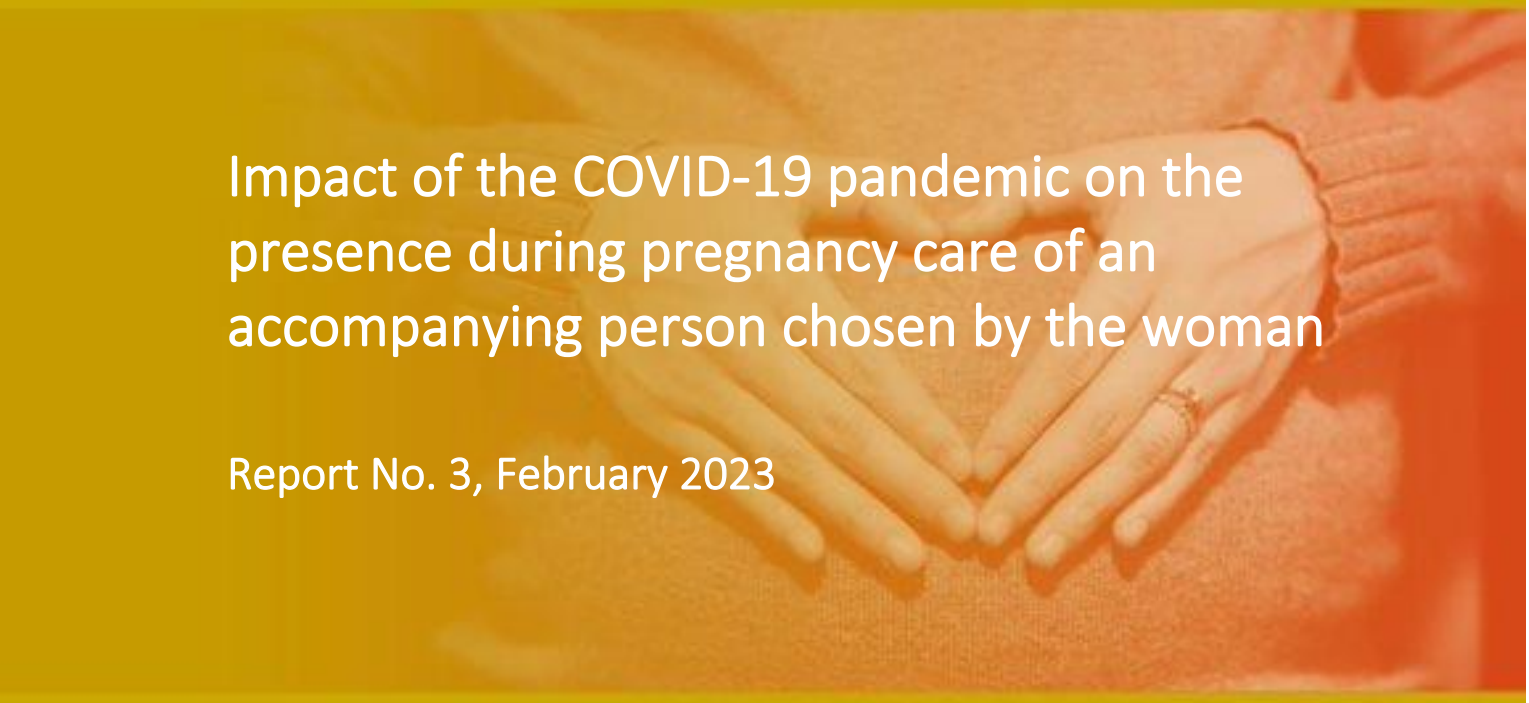
Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia



Impact of the COVID-19 pandemic on the presence during pregnancy care of an accompanying person chosen by the woman

Report No. 3, February 2023

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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, 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, for example, 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 it had been carried out up to that moment. Furthermore, some voices denounced that the sexual and reproductive rights of women during pregnancy, labor, or postpartum were being subordinated to the demands of the management of the pandemic and, in some occasions, violated.

In some countries, the possibility of having a companion at pregnancy follow-up visits and tests was suspended during the first wave of the pandemic, mainly in the public health care system (Gazar et al., 2021; Vasilevski et al., 2022; Irvine et al., 2022; Linden et al., 2022). In other cases, if appropriate precautions were taken, pregnancy follow-up appointments and tests continued to be performed by allowing access to the accompanying person of the pregnant woman's choice (*Coronavirus (COVID-19)*, 2022; NHS Scotland, 2022; NHS Wales, 2022; NHS Kingston Hospital, n. d.; Martins, 2022). Regardless of the crisis scenario, the World Health Organization (WHO) advocated for the maintenance and protection of the rights of pregnant women, for ensuring dignified treatment, clear communication between women and health personnel, and for accompaniment during labor (World Health Organization, 2022a). However, these guidelines were not respected in a cross-cutting or homogeneous manner.

