.'s birth changed everything, especially with the pandemic. (Family 8)*

Category 5: Support network

This category includes the potential of a structured support network, as well as the consequences of one weakened by the pandemic. The following point to structured support networks:

> *My husband was very supportive, my sister was always with me too, and friends were always texting me, calling me to talk, I talked to people basically all day [...]. (Family 1)*

The following statement shows the financial support received by families during the pandemic:

> *I have help from my in-laws, my husband, who gets food stamps and gives me money to buy things. (Family 7)*

The following statement illustrate a weakened support network. The conflicts that arose during the pandemic were a factor in the fragility of the support network, as evidenced by family 5:

> *I have problems with my husband, we've been fighting a lot since the birth because of different opinions about how to raise the baby. We also fight because we're scared of COVID. […]Because of the pandemic, my support network shrunk. My family doesn't take care of themselves or wear masks properly, and this has made it more difficult [...]. The support network diminished too, now it's just my mother and brother.*

Families also exposed in their statement the social isolation as a factor that had a negative impact on the support network:

> *It changed everything, it drove everyone away. The family only met Y. months after he was born. At the beginning, they only saw him in photos and video calls. (Family 2)*

Social interaction is seen by families as a factor in strengthening the support network:

> *When this (pandemic) is over, I'll have more support and the baby can meet more friends and have more contact with the family, go out more (Family 5).*

What does the article contribute new?

With our findings, we can see that experiencing prematurity, especially in a context of adversity such as the pandemic, represents an element of risk for family functioning, since it entails a significant level of stress for parents and challenges in the development of family resilience. And also, for health services and systems to the importance of their organization. It is clear that structured policies for family and PTNB care are a factor in protecting neonatal health and supporting the family.

Discussion

During pregnancy, there is the expectation of returning home with the child, the care process, the affection, and the emotional bond that will be forged with the baby. With the need to be admitted to a NICU, this expectation is shattered, bringing feelings of sadness, helplessness, fear of neonatal death, anxiety, and inability to cope with the situation (20,21).

The emergency care and referral of the NB to the NICU prevents the first golden hour from occurring, proven in the literature to be a fundamental factor in creating the mother-child bond. Early breastfeeding at this time contributes to immunological and psychosocial benefits, as well as preventing neonatal morbidity and mortality and early weaning (22).

Positive experiences in the breastfeeding process are associated with better maternal mental health outcomes. The importance of early breastfeeding was understood by the mothers, as shown in another study (23). Mothers with COVID-19 who had positive expectations about breastfeeding, but were prevented from doing so experienced feelings of frustration, sadness, guilt and loss of control over motherhood, and feelings of remorse, as seen in family 3's statement.

Negative feelings regarding the challenges of caring for premature babies continue after discharge, especially in the context of adversity caused by the pandemic. Newborns still require constant monitoring to keep up with child growth and development (24).

The families' statements express the concern and fear of contagion by COVID-19. These data were also found in another study (12), which mentions fear of being exposed to COVID-19, especially when it comes to public transport, as a factor in discontinuing child health monitoring.

The stressful events experienced, as well as the consequences of COVID-19 infection, are harmful because they generate psychological suffering, affecting

https://doi.org/10.29375/01237047.4830 Vol. 27(2):177-186, August - November 2024 Med UNAB ISSN 0123-7047 Impreso ISSN 2382-4603 Electrónico

the families' resilience. Family resilience involves the potential for recovery (14,25), repair, and growth in families facing serious challenges in life. In addition to the pandemic, the experience of multiple losses, such as the loss of the opportunity to breastfeed, the first skin-to-skin contact, and expectations about the postpartum period, hinders the normative process of resilience.

However, even with negative experiences in the midst of the pandemic, some families had positive ones, as shown by family 8, whose experience of isolation was seen as positive. Viewing life with a new meaning after conflicting experiences was seen in family 2's statement.

