

Coronavirus and the impact on people with protected characteristics

Birthrights evidence, April 2020

Overview

Birthrights is the UK charity that champions respectful care for women during pregnancy and childbirth by protecting human rights. During the pandemic, babies continue to be born at the same rate as ever and health services must recognise that pregnant and labouring women and birthing people are a vulnerable and unique group with a fundamental human right to safe, compassionate and respectful maternity care.

Over the last month, hundreds of women have contacted our advice line with serious concerns about their maternity care. We are particularly concerned about the following issues during the pandemic:

- **Suspension of maternity services, including home birth and midwifery-led birth centres and restricted access to pain relief**
- **Impact on women from disadvantaged and vulnerable groups**
- **Continuity of care**
- **Permitting birth partners to support women before, during and after labour**

There has been an exemplary response to the crisis by many NHS Trusts. They have rapidly adjusted in very difficult circumstances to provide women with continued access to safe and supportive maternity care that respects their choices.

However, there has been an **inconsistent, disproportionate and inhumane** response by some NHS Trusts, which are not taking evidence-based decisions in line with national guidance. And many Trusts are applying policies in a blanket way and **are not considering exceptions based on women's individual circumstances,**

We are concerned that in many areas Trusts acted too quickly to withdraw services, and aspects of services that are essential to women's psychological and physical safety such as allowing partners to video-conference into scans, continuing to operate home birth services and midwifery-led settings and a continuity of care model. In addition, timely communication of changes to maternity services has been poor in many cases. We believe this has contributed to anxiety amongst women to attend antenatal appointments in hospitals and to come into hospital to give birth. It also means that Trusts have lost contact with some of its most vulnerable women and birthing people.

We have written to NHS England and Improvement to express concerns about the proportionality of decisions that are being taken by maternity services, and to call for transparency in Trust decision-making and planning, including publication of service closures notified to the Department for Health and Social Care and of escalation plans that include withdrawing services notified to NHS England & Improvement.¹ Whilst we understand that decisions faced by Trusts in order to run a safe and effective service are not easy, and that the situation is constantly evolving, **we believe that the best way to**

¹ <https://www.birthrights.org.uk/wp-content/uploads/2020/04/Letter-to-NHSE-re-transparency.pdf>

ensure decisions are evidence-based and robust is to ensure that Trusts are open and transparent in their decision making. This will ensure that reasoning is well understood and easily communicated, and that disparities across the country can be properly examined. This must happen now: we understand that individual Trust decisions will need to change over time to reflect local circumstances during the pandemic, however transparency should be maintained throughout.

Looking to the longer term, we are concerned that NHS Trusts **lift any restrictions as soon as possible**, continuing to make exceptions for women's individual circumstances throughout this process. We are keen to see the NHS resume a focus on achieving the **aims and outcomes of the Maternity Transformation Programme** as soon as possible, including a particular focus on measures to improve care for women from Black and Minority Ethnic populations and women facing severe disadvantage.

Looking ahead, services also need to be prepared for the additional mental health support needs of women and families who have experienced pregnancy, birth and early motherhood during this period, and the need for trauma-informed support and care for women, families, and for NHS staff.

What needs to be done

Now and in the immediate future

Changes and restrictions to maternity services must be **proportionate** to the real risks and any restrictions must not compromise caregivers' ability to provide safe, compassionate care.

- Trust decision making must be transparent, with service closures and escalation plans that include service closures published by the Department for Health and Social Care and NHS England.
- Trust-wide decisions about visitors and service suspensions should not be automatically applied to maternity services, whose population and needs are very distinct from the general hospital population.
- Any decisions regarding restrictions to maternity services must be proportionate and transparent, so that women and others with an interest can understand how infection control has been balanced against the impact of restricting the rights of pregnant individuals and their partners.
- Where restrictions are imposed in maternity services, individual exceptions must be considered on a case by case basis. Exceptions to blanket policies must be proactively considered where they may comprise reasonable adjustments for women under the Equality Act 2010.
- Trusts must ensure that they are providing appropriate support and maintaining offers of contact with women who are facing disadvantage or are otherwise in need of additional support.
- Every woman should have an asymptomatic birth partner of their choice with them during labour including in an operating theatre, in the birth room and throughout an induction of labour.

