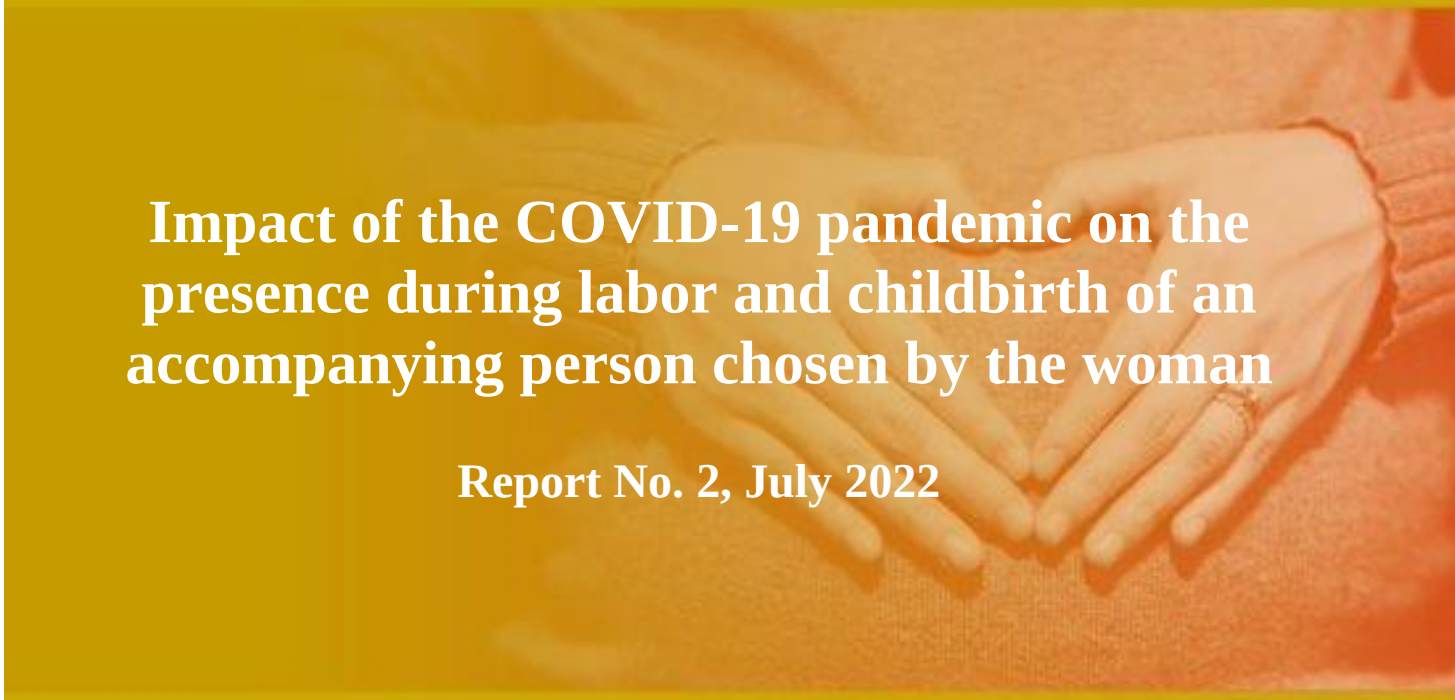
Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia



Impact of the COVID-19 pandemic on the presence during labor and childbirth of an accompanying person chosen by the woman

Report No. 2, July 2022

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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 created an international health and care crisis. In Catalonia, as in many other places in Spain, Europe and the world, health services were overwhelmed not only to respond to the ravages caused by the new disease but also to address other situations, such as care of women during pregnancy, labor and childbirth, and postpartum.

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. One of the manifestations of these changes was the introduction of restrictions in many countries on the presence during labor and childbirth of an accompanying person chosen by the woman (Horsch, Lalor, & Downe, 2020; Mollard & Wittmaack, 2021; Stephens, Barton, Bentum, Blackwell, & Sibai, 2020). In some parts of Catalonia and Spain, this occurred even though both the Spanish Ministry of Health (2020) and the Catalan Department of Health (2020) established that, given the necessary protective measures were adopted, there was no reason to restrict the accompanying person's access to labor and childbirth. In fact, since the beginning of the pandemic, numerous professional recommendations were published defending the preservation of the sexual and reproductive rights of pregnant women (International Confederation of Midwives 2020) and recalling that even in crisis contexts such as the one experienced from March 2020, all women have the right to a safe and positive labor and childbirth experience (FAME 2020). Faced with this situation, numerous voices were raised denouncing that the sexual and reproductive rights of women during pregnancy, labor and childbirth, and/or postpartum were being subordinated to the demands of the management of the pandemic and, on some occasions, violated (Mujer Luz, 2021; El Parto es Nuestro, 2020; Vivas, 2020). As a result, responses were organized from civil society (El Parto es Nuestro, 2021) and professional fields (Pastor, 2020).

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 derived from the project, from the research team we consider that the data 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 attention focused on their needs and desires,
- to those responsible for managing services and promoting policies for pregnancy, labor and childbirth, and postpartum care,
- to the media,
- to all citizens.

As we said, the COVID-19 pandemic had a devastating impact, of yet unknown dimensions, on the Catalan health care system. This impact has 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 have been 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; 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 nor 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 generate lessons to reverse the setbacks that the pandemic has generated in women's sexual and reproductive rights and to promote them again.

This is the **second 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 accompaniment to labor and childbirth by the mother's person of choice during the pandemic**. This person is usually associated with the other parent, although it can be a relative or person close to the mother, and also a *doula*. Scientific evidence points to the presence of the accompanying person during labor and childbirth as an important physical and emotional support to the woman (López-Villar, 2011) and essential to ensure a satisfactory birth experience (Macpherson, Roqué-Sánchez, Legget, Fuertes & Segarra, 2016; Waldenström, Hildingsson, Rubertsson, & Rådestad, 2004). In turn, the World Health Organization includes among its recommendations: "Access to having a continuum of support of choice is imperative to act in a woman-friendly manner and maintain good maternity care, meeting the needs of the family" (Oladapo et al., 2018). Thus, it is hugely relevant to understand the extent and way this support has been curtailed during the pandemic.

We have chosen this theme to continue this collection of reports on the impact of the pandemic on maternity health care in Catalonia with the aim of contributing to the reflection on the tensions that have arisen during this crisis between personalized and humanized care for women -and specifically, with respect to the possibility of being accompanied at all times by the person of the mother's choice-, and security measures that were adopted in a context of risk of contagion, measures that often materialized in protocols and decisions that contradicted the expectations, desires and needs of women. Health policies and maternity care services should not only focus on protecting the safety of women and the health professionals who care for them but also on promoting women's feelings of control and safety in their birthing space (Mollard & Wittmaack, 2021).

