Impact of the pandemic on COVID-19 positive women's labor and childbirth care

Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

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Pacto de Estado
contra la violencia de género

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1. Introduction

In March 2020, the global pandemic caused by COVID-19 generated an international health and care crisis. In Catalonia, as in many other places in Spain, Europe and the world, the health services were overwhelmed and at risk of collapse, not only to respond to the ravages caused by the new disease but also to address other situations, such as care for pregnant women before, during, and after childbirth.

In this context, the measures adopted in the health services to face the emergency scenario caused important alterations in the processes of maternity care as they had been carried out up to that moment. Furthermore, some voices denounced that the sexual and reproductive rights of women during pregnancy, labor and childbirth, or postpartum were being subordinated to the demands of the management of the pandemic and, on some occasions, violated.

Based on the interest in understanding the extent and the way in which health care for women was affected at such a fundamental moment in their lives, from the Inclusive Societies, Policies, and Communities Research Group (SoPCI) and the UNESCO Chair Women, Development and Cultures of the *Universitat de Vic-Universitat Central de Catalunya* we promoted the research project Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia. The project initially received funding from the Ministry of Equality (Secretary of State for Equality and against Gender Violence/State Pact against Gender Violence). Subsequently, it has also received support from the Secretariat for Universities and Research of the Department of Enterprise and Knowledge of the *Generalitat de Catalunya* (2017SGR0657). The study was approved by the Research Ethics Committee of the *Universitat de Vic-Universitat Central de Catalunya*.

Beyond the publications and other scientific results that may be derived from the project, from the research team we consider that the data that have been generated are of great relevance to, firstly, make visible situations, not always positive, that thousands of women in Catalonia had to live at a time in their lives of maximum vulnerability and need for care and support. On the other hand, it also seems important to us to publish the main results of the research in this brief report format to make them accessible to different audiences:

- to women who have been pregnant or have become mothers in times of pandemic,
- to the groups, entities, associations, and other feminist spaces dedicated to promoting and defending the rights of women to become mothers in conditions of care, respect, free choice in the different phases of their process, and with special attention on their needs and desires,
- to those responsible for managing services and promoting policies for pregnancy, childbirth, and postpartum care,
- to the media,
- to all citizens.

As we said, the COVID-19 pandemic had a devastating impact, of unknown dimensions, on the Catalan health care system. This impact resulted not only in enormous difficulties in responding to the ravages caused by the disease, but also in maintaining attention to other situations and health care needs. In a context marked by tragedy, where thousands of people lost their lives or were seriously ill, the "collateral effects" of the pandemic and the indirect impacts of the situation on other groups in need of health care were silenced and relegated to the margins of the media, political and social agenda.

Pregnant women or women who had recently become mothers are an example of this: follow-ups, tests, support groups to pregnancy, labor and childbirth and postpartum were cancelled; the entry of companions was often prohibited during tests and labor itself; hospital visitors were forbidden; women were forced to give birth wearing masks; the hospitals where they were supposed to give birth were changed at the last minute and, overall, neither the changes or their impacts were reported. Going deeper into these situations based on the women's own accounts is essential not only to make them visible, but also to understand the impact they have had on the women, their children, and their immediate environment. And, above all, we hope that a photography such as the one we propose to offer here will contribute to generating lessons that will help to make things a little (or a lot!) better, particularly regarding placing respect for and defense of women's sexual and reproductive rights at the center of public policies and health services.

This is **the first report in a series of reports resulting from the research project Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia**. It focuses on the **experiences of women who tested positive for COVID-19 on the day of their labor or shortly before**. We have chosen this theme to begin this collection of reports on the impacts of the pandemic on maternity health care with the desire to contribute to the reflection on the tensions that were generated during the worst moments of the crisis between personalized and humanized care for women and security measures that were decided to adopt in a context of risk of contagion. No one better than the women who gave birth while being positive of COVID-19 to shed light on how this tension is experienced and suffered in their own flesh.

If you would like to be informed about the publication of data and results of the research project and receive future reports, please write to us at maternitats.covid@uvic.cat and we will send them to you.

2. Methodology

2.1. Preparation of the research

This research has an eminently exploratory character and a quantitative approach, based on the collection of data from a survey of women who were pregnant from January 1, 2018 until the end of September 2021. We had therefore a target group (women with an experience after March 13, 2020) and a control group (women with an experience prior to that date).

