Special Section
COVID-19

TEXTO & CONTEXTO ENFERMAGEM
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THE DIALOGICAL EXPERIENCE OF BEING A MOTHER OF A CHILD AND A NURSE IN THE COVID-19 PANDEMIC

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ABSTRACT

Objective: to understand the experience of being a mother of a child and a nurse working in the COVID-19 pandemic.
Method: a research study with a qualitative approach, conducted with 17 participants from different cities of the state of São Paulo, Brazil. Data collection took place in the months of April and May 2020, through semi-structured interviews conducted via an open access virtual communication platform. The data were thematically analyzed, based on the Complexity Paradigm.
Results: the absence and mismatch of scientific and systematic information at the beginning of the pandemic, the fragile institutional support, and the concern of contamination of the children generated stress and anguish in the mother-nurses. The support previously offered by schools and family members was hindered by the pandemic, leading to a greater demand for parental care. Creative strategies to provide distraction, as well as religiousness and spirituality were valued to face the chaos experienced.
Conclusion: nurses, while being valued as important frontline professionals in the fight against the pandemic, are invisible in their personal-affective dimension and in that of being a mother. The study indicates the need for structural institutional policies so that mother-nurses are placed in a position of equality and safety for the full exercise of the profession and a healthy intra-family relationship, especially in contexts of adversity such as that experienced during the COVID-19 pandemic.

DESCRIPTORS: Nurses. Child. Preschool child. Mother-Child relationship. Pandemics. Child care. Coronavirus infections. Qualitative research.

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A EXPERIÊNCIA DIALÓGICA ENTRE SER MÃE DE CRIANÇA E ENFERMEIRA NA PANDEMIA DA COVID-19

RESUMO

Objetivo: compreender a experiência de ser mãe de criança e enfermeira atuante na pandemia da COVID-19.
Método: pesquisa de abordagem qualitativa, com 17 participantes de diferentes municípios do estado de São Paulo, Brasil. A coleta de dados ocorreu nos meses de abril e maio de 2020, por meio de entrevistas semiestruturadas realizadas via plataforma virtual de comunicação de acesso livre. Os dados foram analisados tematicamente, apoiados no Paradigma da Complexidade.
Resultados: a ausência e desencontro de informações científicas e sistemáticas no início da pandemia, o frágil apoio institucional e a preocupação de contaminação dos filhos geraram estresse e angústia nas mães enfermeiras. O suporte antes ofertado pelas escolas e familiares foi prejudicado pela pandemia, levando a maior demanda de cuidado parental. Estratégias criativas para proporcionar distração, bem como a religiosidade e a espiritualidade foram valorizadas para o enfrentamento do caos vivido.
Conclusão: as enfermeiras, ao mesmo tempo que são valorizadas enquanto profissionais importantes da linha de frente no combate à pandemia, são invisibilizadas na sua dimensão pessoal-afetiva e do ser mãe. O estudo indica a necessidade de políticas institucionais estruturantes para que as mães enfermeiras sejam colocadas numa posição de igualdade e segurança para o exercício pleno da profissão e da relação intrafamiliar saudável, especialmente em contextos de adversidades como o vivenciado na vigência da pandemia pela COVID-19.

DESCRITORES: Enfermeiras. Criança. Pré-escolar. Relação mãe-filho. Pandemias. Cuidado da criança. Infecções por coronavírus. Pesquisa qualitativa.