If you wish to be informed of the publication of data and results of the research project and receive future reports on other aspects and topics of the impacts of the COVID-19 pandemic on maternity health care in Catalonia, please fill in the form that you will find in the following link, and we will send them to you:

https://mon.uvic.cat/catedra-unesco/activitats-2/maternitat-i-pandemia-covid19-a-catalunya/

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 of analysis helped measure the impact of the management of the COVID-19 pandemic on the health services for maternity care and support were structured considering three axes: 1) the impact on services, 2) the impact on women's experiences, and 3) women's strategies and agency in the face of the 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, labor and childbirth, 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 childbirth during the pandemic. The survey was also reviewed by a practicing 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/chilbirth, 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 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, with 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 at the time of labor and childbirth

The most common profile of the women who participated in the study and who responded to the questions on the accompaniment of labor and childbirth during the pandemic is that of a woman between 30 and 37 years of age, first-time mother, considered to have a low level of risk during pregnancy and with a delivery at term (non-preterm).

- Age. 52.2% of the mothers are between 30 and 37 years of age, and overall, about 63.6% of the cases are concentrated between 30 and 40 years of age.
- Primiparity. 63.0% of the sample corresponds to mothers of a first child while 37.0% already had a daughter/son. No results were obtained for a mother with more than one previous child.

- Pregnancy risk. 57.3% of pregnancies were considered low risk, 24.9% medium risk and 18.8% high risk.
- Prematurity. 10.3% of the deliveries were preterm, except for one case, all of which were moderate or late, and the remaining 89.7% were deliveries at term.

3. Main results

3.1. Accompaniment before and during the pandemic

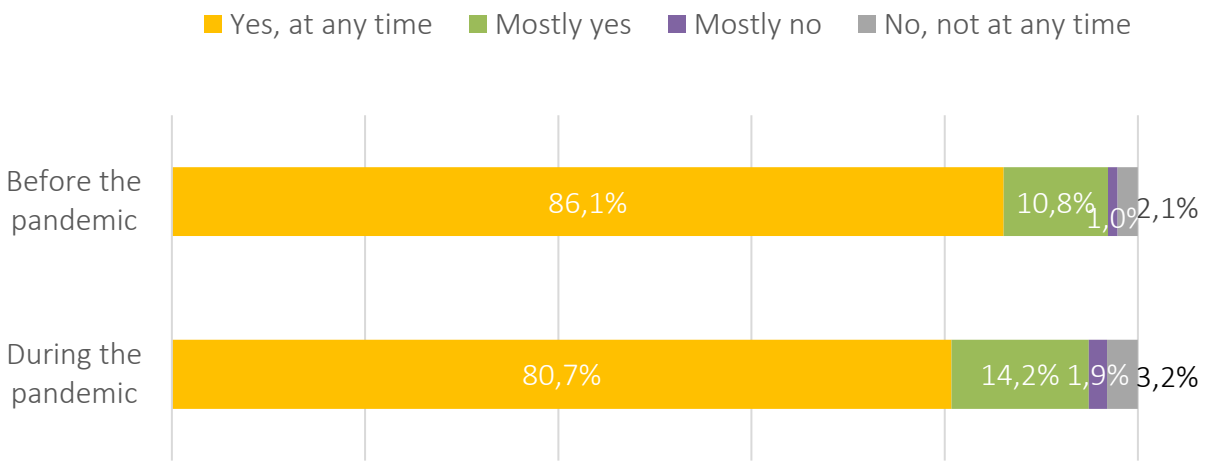
- Accompaniment during labor and childbirth by the person of the mother's choice has been conditioned by the context of the pandemic. There was a decrease in continuous accompaniment (that which occurs at all times) and an increase in other (lower) intensities of accompaniment (where the accompanying person is present but not always; where the accompanying person is mostly not present; and where the accompanying person is never present). The most pronounced decrease in continuous accompaniment occurred during the first state of alarm or first wave of the pandemic (March 14 to June 21, 2020). In the following months, although the presence of the accompanying person partially recovered, it did not return to the values of the pre-pandemic context.

- Before the pandemic, the percentage of women who were accompanied at all times during labor and childbirth by the person of their choice was 86.1%, a figure that dropped to 80.7% for all deliveries during the pandemic and 59.2% for deliveries of COVID-19 positive women. At the same time, women who were mostly but not always accompanied increased by 3.8%, those who were almost unaccompanied by 0.9% and those who could not count on the company of the person of their choice at any time of labor and childbirth by 1.1% (see Graph 1).

- During the first state of alarm, accompaniment at all times decreased from 86.1% to 74.6%. In other words, 1 in 4 women was not continuously accompanied by the person of her choice during labor and childbirth. After this period, the figure increased by almost 5 points to 81.4%. Despite recovering, it does not return to the pre-pandemic value of 86.1%. At the other extreme are the women who were not accompanied at any time, who represent 7.1% of the total during the first state of alarm. This figure is 5 points higher than the pre-pandemic figure and 4.5 points higher than later data (see Graph 2).

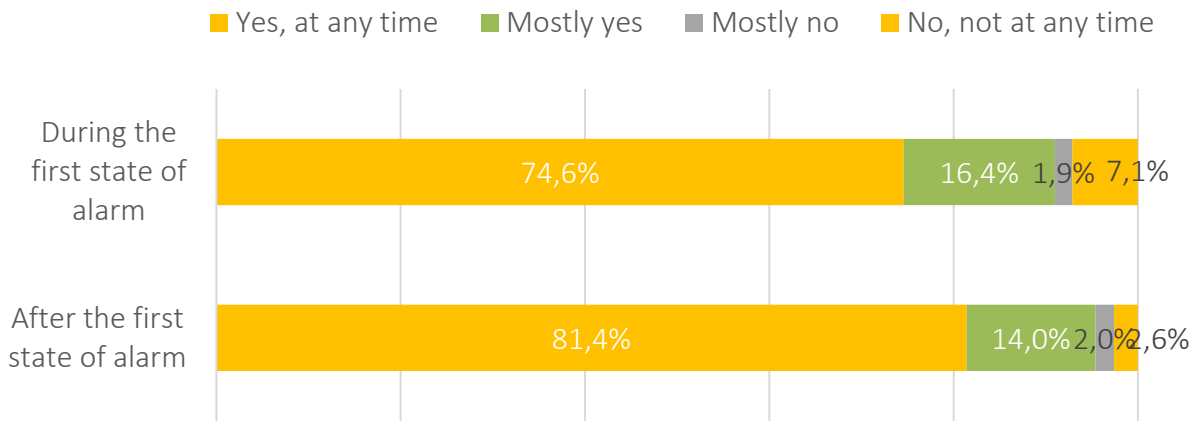
- In addition, as noted in the first report of this series, during the pandemic period studied, women with a positive COVID-19 result were less likely to have been accompanied during labor and childbirth by the person of their choice than those with a negative result: specifically, there is more than a 20 point difference in being able to be accompanied at all times during labor and childbirth. In addition, 15.6% of the women with a positive result could not be accompanied for a large part of the time and 9.4% were not accompanied at any time.