- Women should be able to have a single visitor on the postnatal ward where space permits social distancing. This will be particularly important for post-operative women and women with physical and psychological health needs.
- Women must be provided with a range of evidence-based pain relief options during labour, including epidurals and the use of birth pools. Access to pain relief should not be arbitrarily suspended.
- Any changes to homebirth services, closures of midwife led units, or restriction on elective c-sections, should only be undertaken as a last resort and after alternative options have been rigorously examined as advised by national guidance.
- The impact of remote hearings on reproductive health and choice cases before the Court of Protection must be kept under evaluation, to ensure that women are not disadvantaged and do not risk being unrepresented or unheard in hearings which are considering serious and long-lasting questions of bodily autonomy.

Over the longer term

- All restrictions to services should be lifted (as soon as possible), assuming the situation continues to improve.
- NHS England and Improvement should resume their focus on achieving the aims and outcomes of the Maternity Transformation Programme within six months, or sooner if possible.
- Evidence must be collated on the impact of service changes and restrictions on women's experience and outcomes, with a focus on sharing 'least restrictive' best practice to inform any future pandemic or peak scenarios.
- Evidence must be gathered on the particular impacts of maternity service changes (including service and visitor restrictions and a move to telephone appointments) on the experiences and outcomes for women from Black and Minority Ethnic backgrounds, women facing severe disadvantage, women with disabilities (including long term physical and mental health conditions), and LGBT+ birthing people.
- Services need to be prepared for the additional mental health support needs of women and families who have experienced pregnancy, birth and early motherhood during this period, and the need for trauma-informed support and care for women, families, and for NHS staff.

What is happening to pregnant and labouring women?

Our advice service has heard from hundreds of pregnant women who are anxious and frightened about what will happen to them during labour and after their baby is born. They are scared about the changes that are being made to their plans for birth, often without consultation and without adequate information about what they can expect. We are aware that women are experiencing mental health problems related to uncertainty, stress and anxiety cause by service restrictions and lack of clarity in communication, on top of concerns relating to Covid-19 itself.

" I have a history of anxiety and I'm feeling increasingly terrified as it gets closer to my due date and I don't know if there's anything I can do to avoid giving birth in a hospital. I feel completely powerless. Right now I feel like I might have no option but to freebirth, or go alone into somewhere that has a strong association with trauma for me."

We are particularly concerned that restrictions are being applied in a blanket way and that there is little consideration or capacity to consider exceptions where women and birthing people are particularly vulnerable and/or have protected characteristics.

Service suspensions and restricted access to pain relief

Women have a right to make choices about where and how they give birth. Restrictions on women's choices can only be imposed if they are necessary and proportionate.

Many NHS Trusts have **suspended midwifery-led services** and centralised maternity care on labour wards. Home birth services have been suspended in some areas because of staffing shortages and concerns about ambulance response times. Some home birth services are now being reinstated in London, Some Trusts have also closed midwifery-led units. We have heard from women who do not feel safe attending hospital because of the risk of infection or the restrictions on birth partners, some of whom now intend to give birth at home alone.

We have also heard that some Trusts are **no longer respecting women's requests for elective c-sections**. Whilst Trusts may classify these caesareans as "maternal request" we have been contacted by women are seeking them because of long term physical and mental health conditions. One Trust wrote to all women, at the beginning of the pandemic saying that maternal request caesareans had been suspended. And in Oxford, a woman with a serious genetic medical condition which had led to the death of a relative in childbirth was told she could not have a c-section and would be induced instead. We have also heard of Trusts refusing women's requests for elective c-sections in late May and beyond, when the Trust situation in relation to Covid-19 cannot be yet known.