LA EXPERIENCIA DIALÓGICA ENTRE SER MADRE DE UN NIÑO Y SER ENFERMERA EN LA PANDEMIA DEL COVID-19

RESUMEN

Objetivo: comprender la experiencia de ser madre de un niño y enfermera en ejercicio de la profesión durante la pandemia del COVID-19.
Método: investigación con enfoque cualitativo, realizada con 17 participantes de diferentes municipios del estado de San Pablo, Brasil. La recolección de datos tuvo lugar en los meses de abril y mayo de 2020 por medio de entrevistas semiestructuradas realizadas a través de una plataforma virtual de comunicación de acceso libre. Los datos fueron analizados temáticamente, sobre la base del Paradigma de la Complejidad.
Resultados: la ausencia y disparidad de información científica y sistemática al inicio de la pandemia, el débil apoyo institucional y la preocupación por contaminar a los hijos generaron estrés y angustia en las madres enfermeras. El apoyo antes ofrecido por las escuelas y los familiares se vio perjudicado por la pandemia, derivando en una mayor demanda de cuidados por parte de los padres. Se valorizaron estrategias creativas para proporcionar distracción, al igual que la religiosidad y la espiritualidad, para enfrentar el caos de la presente realidad.
Conclusión: las enfermeras, a la vez que son valorizadas como importantes profesionales importantes de la primera línea de lucha contra la pandemia, se encuentran invisibilizadas en su dimensión personal-afectiva e de ser madres. El estudio indica la necesidad de implementar políticas institucionales estructurantes para que las madres enfermeras sean colocadas en una posición de igualdad y seguridad para el pleno ejercicio de la profesión para hacer posible una relación intrafamiliar saludable, especialmente en contextos de adversidades como el vivido durante la pandemia del COVID-19.

DESCRIPTORES: Enfermeras. Niño. Niño en edad preescolar. Relación madre-hijo. Pandemias. Cuidado infantil. Infecciones por coronavirus. Investigación cualitativa.

INTRODUCTION

Currently, the most discussed subject is the COVID-19 pandemic and its management, being considered the greatest worldwide threat to public health.[1] Specifically, COVID-19 is the disease caused by the SARS-CoV-2 virus and results in a severe acute respiratory syndrome, among other disorders. It was first identified in the city of Wuhan, Hubei province, China, in December 2019, having spread rapidly across the country and subsequently reaching the whole world.[1] In Brazil, until August 14th, 2020,3,164,785 COVID-19 cases were confirmed, with 104,201 deaths and, worldwide,20,687,815 cases and 750,400 deaths are identified.[2]

Countries and health services have been supporting their efforts on diverse scientific evidence to manage this emergency situation, characterized by exponential and rapid changes.[3] Much information related to the new health reality has emerged in real time, challenging science, and there are still no answers on different levels of the impact of the virus and of the disease on society. Several scholars already indicate that epidemiological research studies on the subject are necessary, but it is also important to understand how the population and professionals are experiencing the pandemic. Isolation and restriction of social contact are configured as control measures for COVID-19, by maintaining a safe distance between people.[4] These measures also changed the routine and the way of organizing life.[5–6]

At the forefront of coping are health professionals, especially the Nursing team. In addition to the demands of the services, these professionals face the objective issues of their lives, their families, their children, and the need to reorganize the routine to serve the population and avoid further chaos in the services.[7] In this context, it is known that the majority of the Nursing workforce is composed of women, and that the care demand for children still remains centered on these figures, despite advances in gender equality.[8] So, paradigms were generated that need to be understood because, in addition to health professionals vital to the success of coping with COVID-19, many of these nurses are mothers and, in this sense, play a multiplicity of equally important social roles.

Being at the forefront of coping with COVID-19 heightens concerns and fears, with an emphasis on the fear of being infected and, therefore, infecting their family members, especially their children.[5] Although it is claimed that children are not a risk group for infection or worsening of the disease, little is known about the evolution of the disease in this population.[9] Furthermore, the impact on children's mental health is highlighted, as they are sensitive observers and react to the stresses experienced by their parents, family and community.[10]

When considering: isolation and restriction of social contact movement related to the preventive measure against the spread of COVID-19; the challenge of reorganizing childcare in this time of crisis; the particularities of the work of mother-nurses; and the possible impact on the care of their children; the question is "How is the experience of being a mother of a child and a nurse working in the COVID-19 pandemic?". The aim of this study was to understand the experience of being a mother of a child and a nurse working in the COVID-19 pandemic.

METHOD

A research study with a qualitative approach,[11] sustained by the theoretical framework of Complexity Paradigm. The word complexity derives from the Latin *complexus*, which means "woven together" or "intertwined". It aims to understand the meaning of complex phenomena, characterized by their instability, non-linearity, and the impossibility of being described in a number of steps and finite space of time. The articulation of the multiple dimensions that make up the studied phenomenon expands the degree of understanding and knowledge that can envision its complexity. The dialogical

principle, understood as the coexistence of two antagonistic elements in the same phenomenon, at the same time, guided the analysis.[12]

A total of 17 mother-nurses were the participants. They were included according to the following inclusion criteria: being a mother of a child between zero and 10 years old, according to the age group recommended by the World Health Organization; being a nurse; and working in a health service during the pandemic, regardless of providing direct assistance to patients with a confirmed COVID-19 diagnosis. The exclusion criterion was being a mother of children diagnosed with a chronic disease due to differentiated care requirements.