Graph 1. Possibility of being accompanied during labor and childbirth. Comparison between target group (during the pandemic) and control group (before the pandemic). In percentage, Catalonia.



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

Graph 2. Possibility of being accompanied during labor and childbirth. In percentage, Catalonia.

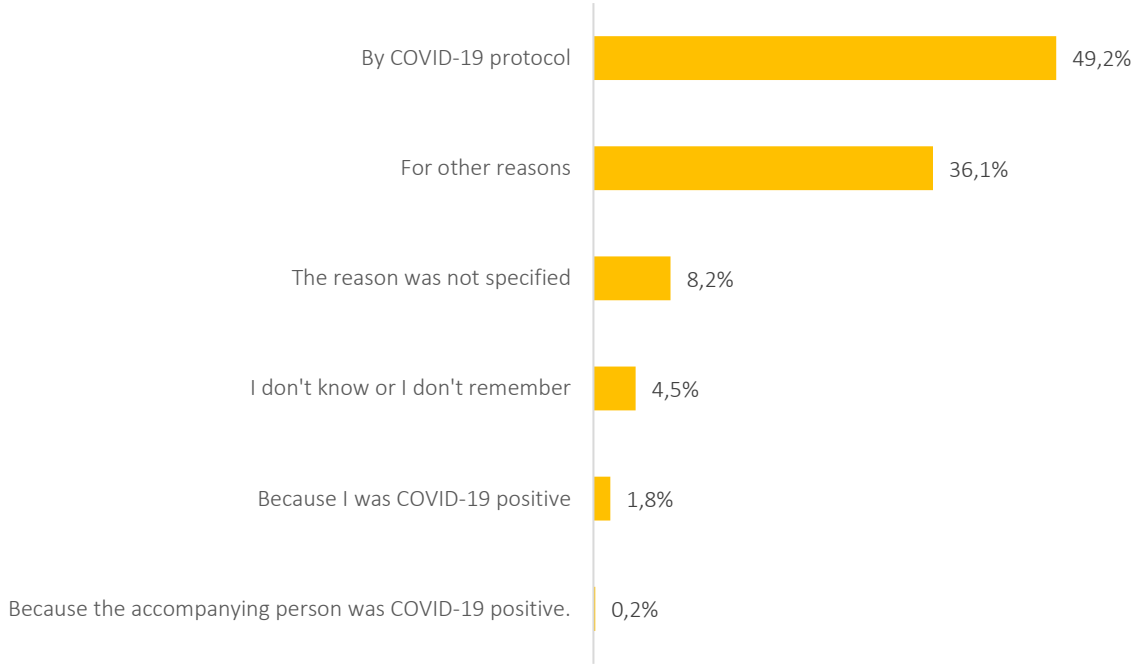


Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

- Among the women who could not be always accompanied during labor and childbirth, the reasons for the lack of accompaniment were analyzed with the main factor safety to avoid SARS-COV2 infection. Thus, the reasons for the lack of accompaniment included: the protocol established because of COVID-19, the positive diagnosis of the mother and the positive diagnosis of the accompanying person. Other options for lack of accompaniment that would not be justified by the pandemic context were also considered.

- In practically half of the cases in which the woman could not be accompanied at all times during labor and childbirth, the reason given by the health professional team was the COVID-19 protocol. In 36.1% of the cases the reason was unrelated to the pandemic and in 8.2% the reason was not specified. In addition, 4.5% of the women do not recall the specific reason given. Finally, in 2% of the cases the reason was the mother's (1.8%) or the accompanying person's (0.2%) positive COVID-19 result (See Graph 3).

Graph 3. Reasons for non-accompaniment in labor and childbirth. In percentage, Catalonia.



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

3.2. Accompaniment according to type of delivery

- There are two possible methods of delivery: vaginal delivery and caesarean section. Vaginal delivery is the most common way of delivery of the baby and, in the case of the sample reached in this research, it accounts for 82% of the total number of deliveries, while caesarean sections account for the other 18%[1]. Among the types of caesarean sections that can occur, 36.5% were due to non-progression of labor, 30.8% were scheduled by the professional team, 30.2% were emergency caesarean sections due to risk to the life of the mother or baby, and 2.8% were scheduled at the mother's request.

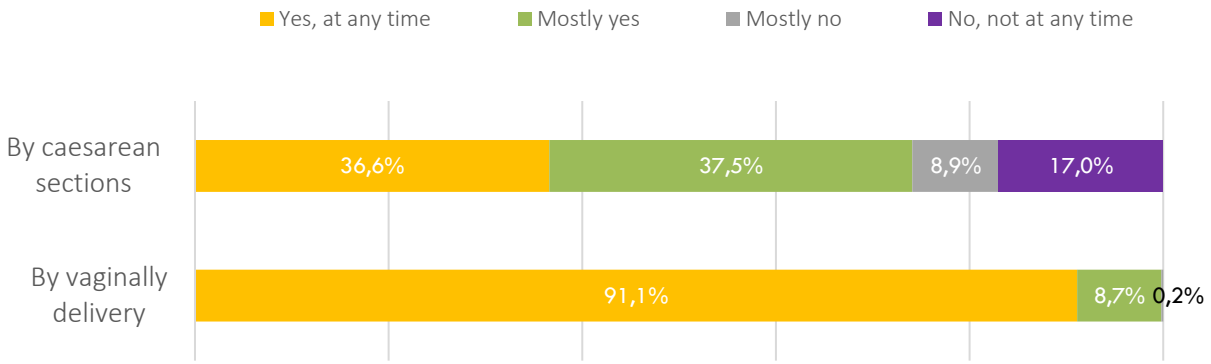
- The results of the study show that the way in which the type of delivery determines the mother's possibility of being always accompanied. In fact, within the context of the pandemic, the distance according to this factor is more than 50 points, with women who ended the delivery by caesarean being very clearly the least accompanied.