While fears increase the risk of family dysfunction, stories of resilience can inspire positive adaptation. Therefore assessing the adverse context and focusing your efforts on making the most of the options available requires accepting what is beyond control and cannot be changed, and directing your attention to present and future possibilities (14). It is important that families receive professional support from the healthcare team, who will listen and help them cope with adverse situations.

One of the prerequisites for parental activity's development is to recognize and interpret the child's condition and needs and to respond appropriately. Parental activities include physical, emotional, and social care (10).

Recognizing children's health needs is a strategy that promotes healthy growth and development. Studies have shown that physical protection and safety are essential for the care of premature children (23), and these needs can be met through periodic assessments. This approach allows for the early identification of developmental changes and provides guidance to families on how to care for the child, reinforcing the importance of quality follow-up after discharge. We emphasize the importance of qualified professionals in the care of PTNB and families to assess child development and provide guidance to families, whether in primary or specialized care services.

The COVID-19 pandemic has brought challenges to healthcare around the world. Health systems had to organize themselves to meet not only the common demands of the population, but especially the demands brought on by the new disease, aiming to reduce its consequences, such as the high number of deaths (12).

In Brazil, Primary Health Care (PHC) is the gateway to the Unified Health System (SUS) and plays a fundamental role in preventing and resolving individuals' health problems. The reorganization of PHC's physical structure was one of the main strategies adopted to reduce the risk of contagion and avoid contact between symptomatic and non-symptomatic patients (26).

When the health crisis was declared, the Health Ministry issued a technical note limiting the attendance of children in health services, in order to avoid crowds in these places. This contributed to the vulnerability of health monitoring, especially of high-risk children, as premature infants are classified (12).

In this study, some of the families sought care at the UBS and experienced the fear of their child being infected by COVID-19 due to deficits in structural reorganization, and thus ended up not attending appointments at the facilities. This is a risk factor for PTNBs due to the lack of professional monitoring of child development in their area, since even specialized care must be shared with the UBS.

Accessing health services is an individual right, as provided for in the Brazilian Federal Constitution (27). Our data showed that accessibility to hospital outpatient services for monitoring the growth of high-risk children was maintained. Another study described that the continuity of in-person monitoring for infants with comorbidities and low birth weight was maintained during the pandemic (28). However, in the same study, the majority of infants born prematurely (58.5%) were not being monitored, resulting in maternal dissatisfaction.

Considering our findings, we can see that in-person consultations were prioritized for high-risk premature babies during the pandemic. We draw attention to the importance of organizing health services to meet the demands of this population, as many PTNBs develop comorbidities and require care from different specialties, thus having repercussions on the quality of care and the satisfaction of the people served. Hospital care, the place where we conducted this study, refers to a hospital that has implemented the Kangaroo Method Policy.

We highlight the different specialties for the care of PTNBs, where families reported referral and access to, as well as the priority of care due to prematurity. Unlike another study (29), which shows that these services were interrupted during the pandemic, thus weakening access for PTNBs.

Another prerequisite for parental development is the family's economic resources. Income is one of the external factors that interfere with the dynamics of care in early childhood development, as it influences the parents' investment in providing the child's basic needs, such as food, clothing, healthcare, housing, and education. Insufficient income can be a stress factor for parents, resulting in conflicts that directly affect childcare (10).

Some families reported that the pandemic caused financial damage to the family unit, worsened by unemployment or the inability to work due to the measures imposed.

As a result of insufficient income, families began to feel insecure and realized the direct impact on their members' care. Similarly (13), economic insecurity, emphasized by the pandemic context, can have a negative impact on the physical and emotional integrity of these children. Therefore, we highlight the need for guidance from professionals so that families can seek access to the government social policies available to help them.

The pandemic changed family structures, causing the need to adapt to new formats and restrictions. At the same time, having a PTNB who needed NICU care contributed to changes in family dynamics, based on changes in daily life.

The mother's stay in the unit is fundamental for strengthening the fragile bond, developing skills in caring for the PTNB, affection, skin-to-skin contact (Kangaroo Method), milking breast milk, among other care measures.