The participants were recruited using the snowball technique (Snowball Sampling), a way of locating participants in which each identified participant can point out other key informants, constituting a chain of indications.[13] The first participant (known as the index case) was recruited for convenience in the research group of the study proponents. This participant indicated other mother-nurses who met the criteria, and so on. No participant refused the invitation.

The strategy for data collection was the semi-structured interview, conducted through an open access on-line communication platform. This interview started from questions, previously established by the researchers to guide the conversation with a defined purpose; however, it allows for the introduction of other statements/questions in the direction of understanding what the participant expressed.[11] In the case of this study, the interview script contained three pre-established questions: "How has it been for you to take care of your child at this time of the COVID-19 pandemic? What are your concerns and strategies? How have you managed social isolation?"

Data collection took place in April and May 2020, being carried out by the first three authors of this article. The interview was mediated by the Google Hangout® communication platform. The invitation to participate in the research was made my telephone contact. At that moment, the study, its objectives and data collection strategy were presented and, when the participants stated their interest and availability to contribute, an email was sent to the link of the on-line form. This form included the Free and Informed Consent Form (FICF) and questions related to the sociodemographic characteristics. Also on the phone call, the date and time for the interview was scheduled. The participants chose to conduct the interviews in a place with preserved privacy, at their homes or during work breaks. The interviews were audio-recorded and transcribed in full. They lasted a mean of 25 minutes.

In this study, data saturation was sought by means of a deeper discussion, rich in details and complex with the data in order to ensure the understanding of a phenomenon of interest[11]. Such saturation was found in the 15th interview, when another two interviews were conducted to compose the preliminary results.

The data were analyzed using the technique of inductive thematic analysis, a method aimed at identifying and analyzing qualitative data patterns.[14] The following steps were taken for analysis: familiarization with the data; coding; search for themes; review of themes; definition and naming of themes; final writing. To guarantee greater validity and reliability, the construction of codes and themes was carried out by two independent researchers and validated by a third one. Furthermore, the results were submitted to validation (member-checking) with six mother-nurses for greater data reliability.[15] The choice of these mothers was intentional, considering the representativeness of the different services and municipalities. The themes generated were shared, all of which were endorsed for analysis, and two women presented written contributions to densify the results. This process was conducted via the participants' personal e-mail addresses.

The study met the ethical aspects involving research with human beings, only being started after approval by the Research Ethics Committee. To preserve anonymity, it was decided to identify the participants by means of an alphanumeric coding, according to the chronological order of the interviews, as follows: P1, P2, and so on.

RESULTS

In order to understand the experience of being a mother of a child and a nurse working in the COVID-19 pandemic, it becomes relevant to briefly present the characterization of the participants of this study. According to what is presented in Chart 1, the participants were between 30 and 41 years old, most of them (n=15, 88.2%) were married, and their mean training time was 11.7 years. Regarding their workplace, 12 participants (70.5%) worked in hospital services. Most of them (n=13, 76.5%) had only one child, with the children's ages varying between 1 and 10 years old.

Chart 1 – Characterization of the mother-nurses. São Carlos, SP, Brazil, 2020.

Participant	Age	Workplace	City of origin	Workload[†]	Training time[‡]	Marital status	Age of the children
*P1	38	Pediatric Emergency Department	São Carlos	36	14	Married	4 years old
P2	34	Hospital/Materials Center	São Carlos	40	11	Married	1 year and 8 months old
P3	32	Neonatal Intensive Care Unit	São Carlos	36	10	Married	5 years old
P4	30	Psychosocial Care Center	São Carlos	40	6	Married	3 years old
P5	37	Family Health Strategy	Campinas	36	15	Married	1 year
P6	40	Medical Clinic Ward	São Carlos	36	16	Married	4 years old/ 8 years old
P7	34	Pediatric Ward	São Carlos	36	11	Married	7 years old
P8	32	Nosocomial Infection Control Commission	São Carlos	40	9	Married	3 years old
P9	30	Pediatric Emergency Department	São Carlos	40	9	Single	3 years old
P10	33	Family Health Strategy	Campinas	36	10	Married	2 years old
P11	35	Pediatric Intensive Care Unit	Campinas	30	10	Married	1 year and 11 months old
P12	38	Birthplace	São Paulo	36	15	Married	Twins, 4 years old
P13	33	Family Health Strategy	Campinas	36	12	Married	2 years old/ 4 years old
P14	36	Medical Clinic Ward	São Carlos	36	13	Single	2 years old
P15	41	Pediatric Ward	São Carlos	36	15	Married	5 years old/ 10 years old
P16	37	Basic Health Unit	Ribeirão Preto	20	14	Married	1 year and 7 months old
P17	37	Family Health Strategy	Campinas	36	10	Married	10 months