- In 36.6% of caesarean deliveries, women were always accompanied by the person of their choice, while in 37.5% they were accompanied during most of the delivery, but not continuously. In contrast, 8.9% were almost unaccompanied, and 17% were not accompanied at any time. In the case of vaginal deliveries, in 91.1% of the cases the mother was always accompanied, in 8.7% she was accompanied for most of the time but not always, and in 0.2% she was hardly accompanied at all. In vaginal deliveries there were no cases of no accompaniment at all (see Graph 4).

- In both vaginal and caesarean deliveries, the most common reason given by the health professional team attending the woman for the lack of continuous accompaniment throughout the delivery was the COVID-19 protocol, but there were differences of more than 12 points depending on if the delivery was vaginal (41%) or caesarean (53.6%) (See Graph 5).

[1] The sample obtained presents a higher percentage of vaginal parts than the figures of the IDESCAT Birth Statistics. Despite the fact that the most recent official data are from 2017, in that year 74.5% of the births produced in Catalonia ended vaginally. https://www.idescat.cat/pub/?id=aec&n=839

Graph 4. Possibility of being accompanied during labor and childbirth. Comparison according to type of delivery (vaginal or caesarean). In percentage, Catalonia.



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

Graph 5. Percentage of non-accompaniment by COVID-19 protocol according to type of delivery. In percentage, Catalonia.

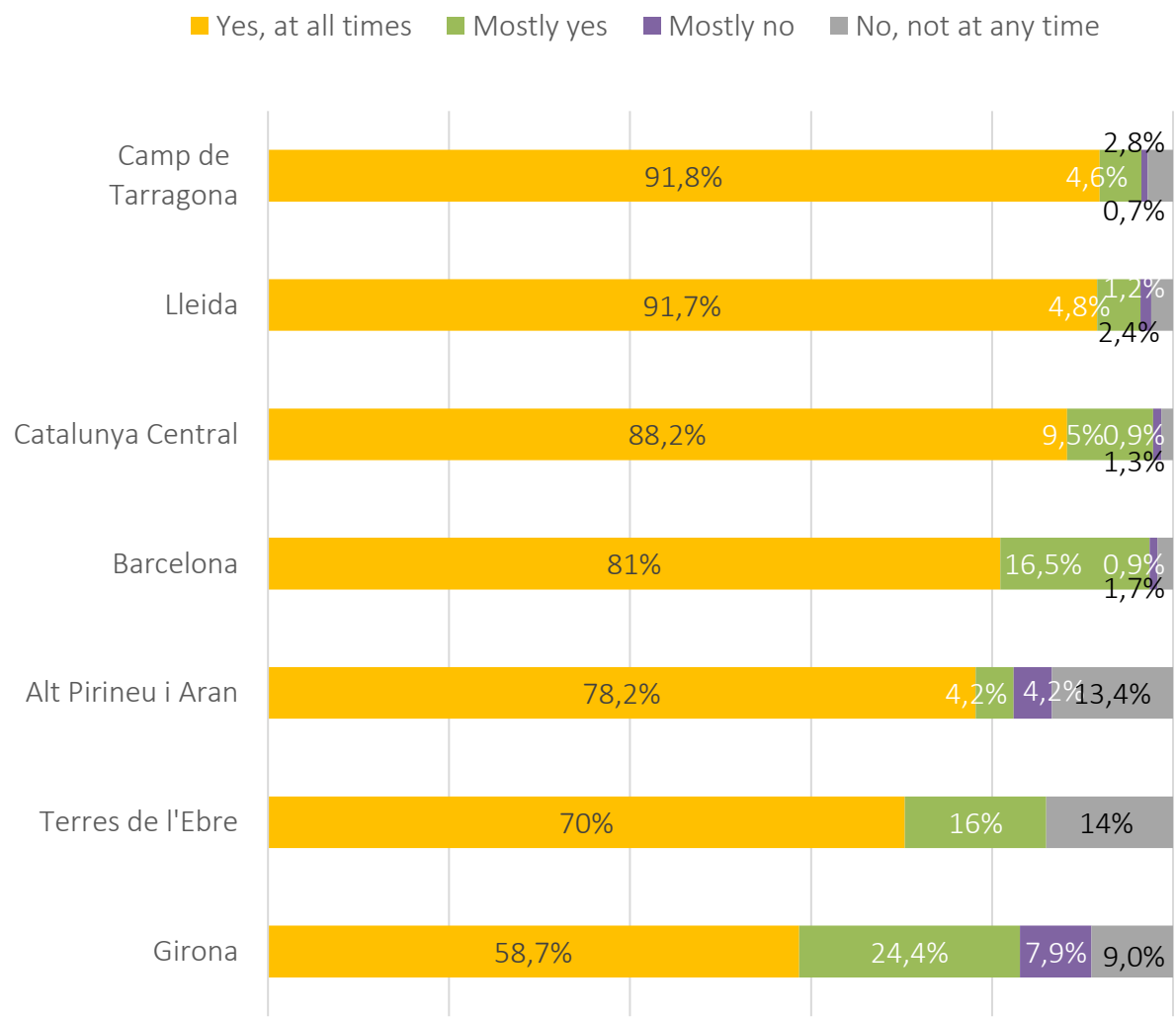
Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

3.3. Accompaniment across Catalan Health Regions

- Territory is a variable that a priori and under normal conditions should not maintain a direct relationship with women's possibility of accompaniment during labor and childbirth by the persons of their choice. However, differences are observed between the Catalan health regions in the context of pandemic. For example, in areas such as *Camp de Tarragona* and *Lleida*, more than 90% of mothers were always able to be accompanied. In this line, *Catalunya Central* stands at 88.2%. In other healthcare regions, specifically *Barcelona* and *Alt Pirineu i Aran*, 81% and 78.2% of women respectively were always able to be accompanied. The healthcare regions where accompaniment was lower is *Terres de l'Ebre*, with 70% and *Girona* with less than 60%. Along similar lines, *Terres de l'Ebre*, *Alt Pirineu i Aran* and *Girona* have the highest number of childbirths that were not accompanied at any time (between 9% and 14% of childbirths) (see Graph 6).