In addition, with the aim of guaranteeing women's sexual and reproductive rights, the WHO recommends interventions in health care systems to improve the use and quality of prenatal care. These include prenatal care, prenatal appointments and accompaniment by midwives during all phases of pregnancy (World Health Organization, 2016). There are studies showing that women without prenatal services are at increased risk of death, fetal death, and other adverse outcomes (Ortiz et al., 2020). In general, the WHO advocates the need to universalize access to sexual and reproductive health (World Health Organization, 2022b). In turn, the Council of Europe has guidelines against obstetric and gynecological violence, which include procedures performed without the patient's consent or without appropriate communication (Blondin, 2019).

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 started in 2021 the research project Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia. The project received funding from the Ministry of Equality (Secretary of State for Equality and against Gender Violence/State Pact against Gender Violence) and the Secretariat for Universities and Research of the Department of Entreprise 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, we believe that the data generated are of great relevance to shed light on situations, not always positive, that thousands of women in Catalonia had to live at a time in their lives with enormous needs for care and support. Therefore, 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 were mothers and/or were pregnant during the pandemic,
- to the groups, entities, associations, and other feminist spaces dedicated to promoting the rights of women to become mothers in conditions of care, respect, free choice in the different phases of their processes and with attention focused 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 on the Catalan health care system. This impact resulted not only in enormous difficulties to respond 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 a clear 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; family visits at the hospital were prohibited; 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 provide 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 **third report in a series of reports resulting from the** research project Sexual and reproductive rights in pandemic times: maternity and COVID-19 in Catalonia. The first report focused on the care received during childbirth by COVID-19 positive women. The second report addressed the impacts of the pandemic on women's ability to have an attendant of their choice present during childbirth. *This third report focuses on women's ability to be accompanied by a person of their choice during pregnancy monitoring in the context of the pandemic*. This person is usually associated with the other parent, although it may be a relative or another person close to the mother or even a doula.

The WHO points out in its recommendations that access to having continuous support of choice is essential to act in a respectful manner with the woman and maintain good maternity care, meeting the family's needs (World Health Organization, 2018). Therefore, restricting the access of companions can significantly affect the support required by women (Ortiz et al., 2020). Thus, the subject of this third

report is relevant because it allows to reflect on the impact of security measures on the process of accompanying and supporting women. Scientific evidence has been published, in turn, on the need and desire of fathers and other parents to accompany mothers during prenatal procedures with the aim of mitigating negative feelings during the management and labor and sharing responsibilities during this period (De Souza Santos et al., 2022). On the other hand, pregnant women, despite showing empathy with the seriousness of the overall health situation during the pandemic, felt impaired in terms of follow-ups and available information, reporting distress and emotional trauma in the process (Sanders & Blaylock, 2021).

The impossibility of having the support of choice for women during pregnancy monitoring has been, in turn, one of the main situations denounced by women and organizations since the outbreak of the pandemic and, as shown by the data resulting from our study, one of the situations that has caused them the most suffering and frustration. By addressing this issue in this third report, we not only contribute to making this suffering and frustration visible, but also aim to fuel debate and reflection on the tensions that arose during this health crisis between the need to provide humanized, person-centered health care and the urgency of providing effective responses to the spread of the disease.

If you wish to be informed about the publication of data and results of the research project and to receive future reports or publications, you can fill out the form you will find in the following link with your contact information, 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 addressed to women who were pregnant from January 1, 2018 until the end of September 202. We had therefore a target group (women with an experience after March 13, 2020) and a control group (women with an experience prior to this date).

The dimensions and axes of analysis helped to measure the impact of the management of the COVID-19 pandemic on health services for maternity care and support. They have been 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 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

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 themes

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 themes

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 had 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 childbirth preparation group or 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 from the target group and 208 from the 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 pregnancy

The most common profile of the women who participated in the study and who answered the questions about pregnancy care during the pandemic is that of a woman between 30 and 37 years old who is a second-time mother, considered to have a low risk during pregnancy, and with delivery at term (not premature).

- Age. 56.6% of mothers are between 30 and 37 years of age and, overall, about 68.0% of the cases are concentrated between 30 and 40 years of age.
- Parity. 40.1% of the sample corresponds to primiparous mothers while 59.9% already had a daughter/son. No results were obtained for mothers with more than one previous daughter/son.