[*]P = Mother-nurse; [†]Workload = Hours/week; [‡]Training time in years

Next, the results are presented, based on two themes.

Theme 1 – The dialog between the protection of the child(ren) and being an active nurse in times of pandemic

This theme revealed a dialogical experience lived by the mothers between their professional performance, characterized by the risk of exposure to SARS-Cov-2, and the desire to protect their children. The search for balance in face of the situation, in the initial moments, was marked by suffering triggered by the feeling of fear/threat: [...] *at first I came home from the hospital crying in tears, panicking. We keep thinking: I'm going home, my husband has an asthma problem, my son is small and what if they die? I already cried a lot at the beginning* (P3).

Problems in the provision of Personal Protective Equipment (PPE) were considered and articulated in this context, increasing the fears: [...] *because at the beginning we didn't have PPE to work with, it was under a lot of pressure from the team* (P4).

[...] *psychologically, it's very tense because the city has insisted that those who are not assisting respiratory symptoms don't need a surgical mask* (P10).

Faced with the uncertainties, they felt the need to equip themselves with knowledge; however, they experienced mismatched information that increased their anxiety and apprehension, especially because they were unable to identify a secure provider of information to anchor themselves, not even in their workplace:

[...] *the hospital was reorganizing so quickly, often with conflicting and excessive information, I was very afraid of everything* (P7).

[...] *at the beginning, I was very nervous, nobody knew, nobody knew how it was going to be, as they still don't know how it's going to be, I think the beginning was more apprehensive* (P6).

In order to alleviate these stress-generating feelings, some participants even reported the need of medication support:

[...] *I couldn't sleep, I took medicine for two weeks to sleep, I could only keep thinking about the service* (P9).

[...] *the first days that we learned that we had contact with a patient who was positive and that we hadn't taken the necessary precautions, it even gave me tachycardia, I had to take a floral medication to see if I calmed down* (P6).

The concern with the protection of the children was constantly narrated by the mother-nurses. Regardless of the workplaces, the fear of bringing the virus home was common among them. Some participants mentioned that if something happened to their children, it could only be their fault for the condition of being health professionals: [...] *I'm concerned about bringing the disease home* (P12). [..] *I was afraid of contaminating them, this was very difficult* (P15).

In view of this concern, at the end of the work shift, strict hygiene measures were incorporated into the routine with the intention of minimizing the chances of taking the virus to the child. Such measures were expressed by participant 12 as a real war operation. The following statement exemplifies the additional care incorporated into the new routine: [...] *it starts soon from the time I leave the service, hand hygiene to get in the car, hygiene to get out of the car, the material and backpack that I use don't enter the house anymore. Shoes are outside, there is a cloth with hypochlorite at the entrance, I'm already taking all my clothes off in the laundry, outside* (P14).

Such measures caused, in a way, a temporary distancing from the children: [...] *I don't even take him, I don't hug, I don't kiss, nothing, I take off my clothes and go to the bath* (P11). [...] *that situation, you know, the kids are already in the bathroom waiting for me to get out of the shower to come and give me a hug. So, this is the part that touches me, right* (P6).

[..] *one thing that was difficult at first was that she always came running to hug me, extended her arms and already asked for my lap. That was difficult, at first I had to ask my parents to hold her*

a little, not to let her come, there was crying. I explained that mom was with pets, that I needed to bathe first and then come to get her, but it was difficult, she's little (P14).

Still in the attempt to protect their children, three participants chose to part with them initially. However, after a few weeks, two of them, facing the emotional impacts experienced by everyone, broke with the strategy: [...] *as soon as this situation started, I decided to leave the house, I was away for three weeks. But, then we started to realize that it started to impact on my and their emotional state, it started to get quite worrying* (P12).