The dimensions and axes of analysis used to measure the impact of the management of the COVID-19 pandemic on the health services for maternity care and support have been structured considering three axes: 1) the impact on services, 2) the impact on women's experiences, 3) women's strategies and agency in the face of these changes. In addition, the specificities of each stage and the magnitude of the elements analyzed made it necessary to segment the axes according to the phases of pregnancy, childbirth and labor, and postpartum. In a schematic way (and without considering the indicators in detail) the operationalization has considered:

Pregnancy

Impact on services

- Proximity and continuity of care
- Support and information services that empower women and enable their active participation in the pregnancy-partum-postpartum process
- Humanized and person-centered care
- Safety measures in the services against the risk of COVID-19 infection

Impacts on women's experiences

- General well-being
- Mental and emotional health

Women's strategies and agency in the face of changes in service operations and risk of COVID-19 infection

- Seeking alternatives
- Seeking safety from the risk of COVID-19 infection
- Non-use of services for other reasons

Cross-cutting issues

Labor and Childbirth

Impact on services

- Proximity and continuity of care
- Support and information services that empower women and enable their active participation in the pregnancy-partum-postpartum process
- Humanized and person-centered care
- Level of demedicalization

- Safety measures in the services against the risk of COVID-19 infection

Impacts on women's experiences
- General well-being
- Mental and emotional health

Women's strategies and agency in the face of changes in service operations
- Seeking alternatives
- Seeking safety from the risk of COVID-19 infection
- Seeking safety from other risks
- Non-use of services for other reasons

Cross-cutting issues

Postpartum

Impact on services
- Proximity and continuity of care
- Support and information services that empower women and enable their active participation in the pregnancy-partum-postpartum process
- Humanized and person-centered care
- Level of demedicalization
- Safety measures in the services against the risk of COVID-19 infection

Impacts on women's experiences
- General well-being
- Mental and emotional health
- Breastfeeding

Women's strategies and agency in the face of changes in service operations
- Seeking alternatives
- Seeking safety from the risk of COVID-19 infection
- Non-use of services for other reasons

Cross-cutting issues

The design phase of the survey took place between April and July 2021, with a previous phase of review of scientific and press articles on the subject, as well as three exploratory interviews with women with their own experience of pregnancy and/or labor and childbirth during the pandemic. The survey was also reviewed by an active midwife prior to its dissemination. The survey has 156 questions divided into the following 10 sections:

O: Filter questions, to determine eligibility to participate in the study, as well as the itinerary to follow once the survey has begun.
A: General sociodemographic and labor, pregnancy, and postpartum data.
B: Data on pregnancy follow-up.

C: Data on possible bad news and/or complications during pregnancy follow-up.
D: Data on the labor and childbirth preparation course and other preparation resources for pregnancy follow-up.
E: Data on the overall assessment of pregnancy follow-up.
F: Data on labor and childbirth.
G: Data on COVID-19 positive or considered false negative women at the time of labor.
H: Data on hospital postpartum.
I: Data on home postpartum.

Depending on the time at which the pregnancy occurred, there were different itineraries: women who had experienced the entire pregnancy, labor and childbirth, and postpartum process in the context of the COVID-19 pandemic; women who had experienced labor, childbirth, and postpartum in the context of the COVID-19 pandemic; women who had experienced postpartum in the context of the COVID-19 pandemic; women who were still pregnant at the time of the survey or who had had a pregnancy termination or abortion in the COVID-19 pandemic context; and women who experienced the entire pregnancy, labor and childbirth, and postpartum process previously to the COVID-19 pandemic.

The data collection phase was carried out during the months of July, August and September 2021. The questionnaire was disseminated online in Catalan, Spanish and English. It was distributed through social media, carrying out specific dissemination actions in local media and/or media related to the subject. A total of 2,600 responses were obtained, of which 2,070 were considered valid (1,862 target group and 208 control group). The sample size offers a margin of error of ±2.3% for a 95.5% confidence and maximum indeterminacy scenario.

The comparative analysis of the sociodemographic characteristics of the sample with the Birth Statistics published by the Catalan Institute of Statistics (depending on the variable, 2017 or 2020 data) points to a bias in the level of education of the participants in the survey, since they have a higher level of education than all pregnant women in Catalonia in recent years. For this reason, the data have been weighted to readjust the results to a representative sample.

2.2. Characteristics of mothers with a positive COVID-19 result at the time of labor and childbirth (or in the preceding days)

The most common profile of the women who participated in the study and tested positive for COVID-19 at the time of labor and birth or during the previous days is that of a woman between 33 and 35 years old who is a first-time mother, considered to have a low level of risk during pregnancy and with delivery at term (not premature).