- **Risk in pregnancy.** 62.9% of the pregnancies were considered low risk, 21.7% medium risk and 15.4% high risk.
- **Prematurity.** 15.5% of deliveries were preterm, except for one case, all of which were moderate or late, and the remaining 84.5% were deliveries at term.
- **Waves of the pandemic.** Of the pregnancies analyzed, 6.3% of the births occurred during the first state of alarm (March-June 2020) and 93.7% afterwards.

3. Main results

3.1. Meaningful accompaniment during prenatal care

- Three types of care were considered in the analysis of accompaniment during pregnancy: the first focused on preparing the mother for childbirth through courses or in-person pregnancy support and childbirth preparation groups; the second on pregnancy tests and follow-up appointments, differentiating ultrasound scans from other tests. Finally, in the case of complications during pregnancy (for example, related to the health of the fetus and/or the mother), emergency room visits, and notification of bad news were considered.

- Among the possible answers to the survey questions about the possibility of being accompanied, women had to choose between the following options: 1) being accompanied all the time, 2) being accompanied most of the time, 3) not being accompanied most of the time, 4) never being accompanied, or 5) having chosen not to be accompanied.

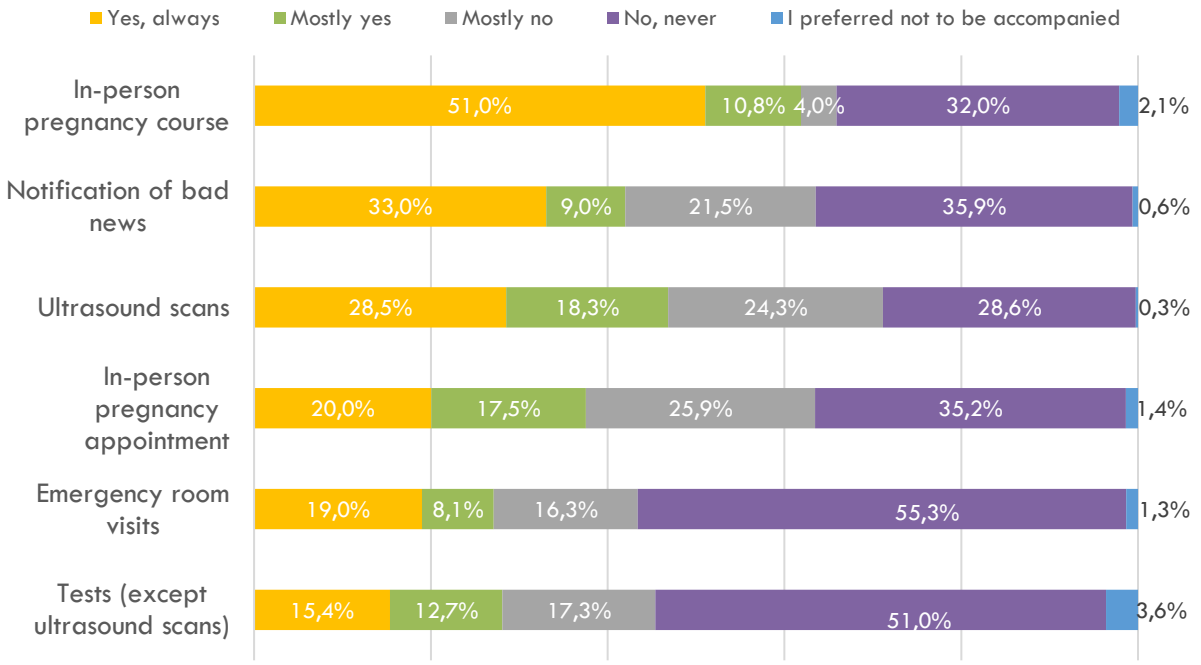
- There are differences between the type of prenatal care and the possibility of being accompanied at all times during pregnancy follow-up. It should be noted that the lack of accompaniment is not related to the mother's decision. For all the care services analyzed, the mothers who chose not to be accompanied did not exceed 4% of the total, and the majority were well below this percentage (See Graph 1).

- In-person childbirth preparation courses or groups were the places where mothers were most able to be accompanied: 51% were always accompanied and 10.8% were mostly accompanied. We should keep in mind that these types of courses or groups do not necessarily take place in hospitals or health centers, but in community centers or primary care centers ("Pregnancy and Maternity Preparation", n.d.; "PREPARATION COURSE FOR BIRTH", n.d.). This may have facilitated access of accompanying persons in comparison with other services (See Graph 1).