Access to pain relief is a fundamental aspect of respectful care during childbirth. Restrictions on pain relief seriously undermine women's autonomy and can cause lasting psychological damage and trauma. Without pain relief, there is a risk that women will experience inhuman and degrading treatment, in breach of Article 3 of the European Convention on Human Rights.

We have heard about many cases of Trusts reducing women's access to pain relief during labour. Some Trusts have **suspended the use of birth pools** for women in labour. Water is an analgesic that is shown to reduce the need for other interventions and many women rely on water as their primary form of pain relief. If a hospital chooses to restrict access to certain forms of pain relief, it must have evidence which clearly supports the need for the restriction. The justification for preventing women from accessing pools in the first stage of labour is said to be based on the risk of transmission of infection but there is no evidence to support this concern.

Any decisions regarding service restrictions must be proportionate and transparent, so that women and others with an interest can understand how infection control has been balanced against the impact of restricting the rights of pregnant individuals and their partners. Where restrictions are imposed, individual exceptions must be considered on a

case by case basis, and must be proactively considered where they may comprise reasonable adjustments for women under the Equality Act 2010.

Impact on women facing disadvantage

We are concerned that restrictions – including those which are evidence-based – may have a disproportionate effect on women facing disadvantage. Women facing multiple disadvantage, including refugee and asylum-seeking women, may be more likely even in normal circumstances to give birth without a partner present. Some charities who provide birth companion and doula support are currently unable to do this, meaning that women may be left **giving birth with no birth partner to provide emotional and advocacy support**. This is despite evidence that having a trusted companion improves women's outcomes.² Other charities are only able to provide phone support.

Our research with Birth Companions last year³ highlighted that women facing disadvantage face barriers to making choices about their care and giving legal consent to interventions. This is exacerbated for women with little or no English. Access to interpretation services is highly variable in normal circumstances, and appears to be worse at present, with a number of **vulnerable women not being offered any interpretation support**. Inadequate, ineffective or completely lacking interpretation is a clear safety risk, as well as a breach of a woman's Article 8 rights, and Article 14 rights to non-discrimination. We have also heard concerns about the availability of information on maternity service changes and restrictions in languages other than English.

We are also concerned about **access to maternity care** for women facing disadvantage when services are stretched. We are aware of women who have no means to telephone maternity services (no credit or no phone), no means of accessing triage beyond travelling to the hospital (a safety concern in itself at present, particularly for women with underlying health conditions), and reliant on charitable programmes for their practical and emotional needs. This is set against a background of amplified stress, anxiety and isolation caused by health and social inequalities including poverty, abuse and trauma. The charity Happy Baby Community which supports pregnant women and new mothers who are seeking asylum or have experienced trafficking was quoted in a recent Guardian article on the impact of digital exclusion:

*"The women we work with have literally no money. They cannot [...] call midwife services or the triage at the hospital when they go into labour. After birth they are alone in their rooms with a newborn, no money, and no way of calling or going online to get any support."*⁴

There are clear safety risks arising from these issues, which need to be seen in the context of the existing severe disparities in maternal mortality and in experiences of care. Women facing severe and multiple disadvantage are more likely to die during pregnancy or after childbirth. Black women already five times more likely to die during pregnancy and the

² <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012449.pub2/full>

³ <https://www.birthrights.org.uk/wp-content/uploads/2019/09/Holding-it-all-together-Full-report-FINAL-Action-Plan.pdf>

⁴ https://www.theguardian.com/world/2020/apr/28/digital-divide-isolates-and-endangers-millions-of-uk-poorest?CMP=share_btn_link

early postnatal period, Asian women twice as likely, and women of mixed ethnicity are three times more likely to die.⁵ Their babies are also more likely to die.⁶

Continuity of care

There is a huge amount of evidence over the benefits of receiving care from the same midwife or same small team. The 2016 Cochrane review concluded that women who received midwife-led continuity of care were 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth.⁷

One of the key aims of Better Births, and the Maternity Transformation Programme resulting from it, has been to roll out continuity of care and there was a target for 35% of women to be receiving continuity of care by March 2020 and a target for the majority of women and 75% of BAME women to be cared for in this way by March 2021.