- Age. 41.2% of mothers are between 33 and 35 years of age, and overall, about 82% of the cases are concentrated in mothers in their thirties (between 30 and 39 years of age).
- Primiparity. 73.5% of the sample corresponds to mothers of a first child while 23.5% already had a daughter/son. No results were obtained for a mother with more than one previous daughter/son.
- Risk in pregnancy. 64.7% of pregnancies were considered low risk, 11.8% medium risk and 20.6% high risk.

- **Prematurity**. 11.8% of the deliveries were preterm, all of them moderate or late, and the remaining 88.2% were deliveries at term.

3. Main results

3.1. Diagnosis of COVID-19 positive cases at the time of labor and vaccination status

- Of the total number of deliveries analyzed in the research project that took place from the beginning of the pandemic until October 2021 (n=1,289), in practically nine out of ten (87.7%) **a COVID-19 test was performed** at the time of delivery or in previous days, while 11.9% were not tested at all and 0.4% of the women had no recollection.
- The **results of the tests performed** indicate that 2.4% were COVID-19 positive diagnosed cases and 0.2% were negative considered as false negative. It is on these two groups that the data are focused (2.6%, a subsample of 34 responses).
- **COVID-19 vaccine**. 60% of women who were eligible for vaccination did not get vaccinated, compared with 40% who did get vaccinated. In 80% of the cases, it is considered that the information on the effects of the vaccine was neither sufficient nor clear.

3.2. Safety during labor and childbirth

- In 57.6% of the deliveries of women with a positive COVID-19 diagnosis, the health care personnel were wearing Personal Protective Equipment (PPE), while in 14% of the cases they did not use it and, in 28.4% of the cases, the women did not remember anything about this circumstance.
- The perception of safety was high in all areas -delivery room, emergency room, operating room, and ward-, where at least 70% of the COVID-19 positive women considered this to be the case. It should be noted, however, that this figure is 10 points lower than that of women with a negative result[1] at the time of delivery or in previous days.
- In all areas - emergency room, ward, delivery room and operating room - women with a positive COVID-19 result had to wear a mask at all times or most of the time. In the emergency and operating rooms, the figures show that 96.2% and 72.2%, respectively, of the COVID-19 positive women had to wear them at all times. The main effects of their continued use were discomfort and shortness of breath.

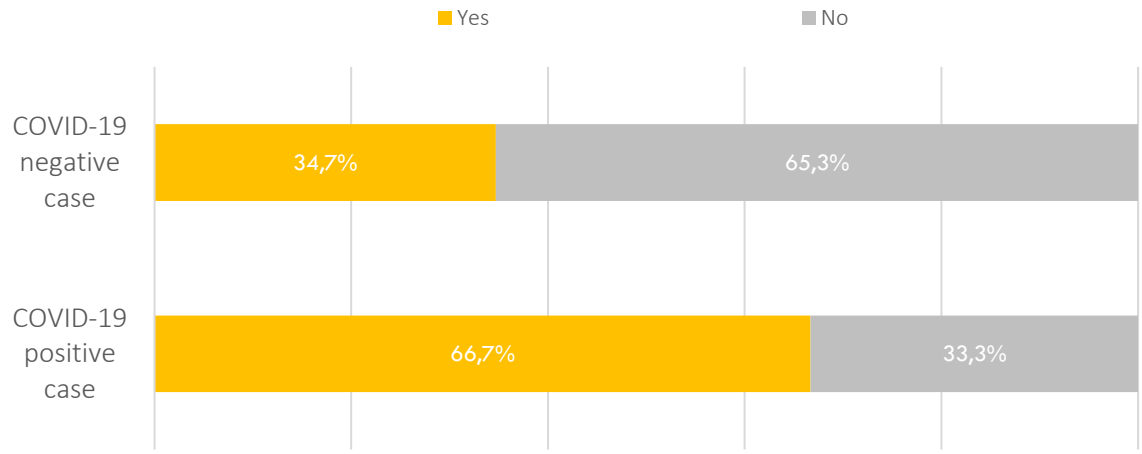
3.3. Interpersonal care received during labor and childbirth

- The fact of being cared for with PPE during labor and childbirth gave rise to different experiences, including the perception of cold interpersonal care (52.2%), difficulty in communicating with health professionals (49.9%) and delay in care due to protective measures (33.2%).

[1] Negative results are those obtained by means of a COVID-19 diagnostic test or by not performing a test.