- The notification of bad news is, after childbirth preparation courses or groups, the moment when mothers were most able to be accompanied (33% always and 9% mostly). That said, it should be noted that during the pandemic, practically 6 out of 10 pregnant women were alone in the notification of bad news related to pregnancy.

- Next, ultrasound scans were the type of tests where mothers could be accompanied the most (28.5%), above other types of tests (15.3%) and in-person pregnancy follow-up appointment (20.0%). The rest of the pregnancy follow-up tests were the times when women were least able to be accompanied, below even emergency room visits (19.0%). In sum, about 7 out of 10 women could not be accompanied during the procedures (See Graph 1).

Graph 1. Possibility of being accompanied during the services. Comparison in-person pregnancy course, ultrasound scans, notification of bad news, in-person pregnancy appointment, tests, and emergency room visits. In percentage, Catalonia.



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

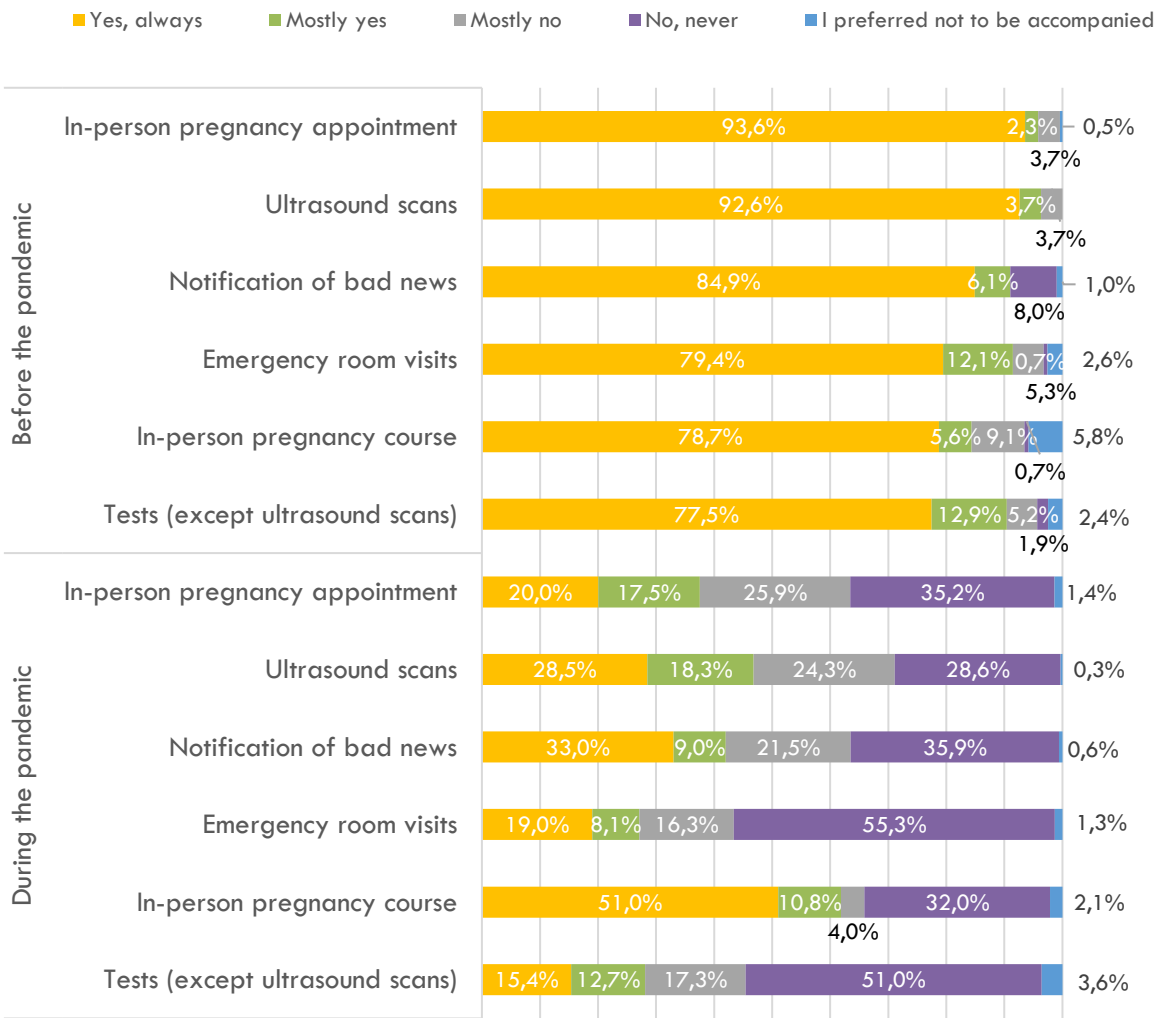
3.2. Reduction of accompaniment during the pandemic