[...] *we had to decide to take our daughters to another city with my family. It hurts me until now (crying), it was very difficult to separate from them, it was a very painful interruption. At night, when I came home from work, I was very depressed, all the children with their mothers and me away from them. I realized that they were getting sad, I saw it on their faces in the video call. A week ago, I brought them back home, I found someone to take care of my daughters here at home* (P15).

Participant 9 did not break with the separation strategy, but decided to relax: [...] *for two weeks we talked on video. Then, there was a day when he started crying, you know, so I couldn't stand it, I cried too. But, as I told my mother, it's difficult, but he's safe there, so, I comfort myself here, even though I'm going there, I rub alcohol gel on my face, I wear a mask, very afraid* (P9).

The changes in the daily care of children in face of the context of the pandemic had a distinct impact on them. In this perspective, two nursing participants revealed the impacts on breastfeeding, but efforts to maintain it*: [...] I came to breastfeed him at lunchtime and now with the COVID question I will no longer be able to come, because you read these manuals and they say that it's only breastfeeding with a mask, but in practice it's complicated, because he sleeps with me, you know, he sucks all night, how do you isolate yourself at home with a baby* (P5)?

[...] *I took the feed off at lunchtime, because I'm afraid to make this entry in the middle of the day. I don't come to lunch at home anymore, there would be no time for me to take a shower and everything, to do the ritual. He feels, so do I, but I can't, it's exposing* (P13).

Theme 2 – The continuous need to (re)create care in an adverse emotional context

As they reach an organization that they consider safe, concerns and anxiety about contamination are alleviated. However, other challenges emerged in the daily lives of mother-nurses, especially in view of the suspension of school activities. They needed to count on the support of the family to take care of the children, especially the child's parents and grandparents: [...] *at the beginning, my husband took care of her, because he's at home, but his productivity demand is huge, he had a meeting with the boss every day, demanding productivity. There, he wasn't handling. Now my mother came to live with us, she doesn't go to the house anymore, she's doing the isolation there with us, so she's the one taking care* (P2).

The support of grandmothers, although indispensable in this context, was also a cause for concern, as many were part of the risk group for COVID-19: [...] *my son stays with my parents on the days I'm working, my father is 64 years old and has no comorbidity, my mother is 58 and is a diabetic. At first I didn't want to leave them, but as I don't have another family member here who is available to help me, unfortunately I had to do so, taking all the possible precautions* (P1).

In the case of mothers of children of preschool and school age, the challenges referred to support in school activities with greater centrality, and no longer as secondary support. Finding time, availability and organization for the issue has been challenging and difficult to manage, especially because it is coupled with other tasks:

[...] *her school took a while to send the materials and when it started to send it started sending a huge amount of things to do. We couldn't to do it. My husband and I, we took turns and even so*

we couldn't handle it. I even felt more overwhelmed, because before school activity came, but it was much less. Due to her age, she still needs support to do her homework, from someone close (P7).

[...] *the school's tasks accumulated and I couldn't keep up, I really couldn't cope, the day I was at home, I was taking care of the house, making food, taking care of the children and taking a break for the next day, right?* (P6). *The double shift became triple, work, home and home school* (P16).

Added to the context were the maternal concerns in ensuring the child's play, especially because the child is not in direct contact with other children. In this direction, the participants revealed creative strategies to provide moments of distraction: [...] *we live at home, then I brought sand from that place, I made several adaptations, until she's fine, she plays a lot* (P2).

[...] *as he's staying at home, I have to find strategies for him to play without going out into the street, I print a drawing, tell a story, put it on TV. These days we bought a puzzle over the Internet* (P3).

[...] *at the end of the afternoon, there's lawn in the backyard, we take her to that lawn so she can run, there's a swing and a slide* (P4).

Although they were concerned with providing leisure and distraction to the child, the participants felt exhausted and highlight the little energy to play: [...] *although my husband and I were always close to them, playing, stimulating, they had a busy day at school. It's something pleasurable, but it also takes time, creativity, it's a little exhausting* (P12).

[...] *There are days when I'm more stressed, so I try to turn the key in me, so that I can really manage the day with her in a way that is light for her. We can't always do it* (P7).