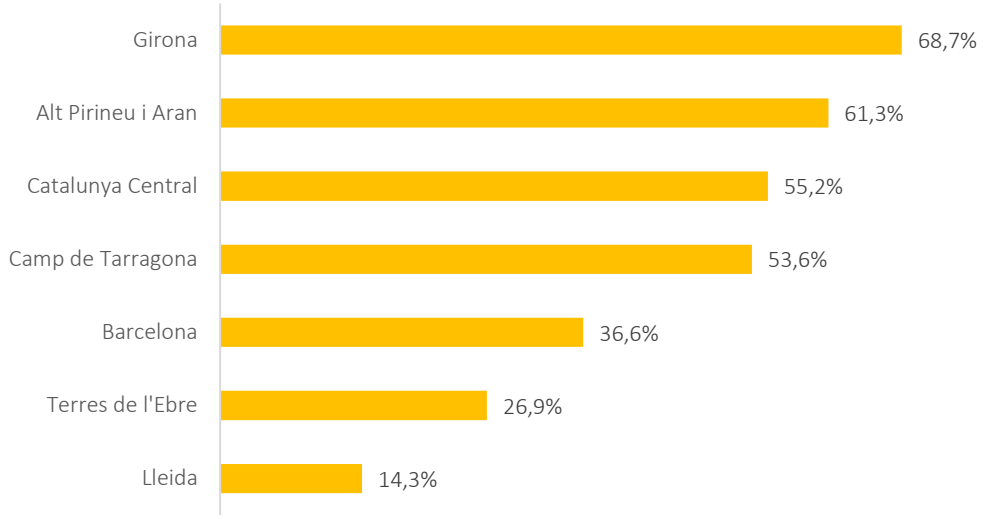
- The regions where the reason for the lack of accompaniment was mostly (over 50% of the reasons) the COVID-19 protocol were *Girona, Alt Pirineu i Aran, Catalunya Central* and *Camp de Tarragona* (See Graph 7). These results indicate a partial relationship between the possibility of being accompanied and the COVID-19 protocol, so there are probably other explanatory factors for the territorial differences.

Graph 6. Possibility of being accompanied during labor and childbirth. Comparison by Health Regions. In percentage, Catalonia.



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

Graph 7. Reason for non-accompaniment by COVID-19 protocol according to Health Regions. In percentage, Catalonia.



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

3.4. Accompaniment in the public and private health care system

- The setting of labor and childbirth, according to whether the labor and childbirth took place in the public or private health care system, does not show pronounced differences in the possibility of mothers being always accompanied. In the public health care system, 81.5% of women were always accompanied, while in the private system, 78.6% were accompanied. Those who were accompanied during most of the delivery process accounted for 13.2% in the public system and 16.8% in the private system. In addition, those who could hardly be accompanied accounted for 2.1% in the public system and 1.4% in the private system. Finally, in both systems, the number of women who could not be accompanied at any time was 3.2%.

- There were also no notable differences in the application of COVID-19 protocols as a cause of the lack of accompaniment in both the public and private systems, with 48.4% and 50.8%, respectively, in cases in which the cause was precisely these protocols.

3.5. Key factors in the accompaniment at all times of the person of the mother's choice

- As has been shown, the pandemic context has been a detrimental factor to the possibility of being accompanied during labor and childbirth by the mother's person of choice, especially during the first state of alarm. In addition, the way in which labor ends and the health region point to clear differences in accompaniment. Thus, a clinical and a territorial factor, separately, mark significant distances. However, this information is insufficient to understand the variations in the accompaniment during labor and childbirth. For this reason, a complementary analysis has been carried out, considering new relationships between variables, which will allow us to go deeper into the question and draw conclusions.

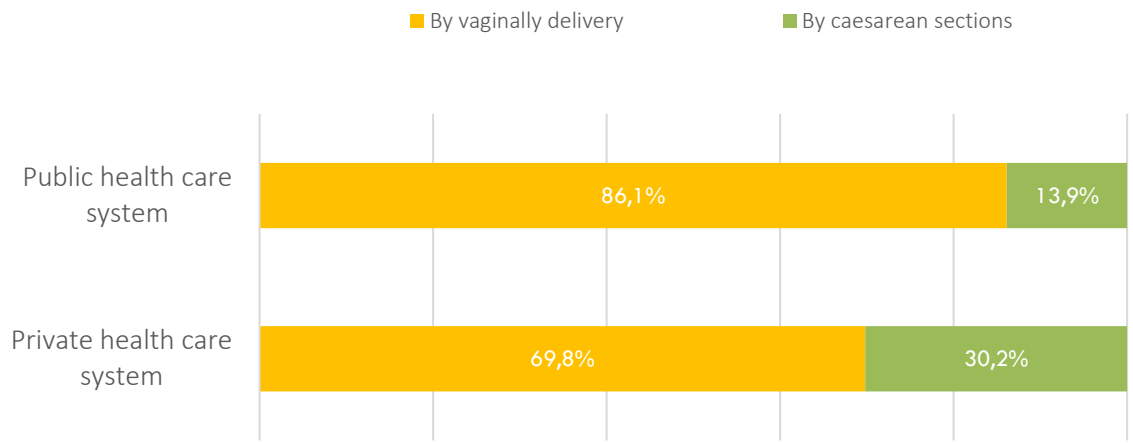
- A first element to highlight is the relationship between the completion of childbirth and the health care system. In the public health care system, 86.1% of deliveries ended vaginally, while in the private system these accounted for 69.8% of the total. Therefore, caesarean deliveries are 2.2 times more likely to take place in the private health care system than in the public system (see Graph 8).

- When analyzing the possibility of accompaniment according to the double approximation -completion of delivery and health care system- in the case of vaginal delivery, accompaniment at all times is very similar in both the public and private health care systems.

- On the other hand, in the case of caesarean sections, there are differences of more than 20 points in the accompaniment at all stages of labor and birth, being 27.1% in the public system and 49.1% in the private system (See Graph 9).

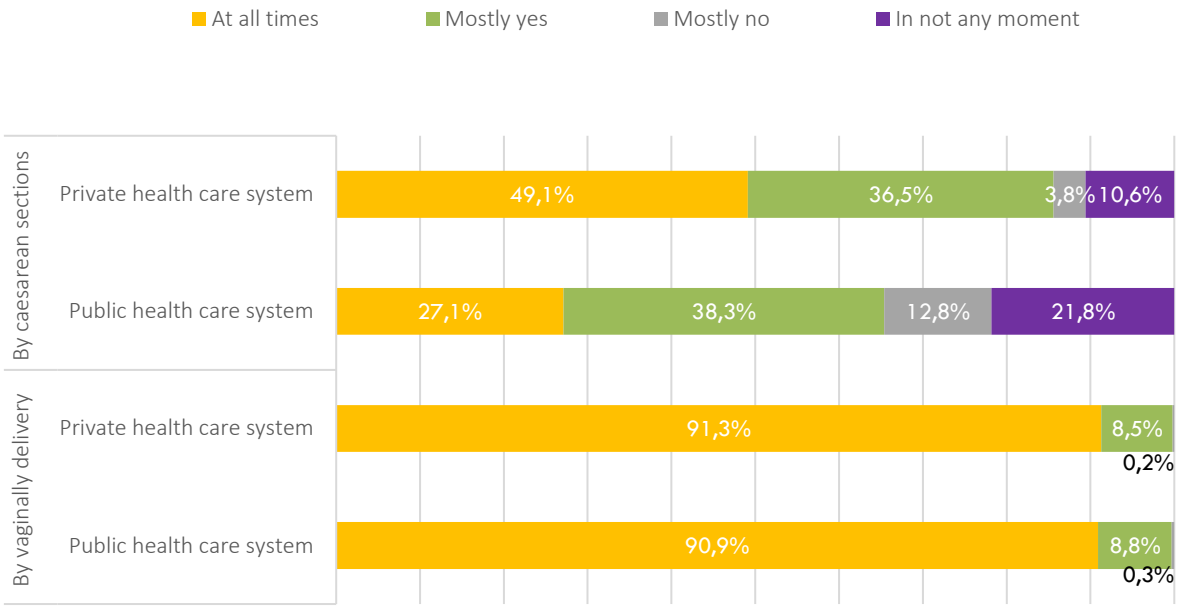
- These differences could be explained by the fact that 38.9% of caesarean sections in the public system were of an emergency nature, a figure that drops to 18.5% in the private system. In fact, the differences in the types of caesarean sections in the two health care systems are evident and are mainly because emergency caesarean sections prevail in the public system, while the predominant caesarean sections in the private system are those scheduled by the professional team (see Graph 10).