- Before the pandemic, despite complete accompaniment was not fully allowed in any of the prenatal care services analyzed, the figures were quite high, ranging from 77.5% of accompaniment at all times in the case of tests (excluding ultrasound scans) to 93.6% in in-person pregnancy appointments. Therefore, practically 8 out of 10 women were accompanied at all times in any of the prenatal care services, a figure in accordance with WHO recommendations on accompaniment.

- With the pandemic, accompaniment during prenatal care was drastically and unequally reduced according to the type of service, the most affected being in-person pregnancy follow-up appointments. In this case, accompaniment at all times was reduced by 73.5 points with respect to pre-pandemic figures (20% versus 93.6%). Ultrasound scans showed a drop of 64.1 points compared to the pre-pandemic period (28.5% versus 92.6%). In other follow-up tests there was also a significant drop in the level of accompaniment (from 77.5% to 15.4%) and in emergency room visits, accompaniment at all times decreased by 60.4 points. In the case of notification of bad news, the possibility of being accompanied decreased by 50 points. Thus, after the first alarm,

almost 7 out of 10 women could not be accompanied during these moments (See Graph 2).

Graph 2. Possibility of being accompanied during the in-person pregnancy course, ultrasound scans, notification of bad news, in-person pregnancy appointment, tests, and emergency room visits. Comparison before and during the pandemic. In percentage, Catalonia.



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

3.3. Accompaniment in the public and private health care system

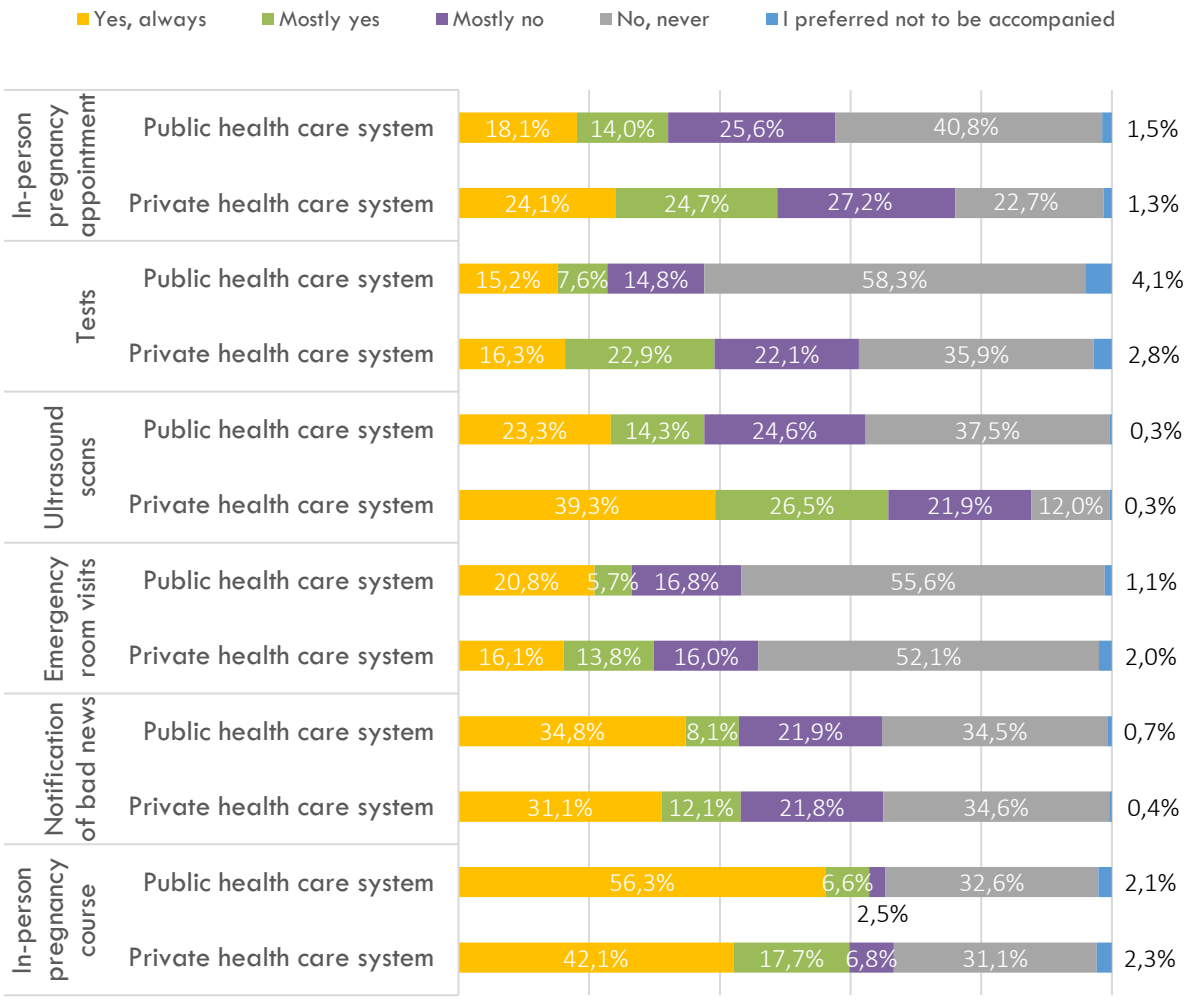
- The possibility of being accompanied according to the type of health service (public or private) shows differences, with the private sector being where women were more likely to be accompanied at all times during in-person pregnancy appointments (24.1% versus 18.1% in the public sector), tests (16.3% versus 15.2% in the public sector) and, above all, during ultrasound scans (39.3% versus 23.3% in the public system).