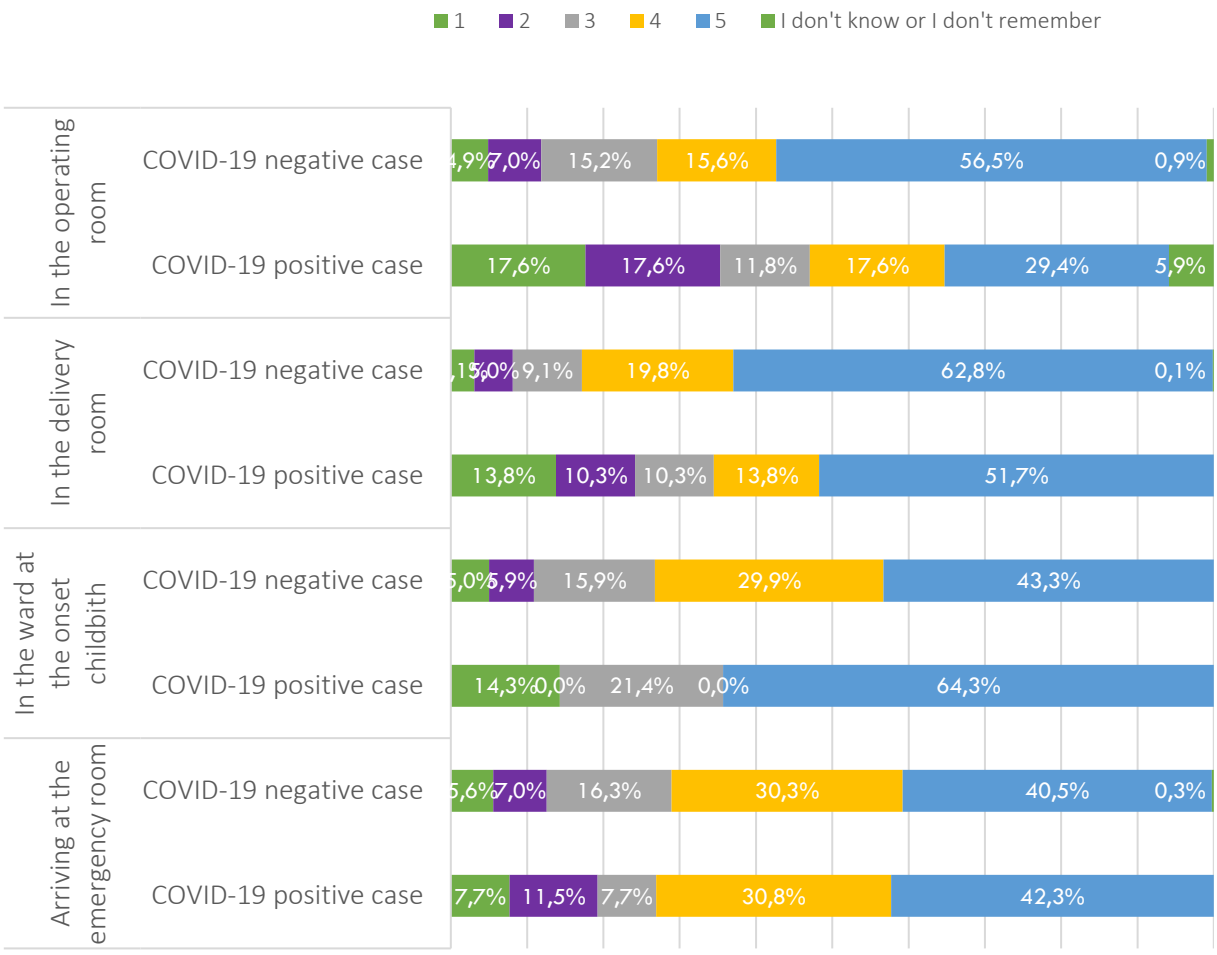
- When asked if safety was detrimental to the interpersonal care received, 6 out of 10 women with a positive result of COVID-19 affirmed this fact, while only half of the women with a negative result (3 out of 10 of the non-positive cases) did (See Graph 1).
- The interpersonal care received in all areas is valued, overall, as positive. On a scale from 1 (negative) to 5 (positive), the most frequent score was 5. In comparison with the women with negative COVID-19 results, we observed that the greatest distances were found in the delivery room, operating room, and ward, while no significant differences were observed in the emergency room (see Graph 2).
- Among the adjectives most frequently cited by women with a positive COVID-19 result, two stand out as being particularly different from the sample as a whole: respect (positive) and little empathy (negative).