In the speech below, there is physical and mental exhaustion of a participant, who reported that, sometimes, it is her children who are taking care of her:

[...] *many times, I come home very tired and sometimes I feel that they are taking care of me and not me of them, mainly the day that I work 12 hours. I come home very tired, exhausted and then they already got used to it* (P6).

Spirituality and religiousness contributed to facing the situation and belief in better times: [...] *I have religious support, I am religious, I am a spiritist, so, I believe that things don't happen if I don't have divine permission* (P5).

[...] *we do the spiritist rituals, always before sleeping the family prayer, the children are also very engaged with this* (P12).

[...] *I surrender to God and whatever has to happen will happen, I tried more to control myself based on my beliefs, we pray that if we get the disease it is not serious* (P3).

DISCUSSION

This study revealed the complexity of elements required from mother-nurses to make dynamic arrangements for the care of their children during the COVID-19 pandemic. The need to care for children in social isolation concomitant with constant exposure to the virus are two elements that, despite being antagonistic, are interdependent and necessary to seek a new organization that reaches the physical and mental health of the participants and their children, balancing order and disorder.[16]

The consequences of a poorly prepared health system for epidemics and pandemics have been documented, and access to information has emerged as a relevant strategy for dealing with the pandemic.[17] Experiences of Ebola virus outbreaks and severe acute respiratory syndrome emphasized the importance of preparing the health professionals. Along with the education and availability of PPE, it is essential to ensure reliable sources of consistent, synthesized and scientific information to assist the professionals.[18] A qualitative study developed with primary care professionals from Australia, Israel and England, investigated the challenges in facing the pandemic by the Influenza A (H1N1) virus in 2009. One of the challenges was the flow of information from the health authorities to update the professionals on the latest guidelines. The large volume of information, the lack of time for updating,

and the multiple sources of information (national, state and municipal) that were poorly coordinated and confusing contributed to this challenge, corroborating the statements of the participants of the present study.[19]

Studies with health professionals have also documented work-related mental health problems during the COVID-19 pandemic. According to these surveys, the professionals needed to deal with a new scenario in the services, for which there was no preparation/training and, at the same time, there is a shortage of individual safety equipment in many cases.[20–21] It has also been revealed that female nurses are the most susceptible to depressive symptoms, anxiety, stress and sleep-related problems when compared to male nurses.[20] Lessons learned in other pandemic times also indicate that there is a great possibility for health professionals to present mental health problems or post-traumatic stress disorders related to the experiences in the services, the fear of contaminating family members or the apprehensions that are triggered by the lack of safety at work.[5]

Nursing nurses reported issues related to breastfeeding. A study argued that, although the World Health Organization provides guidelines and guides that promote proximity and breastfeeding for mothers and children during the pandemic, including those contaminated by COVID-19 with adequate respiratory precautions, some contexts have imposed separation. This can cause cumulative harms relevant to the children's health, such as limiting protection against infectious diseases and impacts on social and psychological development.[22] International maternal and child health agencies reinforce precautions to prevent the spread of the virus via breastfeeding, such as hand washing before breastfeeding and wearing a face mask.[4]

As perceived in the participants' speeches, the experience of the pandemic in the services and the management of care for children require a state of permanent attention, development of previously unthinkable skills, and how to help in the teaching-learning process that abruptly happened in the domestic context. The distancing of this population, which is in a peculiar developmental process, from its educational activities and institutions, as well as domestic confinement can interfere with the sense of structure, predictability and safety.[10] A study on the behavioral and emotional reactions of Chinese children to COVID-19 revealed excessive dependence on parents, anxiety, inattention, worry, sleep problems, lack of appetite, nightmare, discomfort and agitation. It also points out that younger children (3 to 6 years old) were more likely to present dependence and fear of family members getting the infection.[23]

A number of studies have reported the importance of maintaining recreational activities during the pandemic period, especially because of the risks that children are exposed to, such as poor diet, less physical exercise and longer exposure to screens.[24–25] According to a recent editorial, games can be used for communication and distraction with children, and parents are the closest resources for children to seek support, although care must be taken with the disinfection of toys.[4]

Childcare responsibilities should be shared between men and women, but that is not the reality. This hypothesis is based on the data collected and on studies prior to the pandemic, which indicated that mothers were, admittedly, the ones that most engaged in matters related to the education of their children, who showed greater care and more attention in carrying out homework.[8] Future studies may investigate this experience, specifically, in pandemic times.