- On the other hand, in-person pregnancy courses or groups, emergency room visits, and notification of bad news were the places where pregnant women were accompanied to a greater extent in public health services than in private ones.

- In the case of notification of bad news, the accompaniment was similar: In the public services, 34.8% of the women were able to count on a companion at some point, compared to 31.1% in the private sector. Another discrepant result is the in-person childbirth preparation course or group. In this case, public health services exceeded the proportion of accompaniment observed in the private sector (56.3% vs. 42.1%). In the case of emergency room visits, the percentage of accompaniment was 20.8% in the public sector and 16.1% in the private sector (see Graph 3).

- For the other procedures -in-person follow-up appointments, tests, and ultrasound scans- care in the private sector allowed for a higher rate of accompaniment. For in-person appointment, only 18.1% of the women attended by the public system were able to access them with a companion, while 24.1% of the women attended by the private system were accompanied at some point. The lowest percentages of accompaniment were recorded for the tests: The ratio between the public and private systems was very similar, with 15.2% for the public system and 16.3% for the private system. Finally, the greatest differences (16 percentage points) were observed between public and private services in the accompaniment of women in ultrasound scans examinations, with the private health services allowing it to a greater extent than the public ones (See Graph 3).

Graph 3. Possibility of being accompanied during pregnancy care services. Comparison by public and private health care system. In percentage, Catalonia.



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

3.4. Differences in accompaniment according to health region

- Although the territorial distribution should not present discrepancies in the possibility of accompaniment in pregnancy care services, the data point to a lack of homogeneity between health regions in Catalonia. *Alt Pirineu i Aran* is a paradigmatic case where practically all the women could be accompanied at all times in all the services analyzed, especially during the in-person pregnancy courses or groups and the notifications of bad news. For tests and pregnancy appointment, the lowest percentage in this health region was 92.3% and was recorded for tests other than ultrasound scans. The low

density and small population, as well as the exclusive use of public health services among the sample collected, may help to explain these results.