Graph 1. Perception of whether safety was detrimental to the interpersonal care received according to whether the mother was diagnosed with COVID-19 at the time of delivery or in the previous days. In percentage, Catalonia.



Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

Graph 2. Satisfaction with the interpersonal care received in different areas of the health center before and during labor and childbirth of women with a positive COVID-19 result and women with a negative result. Scale from 1 (not at all satisfactory) to 5 (very satisfactory). In percentage, Catalonia.



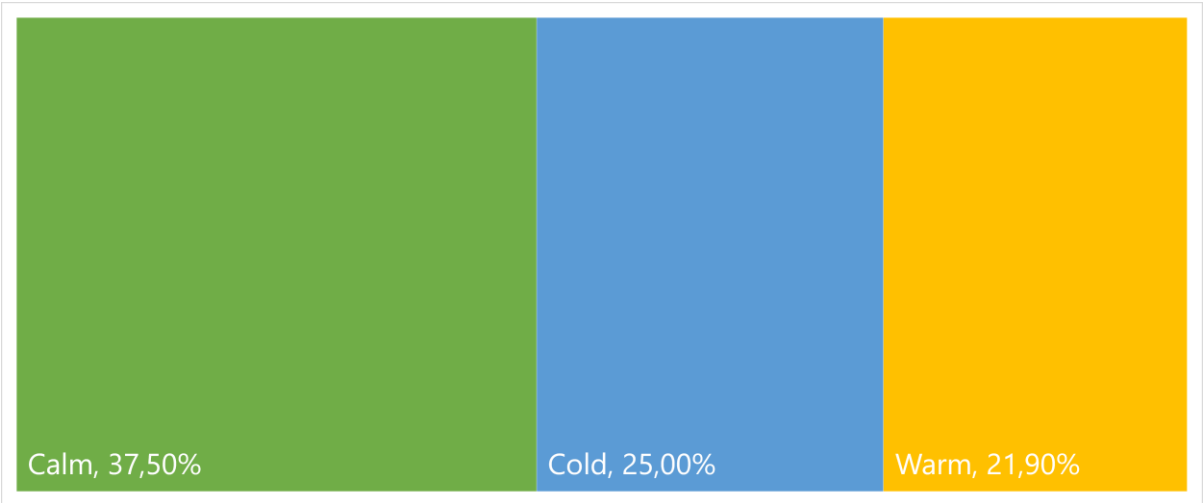
Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

3.4. Characterization of the environment in which labor and childbirth took place

- Regarding the environment, the adjective that most often describes the spaces - emergency room, ward, delivery room and operating room- is calm (positive). Cold environments (negative) are also generally mentioned, but with different intensities, depending on the specific space.
- In order to identify the most frequent description of the environments, we analyzed the adjectives with a response rate of more than 20%.
    - In the case of the emergency room, there are three: calm, cold and, antagonistically, warm, which shows the diversity of experiences (See Graph 3).
    - In the delivery room there are five: calm, warm, cozy, cold and tense (See Graph 4).
    - In the operating room there are only two adjectives that exceed 20% and they are cold and tense.
    - Finally, on the ward (before delivery) only calm stands out.

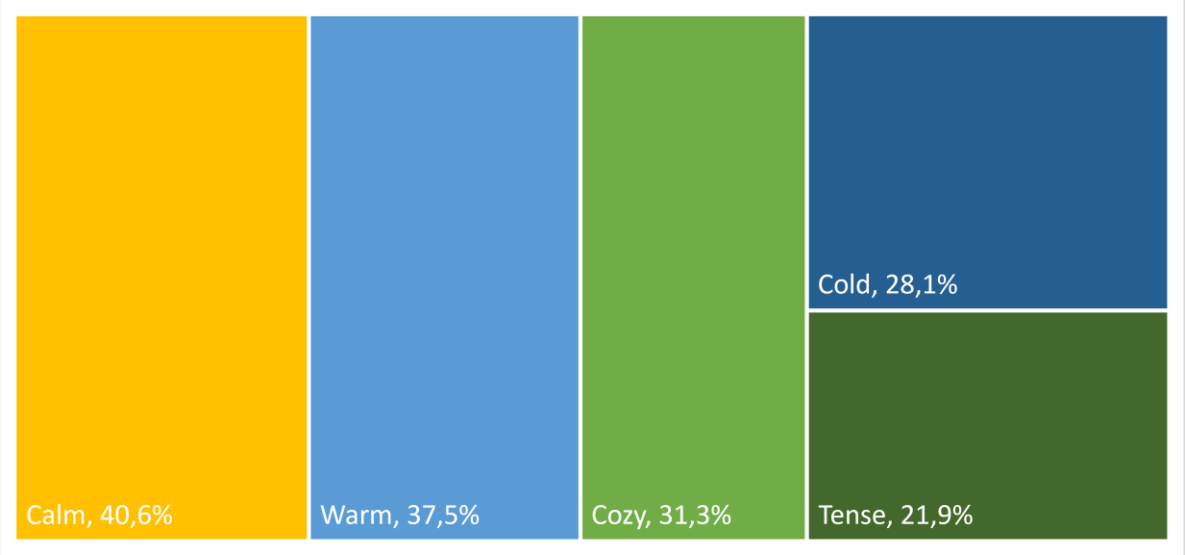
- The results show differences in the perception of the interpersonal care received and the warmth of the environment depending on the spaces, with the operating room and the delivery room having the most negative perceptions. On the other hand, the hospital ward before delivery has more positive indicators than the women in the sample as a whole. Finally, in the case of the emergency room, no differences were observed between women with a positive COVID-19 result and women with a negative one.