The reports presented in our study show that there was a need for family reorganization to accompany the newborn in the hospital environment. However, spending many hours in a hospital can lead to difficulties in managing situations outside the hospital context (30). It is important to emphasize the role of the NICU's multidisciplinary team in supporting families in this adaptation process.

Having overcome the stress of hospitalization, the challenges remained after discharge during the pandemic period. Families faced the need to adapt to a new routine in order to protect themselves. The main factor that changed family dynamics was the adoption of protective measures to deal with the COVID-19 pandemic, as seen in other studies (12). These factors include the use of a mask, hand sanitizer, more frequent hygiene, changing the means of transportation to take the premature baby to the health service and, above all, isolation.

One of the determinants of parenting is the social support network (10). During the pandemic, the transition home from the hospital was a difficult task for the family, since caring for a premature child requires the help of people close to them. However, the pandemic limited this possibility, reducing contact and availability of a structured support network (30).

Similarly (29), social interaction strengthens the support network and child development, so social distancing had a negative impact on these aspects. Despite the negative experience in terms of socialization, the families showed hope that, at the end of the pandemic, there would be more support. This suggests a willingness to face adversity, emphasizing the positive outlook as a key process in family resilience (14).

Conflict was also seen as a factor in the fragility of the support network, while supportive connections with the extended family are seen as protective factors within the family's roles in childcare and development (10). The support network proved to be fundamental, whether in the form of emotional support, material help, or support with the PTNB. Based on our findings, we can say that the strengthened support network was a fundamental element in the care of the premature baby. On the other hand, a weakened support network made it difficult to live through a period of extreme adversity.

One of the limitations of our study is that it only involved SUS users. This results in a relatively homogeneous sample and may not fully represent the diversity of experiences lived by families in different health contexts or cultures. We suggest that further research with private healthcare patients be carried out to better explore the issue, as well as to allow comparisons with our results.

Conclusion

The pandemic brought a series of emotional challenges, such as fear of contamination, anxiety, and the challenge of drastic change in routine. For the parents of a premature baby, these concerns were intensified, as the baby's health is more fragile and requires special care. Additional emotional stress can negatively impact family dynamics, leading to conflicts.

In our study, it was possible to visualize the experience of the families in a health system capable of adapting and providing adequate care for premature babies during the pandemic. The overload with COVID-19 cases and the need to reorganize health services led to limitations and weaknesses in care. Despite this, it was possible to maintain the child's follow-up appointments and the necessary care in a tertiary service with the implementation of the Kangaroo Method, in which the families already had a bond.

During the hospitalization of PTNBs in the NICU, as well as during their home care, an interconnection was found between social support and family functioning. Because, as mothers perceive greater social support during this period, family functioning tends to improve.

Concern about finances was also a source of tension for families. Economic uncertainty, such as job loss and lack of resources, is a risk factor for parents' mental health. Financial worries can spill over into family dynamics, leading to additional conflicts.

With our findings, we can see that experiencing prematurity, especially in a context of adversity such as

https://doi.org/10.29375/01237047.4830 Vol. 27(2):177-186, August - November 2024

the pandemic, represents an element of risk for family functioning, since it entails a significant level of stress for parents and challenges in the development of resilience.

Understanding the influence of the pandemic on prematurity provides recognition of conceptual and empirical elements for the care of premature children in a changing scenario. It is necessary to promote and qualify strategies implemented by health professionals to strengthen the family and reduce risks that could threaten childhood development. The healthcare team must be able to recognize the patient's needs and offer clinical, emotional, and educational support. These actions are essential for the health of PTNBs in order to support the family during this challenging time.

Acknowledgments

The authors would like to thank the Academic Publishing Advisory Center (Centro de Assessoria de Publicação Acadêmica, CAPA – CAPA) of the Federal University of Paraná (UFPR) for assistance with English language translation and developmental editing.

Conflict of interests

The authors state that they have no conflict of interest.

Funding Sources

This study was funded by Council for Scientific and Technological Development (Conselho Nacional de Desenvolvimento Científico e Tecnológico - CNPq).

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