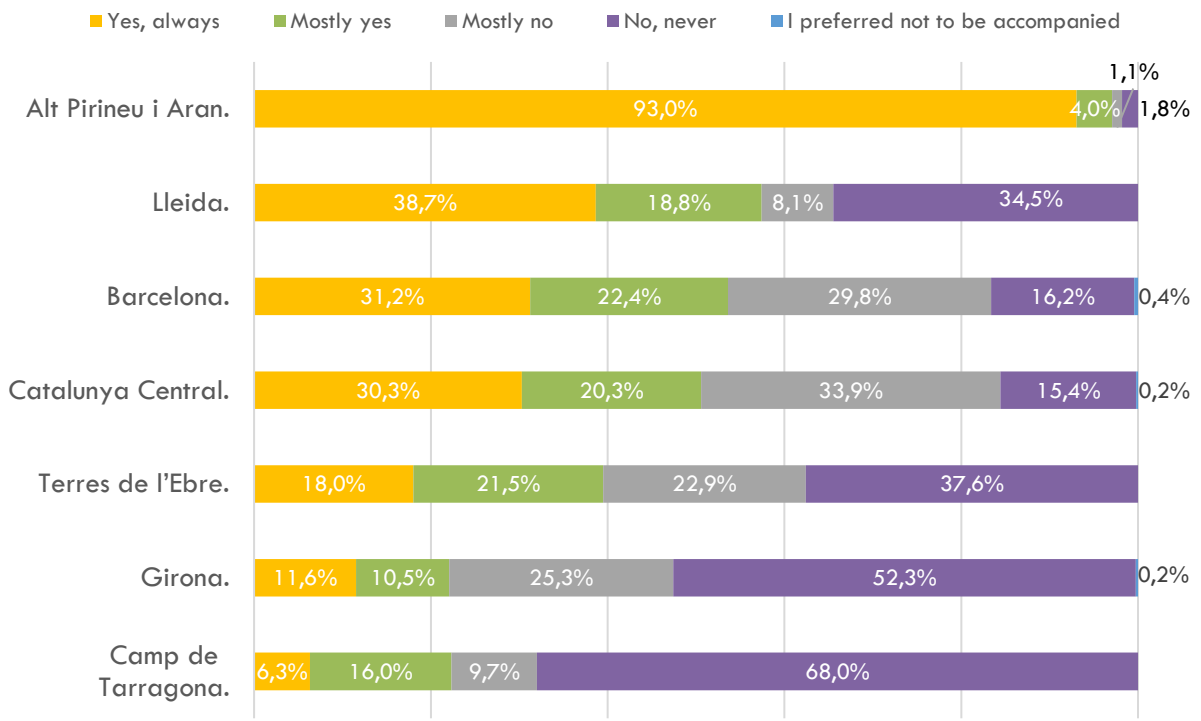
- Beyond the case of *Alt Pirineu i Aran*, the regions of *Lleida*, *Barcelona* and *Catalunya Central* had the highest percentages of accompaniment in general in comparison to the other Catalan health regions. *Girona* and *Camp de Tarragona* had the lowest levels and *Terres de l'Ebre* was somewhere in between. Following this pattern, in relation to ultrasound scans, *Lleida* has the highest percentage of accompaniment at all times (38.7%), followed by *Barcelona* (31.3%) and *Catalunya Central* (30.3%). In turn, *Camp de Tarragona* has the lowest percentages for ultrasound scans (6.3%) followed by *Girona* (11.6%). *Terres de l'Ebre* is in the middle with 18.0% (See Graph 4).

- In general, in-person pregnancy courses or groups were cancelled for the majority of women (55.5%). When we analyze the groups or courses that did remain in-person, *Barcelona* has 54.7% of accompaniment at all times, *Camp de Tarragona* 51.0%, and *Catalunya Central* 58.7%. In an intermediate position is *Lleida* (46.6%) and *Terres de l'Ebre* (38.0%). Finally, *Girona* has the lowest percentage of accompaniment for the in-person pregnancy courses or groups (17.7%) (See Graph 5).

- In in-person pregnancy follow-up appointments, accompaniment at all times reached 55.5% in *Lleida* and 38.6% in *Barcelona*, while in *Girona* it was 18.5% and in *Camp de Tarragona* 19.1%. For tests, *Lleida* (with 35.1%) and *Catalunya Central* (with 28.7%) lead in terms of accompaniment, and *Camp de Tarragona* (11.2%) and *Girona* (16.25%) again present the lowest percentages. In the case of emergency room visits, *Lleida* presents the highest percentage of accompaniment (63.8%), while *Camp de Tarragona* and *Girona* the lowest (7.7% and 9.1% respectively).