During the pandemic, we know that some Trusts have remained committed to this model (including Chelsea and Westminster – see case studies below). However other Trusts have moved away from this model. We are aware that in doing so, some Trusts have lost contact with the most vulnerable women they care for, who in turn may be less able to proactively reach and engage with maternity services (see section above). Trusts must ensure that they are providing appropriate support and maintaining offers of contact with women who are facing disadvantage or are otherwise in need of additional support.

Birth partners

One of the most important aspects of respectful care is a woman's right to companionship of her choice during labour. It is a profound restriction on women's rights to isolate them from essential support during a life-changing experience. Partners also have a right to family life under Article 8 of the European Convention on Human Rights, which protects their right to be present at the birth of their child. Birth is a critical moment for the formation of a family with lifelong psychological and emotional impact. Prohibiting birth partners is a serious infringement of women and their partners' rights to family life.

All NHS Trusts have imposed restrictions on visitors to hospital during the pandemic. Some Trusts initially prevented all women from having a birth partner with them during labour. Following guidance from the Royal College of Obstetricians and Gynaecologists, these Trusts reversed their position and permitted birth partners to accompany women during labour. However, many Trusts continue to impose restrictions:

- **Partners are not permitted to attend antenatal appointments and scans.** Some but not all Trusts are permitting partners to join scans by video. The absence of partners during scans is particularly concerning because scans can reveal that a baby has died or is suffering from abnormalities.
- **Women are prevented from having a birth partner with them during an induction on antenatal wards, despite some Trusts moving to a different**

⁵ <https://www.npeu.ox.ac.uk/mbrance-uk/reports>

⁶ <https://www.npeu.ox.ac.uk/downloads/files/mbrance-uk/reports/MBRRACE-UK%20Perinatal%20Mortality%20Surveillance%20Summary%20Report%20for%202017%20-%20FINAL.pdf>

⁷ <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full>

induction method (Cooks balloons) to enable more out of hospital inductions. This means women are alone during a difficult and physically demanding experience and there is a real risk that they will give birth without their partner.

- **Some women are being coerced into having a vaginal examination before their partner is allowed to join them**
- **Women on postnatal wards are not permitted visitors and must care for their babies without the support of their partners.** This is particularly difficult for post-operative women, who may struggle to move around or look after their baby, and for women with physical or psychological conditions who require extra support.
- At the earlier stages of the impact of the pandemic on the NHS we were hearing that birth partners were not always permitted to accompany women to the operating theatre for assisted births or c-sections, although this situation now seems to have improved.

“Yesterday I was told by my midwife that my partner is not able to be with me during the birth. I am completely devastated. I feel the whole birth will be ruined and I have been crying since I found out. I had already been suffering with anxiety and have a history of depression. Now every time i think of the birth I break down.”

We have heard that exceptions are not being made for women even when they are in a particularly vulnerable situation. We have heard about one woman whose baby tragically died during the birth but her mother was not allowed to visit her in hospital, and another where the woman was not allowed to stay overnight to make memories and there was no cold cot available to take the baby home.

Whilst most women are now able to be supported by a birth partner (if they have one), we are concerned that the initial crisis response by some Trusts was to restrict support altogether, given the evidence that having a trusted companion improves women’s outcomes. We are also concerned about the risk of restrictions being re-introduced should the NHS come under additional pressure due to Covid-19 in future.