Graph 8. Type of delivery. Comparison by health care system, public and private. In percentage, Catalonia.



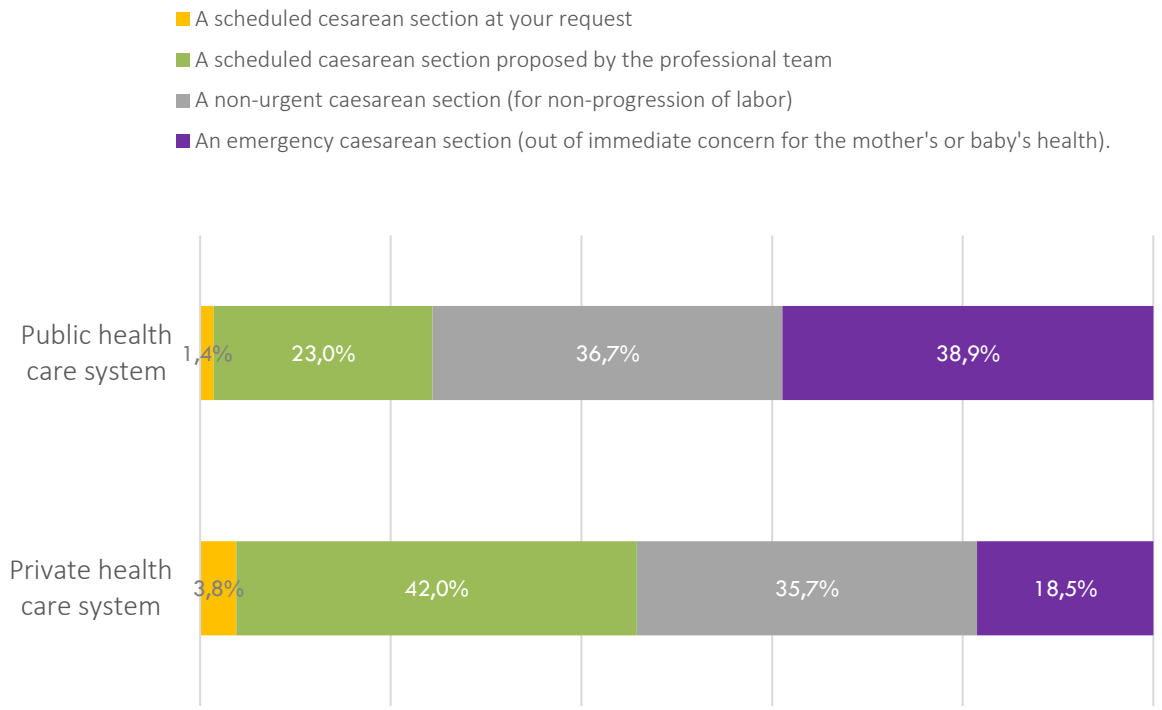
Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

Graph 9. Possibility of being accompanied during labor and childbirth. Comparison by health care system, public and private, and type of delivery. In percentage, Catalonia.



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

Graph 10. Type of cesarean section. Comparison by health care system, public and private. In percentage, Catalonia.

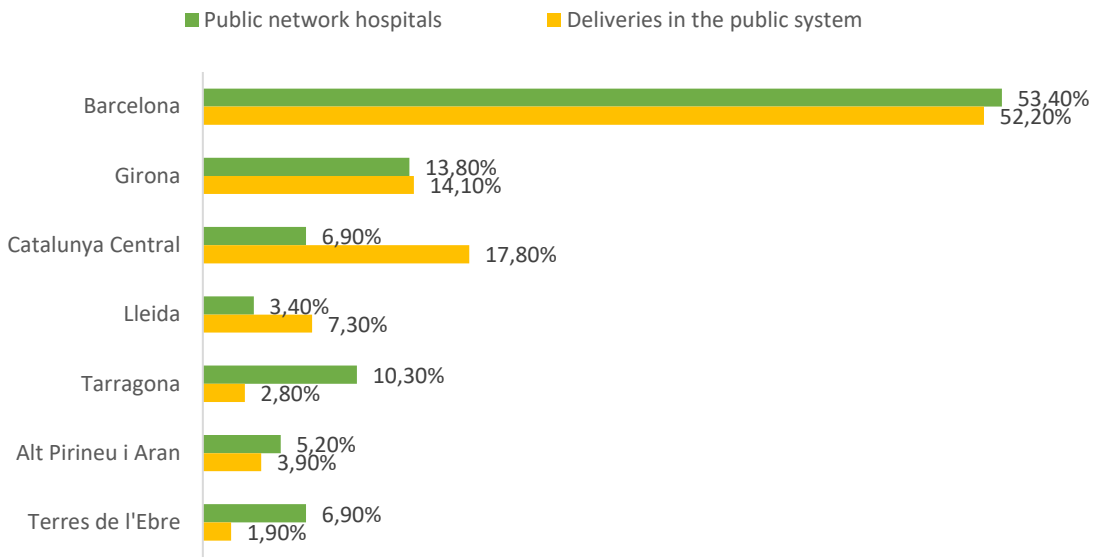


Source: Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

- A second element worth highlighting is the relationship of the territories with access to the public and private health care systems and, consequently, with the choice of the type of center where labor and childbirth take place. The comparison between deliveries in the public and private health care systems according to the health region included in the sample and the distribution of hospitals in the Catalan public network and private hospitals[2] in the territory show very clear similarities, especially regarding the private health care system. Logically, these are not comparable issues (number of hospitals and number of deliveries in a territory), but the similarities in their territorial location suggest that the distribution of hospitals according to type of ownership is an explanatory variable of interest (see Graphs 11 and 12).