Some studies have addressed the impact of schools closing on the work of professionals who are directly involved in coping with COVID-19. According to a study that estimated child care tasks induced by schools closings in the health care workforce in the United States, there may be a reduction in the health workforce due to increased tasks with children.[6] It is recommended that other arrangements be part of the school closure plan, as is the case in England[26], assessing the risk that having children together can undermine the progress in reducing the contagion brought about by school distancing.

The social support mentioned by the participants is important so that they can go to work and leave their children under the care of other people. However, in the recreation of family dynamics, the participants unveiled weakened social support, which essentially emerged from the school institution or grandparents, which is related to the peculiar context of social isolation imposed by the pandemic. According to a research study carried out in China, which aimed to assess the effects of social support on the quality and function of sleep as well as on the self-efficacy of the health professionals who were working directly with COVID-19 patients, the perception of a support network was significantly associated with self-efficacy and quality of sleep and negatively associated with the degree of anxiety.[27]

Overload, compounded by the lack of support from the school environment, the need to reconcile work and care and to keep children busy and safe at home, and the uncertainty of how long the COVID-19 pandemic situation will remain can be configured as risk factors for a healthy relationship between parents and children.[28]

The importance of religiousness and spirituality to face the chaos experienced was essential. These life dimensions appear as an emotional escape valve to deal with the stress caused by work and by her own responsibilities as a mother, which now also adds the responsibility of not contaminating her children. The implications of COVID-19 for the professionals are significant, and well-being or support for resilience can be neglected in the services. In this sense, the religious or spiritual dimension of the professionals, acting as a psychological factor, can mean greater engagement in caring for themselves and for the other, in addition to ensuring a greater commitment to work.[29]

Finally, complex thinking made it possible to embrace the specificities of being a mother of children and a nurse in a pandemic context in a developing country. The mother-nurse sought to reconcile multiple care actions, both in the field of personal, family and domestic relationships, as well as in the professional relationships. Care actions that are intersected by the consequences of the COVID-19 pandemic, which highlights gender inequalities and lack of support, generating crisis, stress and overload. It is understood that, as a social practice, Nursing needs to be seen in all its interconnections, with a multidimensional perspective, not only in the professional field.[30] In this sense, the study articulated singularities and pluralities that have direct implications for health care and management in this peculiar moment in which we live, namely better organization of information flows and permanent education, systematization of the mental health care of health professionals, and a singular look at professionals who are mothers or fathers of children.

This study has limitations that must be considered. First, it is not possible to establish relationships between the feelings expressed by the participants and the current pandemic situation. Second, the semi-structured interview technique used in data collection can favor the manifestation of emotional aspects, but it does not always include the participants' cognitive understanding. The third limitation refers to remote data collection, as there is still no consensus in the literature about its potential or fragility. In addition, the participants worked in different health services, with greater or lesser exposure to the virus. The possible differences arising from this aspect have not been further explored. Finally, the study did not explore different family dynamics, given the inclusion of only one single participant.

Future studies may help to clarify and identify other effects of the experience of the health professionals and mothers during the COVID-19 pandemic, care of the children, and assuming new responsibilities. In addition, research studies are suggested to assess the post-pandemic.

CONCLUSION

Resuming the objective of this study, the dialogical perspective experienced by mother-nurses in caring for their children was perceived: the need for concomitant protection from exposure to the virus. In order to face this situation, they acted with viable resources, sometimes distancing and blaming themselves, sometimes recreating daily life and habits. The great flow of information, sometimes mismatched, was relevant to generate suffering. In this regard, the fragile institutional support of the health service in which they worked was mentioned. The fear of bringing something home was constant, reinforcing emotional stress. The limited social support of other family members and schools, especially due to the peculiar social moment, were implicated in the reorganization of childcare.

Nurses, while being valued as important frontline professionals in the fight against the pandemic, are invisible in their personal-affective dimension and in that of being a mother. Thus, the study revealed the need for structural institutional policies so that mother-nurses are placed in a position of equality and safety for the full exercise of the profession and a healthy intra-family relationship, especially in contexts of adversity such as that experienced due to the COVID-19 pandemic.

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NOTES

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Data analysis and interpretation: Carlos DM, Wernet M, Okido ACC.
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CONFLICT OF INTEREST

There is no conflict of interests.

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