*Graph 3. Perceived environment in the **emergency room** by women with a positive COVID-19 result. Multi-response. Responses exceeding 20% are included. In percentage, Catalonia.*



Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

*Graph 4. Perceived environment in the **delivery room** by women with a positive COVID-19 result. Multi-response. Responses exceeding 20% are included. In percentage, Catalonia.*

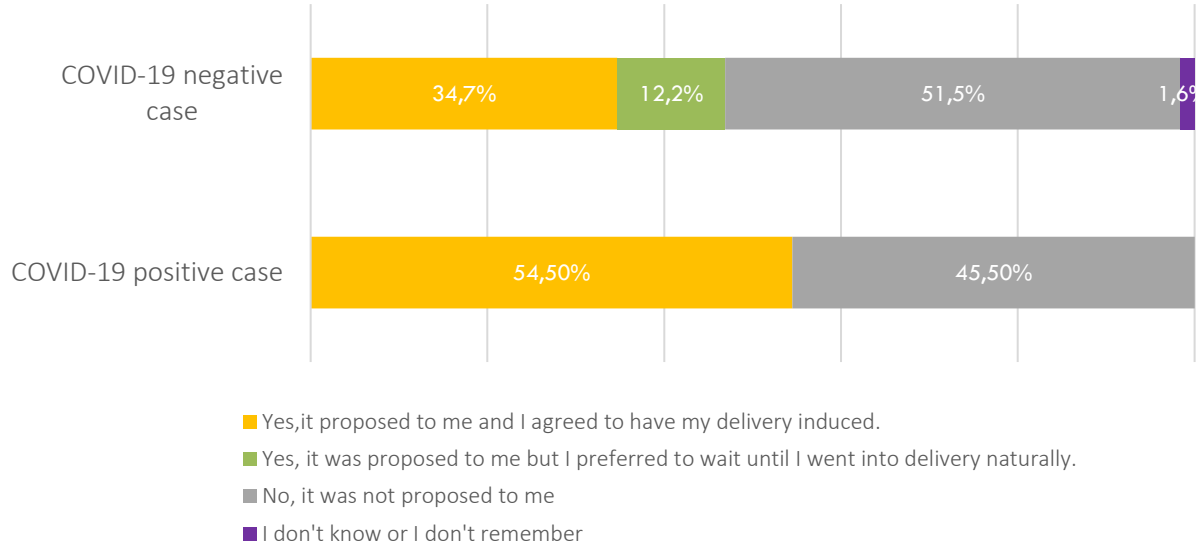


Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

3.5. Medicalization and information on procedures

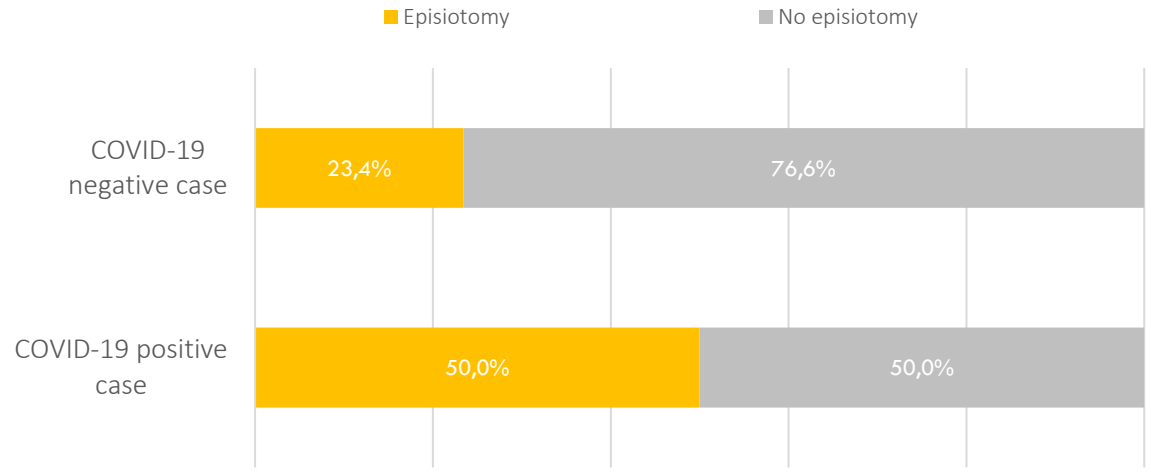
- A first indicator that points to the medicalization of labor and childbirth among women with a positive COVID-19 result is that labor was induced more frequently than among those with a negative result, 8 points more (see Graph 5).
- Overall, the results point to higher medicalization and intervention among women with a positive result, both in interventions performed -episiotomies were performed in half of the vaginal deliveries- and in the number of caesarean sections, where 4 out of 10 women with a positive COVID-19 result ended labor with a caesarean section. Among women with a negative COVID-19 diagnosis, episiotomies did not exceed 24% and caesarean sections were performed in 20% of cases (see Graphs 6 and 7).