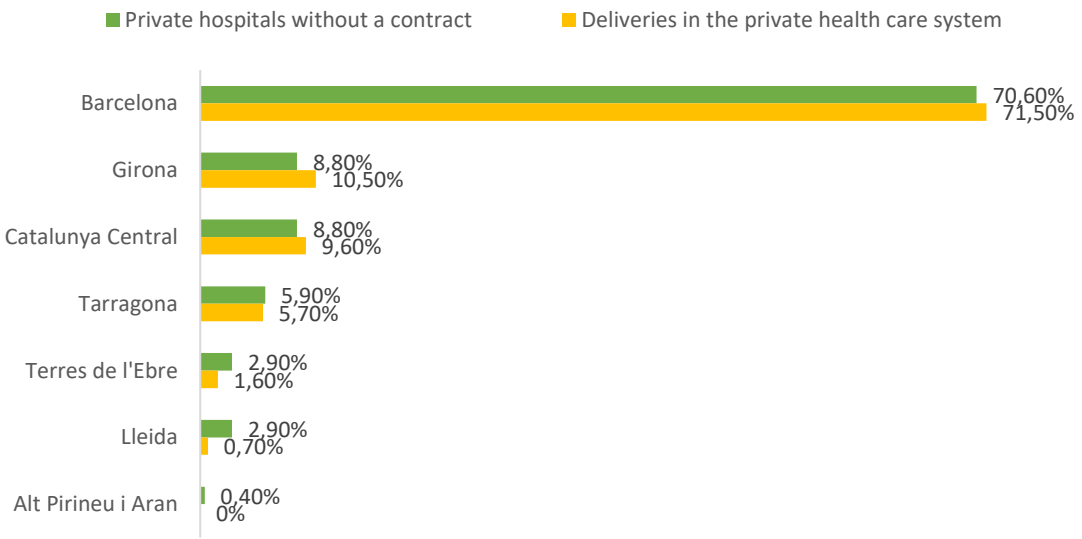
[2] To analyze the hospitals in the public network and those private hospitals without a contract, information was collected from the Ministry of Health's National Catalogue of Hospitals 2021 and only general hospitals and maternity and children's hospitals were selected. https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:9258ff58-7344-35d3-950c-9dcb10179786#pageNum=1

Graph 11. Distribution of Catalan public network hospitals and distribution of the births in the sample in the public health care system. In percentage. Catalonia.



Source: National Catalogue of Hospitals 2021 and Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

Graph 12. Distribution of the private hospitals without a contract with the public health authority and distribution of the deliveries of the sample in the private health care system. In percentage. Catalonia.

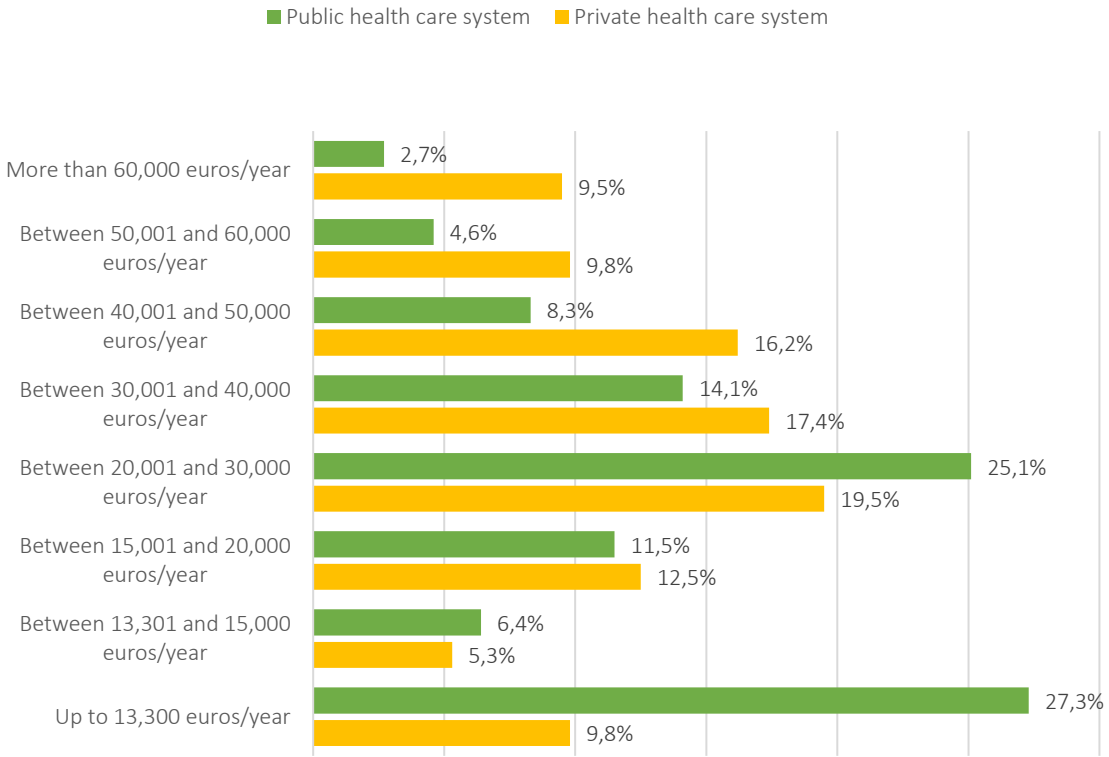


Source: National Catalogue of Hospitals 2021 and Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia.

- Access to private healthcare during labor and childbirth also points to differences according to the sociodemographic characteristics of the mothers, especially about income levels and academic training. Thus, among women who opted for the public health care system, 70.3% did not exceed a household income level of 30,000 euros per year, while in the case of women who opted for the private system, incomes below 30,000 euros per year accounted for 47.1% (see Graph 13).