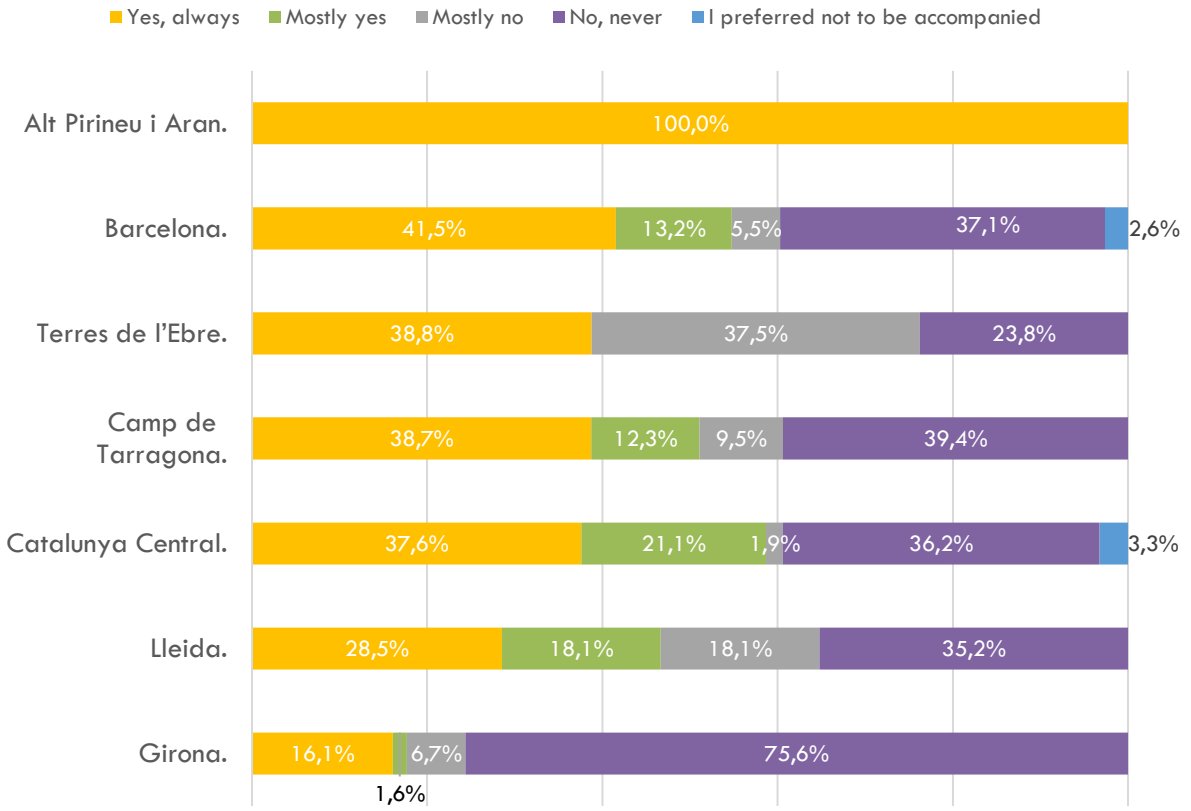
- As observed in the previous report (Impact of the COVID-19 pandemic on accompaniment during childbirth), the data analyzed show a relationship with the territorial distribution of public and private hospitals according to health regions. Thus, there is an asymmetry in the right to accompaniment in prenatal services that a priori cannot be explained by clinical or safety reasons in the face of COVID-19.

Graph 4. Possibility of being accompanied during ultrasound scans according to health regions. In percentage, Catalonia.



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

Graph 5. Possibility of being accompanied during in-person pregnancy courses or groups according to health regions. In percentage, Catalonia.



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

4. In summary

- International agencies and governments have been speaking out for years in favor of the rights of pregnant women, including easy and clear access to information and the right to accompaniment throughout the process of professional pregnancy care (Blondin, 2019; Ortiz et al., 2020; World Health Organization, 2022a; World Health Organization, 2022b). However, the results of this survey show that in the pandemic context the right of pregnant women to be accompanied at all times was seriously compromised.

- In general, emergency room visits and tests (other than ultrasound scans) had the worst accompaniment rates. Moreover, in these services, a slower recovery of the levels of accompaniment prior to the pandemic was observed. In other words, the lack of accompaniment may be becoming chronic once the most serious moments of the pandemic have passed. On the other hand, the in-person childbirth preparation course or group showed the best accompaniment results and the smallest drop during the pandemic period. Again, this tendency could be explained by the nature of the service and the spaces where it is developed.

- Public and private health services show differences with respect to accompaniment. This could be explained, at least in part, by the collapse of public health care during the most critical period of the pandemic. The Catalan health regions also showed different results in relation to the possibility of pregnant women to be accompanied during tests, follow-up appointments and pregnancy groups. In this sense, *Alt Pirineu i Aran* stands out, while *Lleida*, *Barcelona,* and *Catalunya Central* follow very closely in the results. As already noted, the relationship between health regions and the health care system generates a territorial bias in the right of mothers to be accompanied.

- Studies that delve deeper into the causes of territorial disparities and disparities by type of service may shed light on the origin and dimension of the factors analyzed here. In any case, it seems clear that there is a need to advance in policies that guarantee satisfactory levels of pregnancy care, regardless of the epidemiological situation, the territory, or other health factors.

- The protection of health due to the COVID-19 pandemic cannot leave behind the guarantee of women's and infants' rights. Therefore, public policies should be aimed at guiding the resumption and improvement of protocols and services to guarantee these rights (World Health Organization, 2022a).

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