- Among women with a positive COVID-19 result, there was less information on the procedures performed -vaginal examinations, intravenous line placement, monitors, rupture of membranes, etc.- compared to women with a negative result, with distances of more than 7 points.
- The ability to decide on these procedures is 20 points lower in the case of women with a positive result compared to those with a negative COVID-19 result.

Graph 5. Induction of labor according to whether the mother was diagnosed with COVID-19 at the time of labor or in the previous days. In percentage, Catalonia.



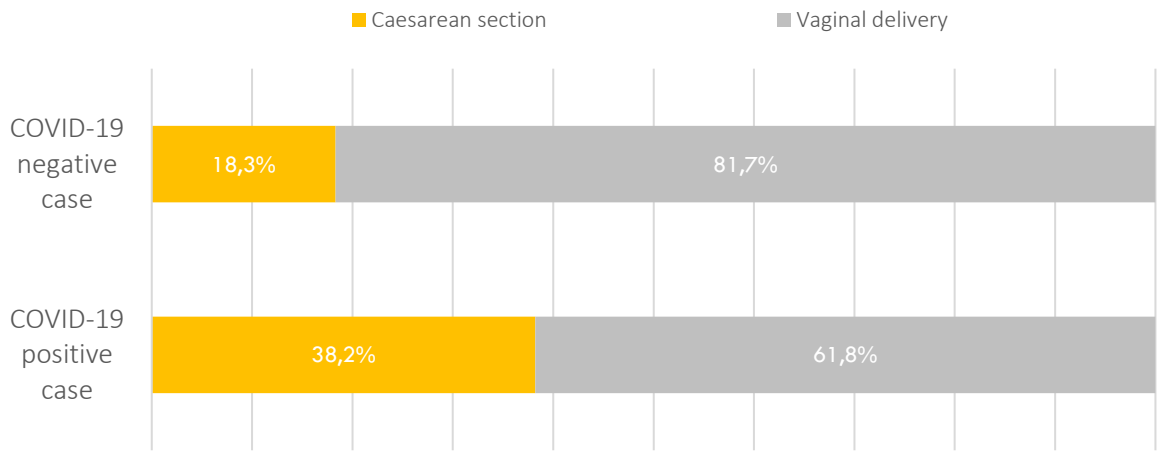
Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

Graph 6. Episiotomies performed according to whether the mother was diagnosed with COVID-19 at the time of labor or in the previous days. In percentage, Catalonia.



Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

Graph 7. Caesarean section and vaginal deliveries according to whether the mother was diagnosed with COVID-19 at the time of labor or in the previous days. In percentage, Catalonia.