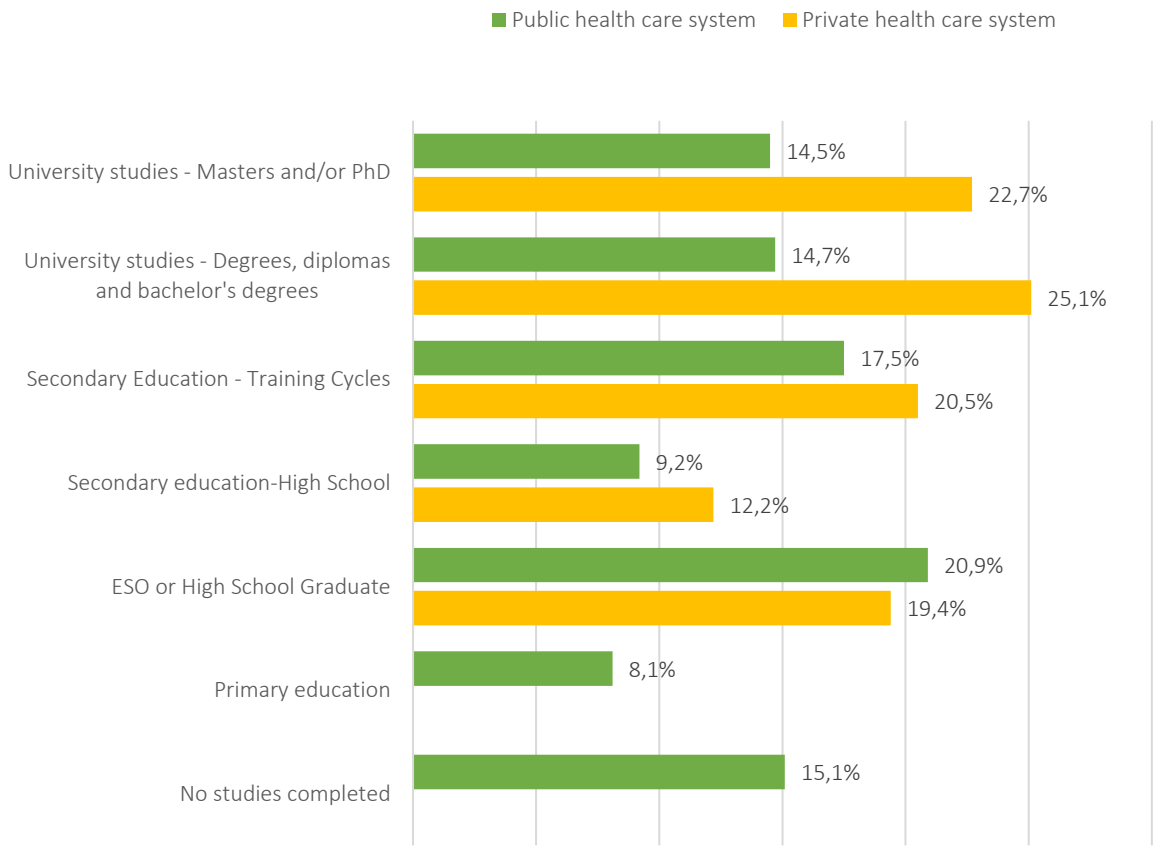
- In parallel, and similarly, women with non-university studies represent 70.8% of the total number of mothers who opted for the public system, a figure which in the private system is reduced to 52.2%. Mothers with lower levels of education, moreover, did not access the private health care system (see Graph 14).

Graph 13. Choice of health care system, public and private, for childbirth, according to household income level. In percentage, Catalonia.



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

Graph 14. Choice of health care system, public and private, for childbirth, according to educational level. In percentage, Catalonia.



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

4. In summary

- The mother's right to be always accompanied by the person of her choice during childbirth has been compromised, to varying degrees of intensity, in the context of the COVID-19 pandemic. In general, during the first state of alarm, the measures implemented to prevent infection, often against official and professional recommendations based on scientific evidence, were detrimental to this right. On the other hand, COVID-19 positive women at the time of labor and childbirth are those who have seen their right to give birth accompanied by the person of their choice most markedly impacted. The data following the first wave of the pandemic point to the need to ensure the right to continuous and interrupted accompaniment during labor and childbirth and to return, at the very least, to pre-pandemic values.

- The main reason for the restriction or prohibition of the accompaniment provided by the health professional teams was the COVID-19 protocol applied in the hospital center despite the fact that, as noted above, the official recommendations during the pandemic included the preservation of accompaniment during childbirth whenever possible. This is the case in the *Girona* health region, where women were less likely to be always accompanied during labor and childbirth and, at the same time, it is the region where the COVID-19 protocol was most often provided as the reason for not being accompanied.

- The way in which the labor and childbirth ends affects the mother's possibility to be always accompanied. In the pandemic context, women who had caesarean deliveries were less accompanied than women with vaginal deliveries, with differences of more than 50 points.

- Differences were observed among the Catalan health regions in the pandemic context in terms of accompaniment at all times by the person chosen by the mother. The health regions where greater accompaniment was allowed were, in this order, *Camp de Tarragona, Lleida* and *Catalunya Central*. The most restrictive health regions were *Terres de l'Ebre*, *Alt Pirineu i Aran* and *Girona*. If different variables are analyzed simultaneously, it was precisely in the *Girona* health region where the most caesarean sections were performed in Catalonia, with a very high percentage of 35% of the total number of deliveries in that territory.

- No pronounced differences were identified in the context of the pandemic in the possibility of mothers to be always accompanied during childbirth by the person of their choice, depending on whether they gave birth in the public or private health care system.

- However, when we analyze the type of delivery and the type of health care system simultaneously, we find relevant differences. Caesarean deliveries are much more frequent in the private health care system than in the public health care system and, although in the case of vaginal births, accompaniment throughout the delivery is very similar in both health care systems, in the case of caesarean deliveries women are

much more likely to be accompanied throughout the labor and childbirth by the person of their choice in the private health care system than in the public health care system. These differences could be linked to the fact that in the public health care system there are more emergency caesarean sections, while in the private system there are more programmed caesarean sections. They could also be related to a greater medicalization of the delivery process in the private sector than in the public health sector (Aznar, 2022). In the absence of being able to go more deeply into this question, it can be concluded that women who have had a caesarean delivery in the private health sector during the pandemic have been more likely to be accompanied than those who have had a caesarean delivery in the public system.

- If we consider that private hospitals are strongly concentrated in some health regions of the Catalan territory, in this sense the territorial differences in accompaniment during caesarean delivery could also be explained, at least partially, by the differentiated access to private health care during childbirth. This is the case of *Girona* and *Catalunya Central*, which are the second and third health regions respectively with more private hospitals and with more deliveries in the private health care system.

- The gap in access to private health care for childbirth during the pandemic is also noteworthy. The socioeconomic inequalities observed in the choice of type of center -public or private- have also produced inequalities in the possibility of being accompanied at such a transcendental moment in women's lives. During the pandemic, women with lower levels of education and income have not had access to the private health care system or have had it to a lesser extent than to the public system. As a result, in the case of caesarean deliveries, have been less likely to be accompanied. Ultimately, structural inequalities are visible in terms of the right to accompaniment or, at least, not only directly explained by the pandemic.

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