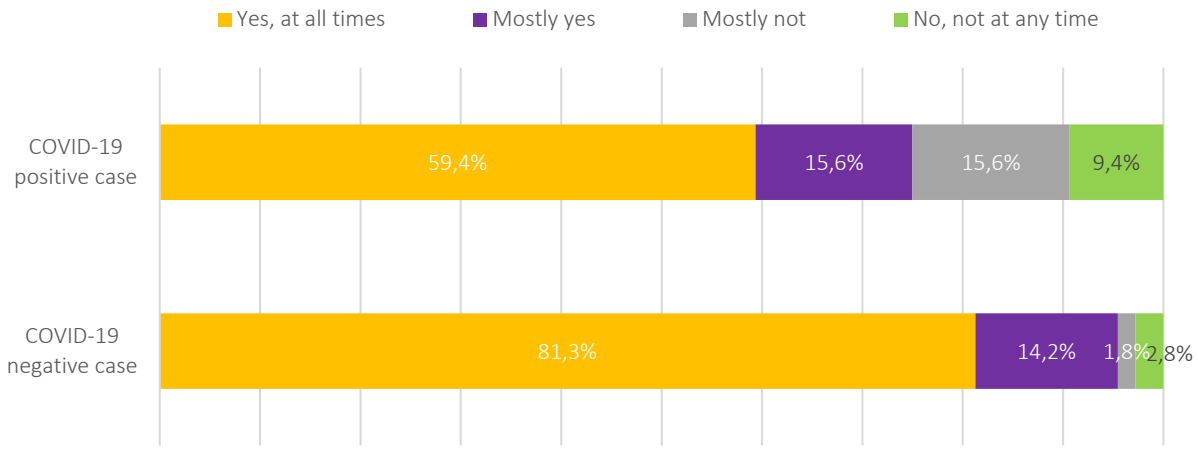


Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

3.6. Presence of a partner during labor and childbirth

- Women with a positive COVID-19 result were less likely to have their chosen partner (non-professional) with them during labor and childbirth than those with a negative result. More specifically, there was a difference of more than 20 points. In addition, 15.6% of the women with a positive result were not able to have their partner of choice with them most of the time and 9.4% could not at any time (see Graph 8).
- A lower percentage of skin-to-skin was also observed in COVID-19 positive women, and this could be related to the higher percentage of caesarean sections among these women.

Graph 8. Ability to be accompanied by the significant other at the time of labor and childbirth. Women with a positive COVID-19 result at the time of delivery and women with a negative result. In percentage, Catalonia.



Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

> They did not know what to do with us and they left me naked on a stretcher in the operating room with the baby on top of us and my husband standing, for 2 hours. They wanted to separate me from the baby. Me on the COVID floor and baby with daddy on the maternity floor.
>
> *Extracted from the open-ended questions of the questionnaire*

> There was no accompaniment until the moment of delivery. They would come in, do the work and quickly leave. They didn't say much. We didn't know who our carer was when they were inside. Many times, they did not come in to answers our questions and, when they did, it was from the hallway.
>
> *Extracted from the open-ended questions in the questionnaire*

4. In summary

While the analyzed sample of COVID-19 positive women could be considered small, starting from a sample of n=30 it is feasible to perform inferential statistical tests. On the other hand, although there is no official data available on women who gave birth with a positive result that would allow us to measure the representativeness of the sample, the results collected in this report point to such wide differences between women with a positive result by COVID-19 and women with a negative result in the different indicators that they reveal important differences in their experiences.

Feelings of insecurity, fear or anxiety may be experienced during labor and childbirth. In the case of women with a positive COVID-19 result, according to the different indicators analyzed, labor and childbirth occurred mostly in a context of hostility: with difficulty in communicating, perception of colder environments, isolation, etc., issues that are added to the possible feelings that arise at the moment of labor and childbirth. It is important to consider this perception of women about their labor and childbirth experiences due to the long-term impact it can have on their health and that of their child.

Women with a positive COVID-19 result at the time of labor and childbirth report having experienced a greater medicalization than women with a negative result, which is reflected in the greater number of inductions, caesarean sections, and interventions during vaginal delivery, such as episiotomies. The excessive medicalization of the birth process is contrary to current sexual and reproductive health policies (*Estrategia de Atención al Parto Normal, 2007 and Estrategia Nacional en Salud Sexual y Reproductiva, 2011*) and when it is not justified, it becomes a form of institutional violence against women (obstetric violence). Finally, women who tested positive for COVID-19 during labor and childbirth also have higher percentages of lack of information than women who tested negative. In this sense, it cannot be ignored that instrumentalization, even when necessary, if performed without prior information or consent, is also included within the framework of obstetric violence, as pointed out in the report approved by the Parliamentary Assembly of the European Council in March 2019[2].

[2] Ms Maryvonne BLONDIN (2018). Obstetrical and gynaecological violence. Committee on Equality and Non-Discrimination. Aprovat pel Consell Europeu (resolució 2306), https://pace.coe.int/en/files/28236