Longer term review and changes

Looking to the coming months, we are concerned that **NHS Trusts lift any restrictions as soon as possible**, continuing to make exceptions for women’s individual circumstances throughout this process. For example, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists has published guidance⁸ which sets out a three-stage process for restricting access to midwifery-led settings and home birth support depending on local circumstances. This guidance states that it is “essential” that any restrictions to services are reviewed daily and de-escalated where possible. It is important that de-escalations happen in the broadest possible way and at the earliest opportunity to avoid disproportionately infringing women’s rights to a private and family life. Throughout this process, Trusts must be looking to **proactively ensure that they are making exceptions** to policies where necessary for women, including exceptions that may be considered ‘reasonable adjustments’ under the Equality Act 2010.

⁸ <https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-17-guidance-for-provision-of-midwife-led-settings.pdf>

We will be keen to see **learning and evaluation** taking place, with a particular focus on service reconfigurations that maintained or generated positive outcomes for women and services. This evaluation should consider Trust responses to the challenges of Covid-19 that supported ongoing delivery of the aims and objectives of the Maternity Transformation Programme, for example provision of continuity of carer and personalisation and choice for women in their maternity care. In particular we are keen to see prompt collection of evidence on the impact of service changes and restrictions on women's experience and outcomes, with a focus on sharing 'least restrictive' best practice to inform any future pandemic or peak scenarios. This must include evidence on the particular impacts of maternity service changes (including service and visitor restrictions and a move to telephone appointments) on the experiences and outcomes for women from Black and Minority Ethnic backgrounds, women facing severe disadvantage, women with disabilities (including long term physical and mental health conditions), and LGBT+ birthing people.

NHS services also need to be prepared for the **additional mental health support needs** of women and families who have experienced pregnancy, birth and early motherhood during this period, and the need for trauma-informed support and care for women, families, and for NHS staff. We are concerned by the number of women contacting our advice line who described the profound effects of stress and anxiety about their maternity care and service restrictions on their mental health. Women and families may be at greater need of postnatal support and mental health care both in the short term and in connection with future pregnancies. The impact of reduced postnatal care and lack of face-to-face access, in a context where many families will be lacking anticipated support from families and friends may also have a negative impact on women's mental health, and support needs must be met. These needs are likely to be greater for women who are already living in the most disadvantaged circumstances, with limited or no access to virtual social support and women with pre-existing and perinatal mental health conditions.

The impact of remote hearings on reproductive health and choice cases before the Court of Protection must be kept under evaluation throughout the pandemic period, to ensure that women are not disadvantaged and do not risk being unrepresented or unheard in hearings which are considering serious and long-lasting questions of bodily autonomy. This may be particularly pertinent for women with learning disabilities, mental health conditions and autistic women,⁹ and women who are socially isolated.

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https://www.equalityhumanrights.com/sites/default/files/inclusive_justice_a_system_designed_for_all_in_terim_report_0.pdf

Case studies

Chelsea and Westminster maternity team are committed to supporting home birth, birth centre birth, water birth as well as labour ward birth, including commissioning a private ambulance service to work alongside London Ambulance Service. They have contracts with eight Independent Midwives. They have provided tablets to women to counteract some of the impact of visitor restrictions in antenatal appointments and postnatally, and have changed their method of induction so that most women do not have to remain in hospital during early labour.

South Warwickshire NHS Trust are positively encouraging all women with uncomplicated pregnancies to consider home birth, are keeping the birth centre open, and remaining committed to continuity of care. They have also agreed a standard operating procedure with West Midlands ambulance service to ensure that all non-urgent transfers from home are done by private transport, leaving the ambulance service to focus on the most urgent cases.

Belfast Health and Social Care Trust are continuing to offer: a home birth service and a midwifery-led service on labour ward, water birth for women who don't have COVID, as well as birth choice clinics. They are also permitting partners to come to scans when women are about to receive bad news, welcoming partners for all fetal medicine appointments, and supporting women in particular circumstances to have their partners visit the antenatal/postnatal wards. In their neonatal unit they continue to welcome mothers flexibly, particularly recognising the needs of mothers trying to establish breastfeeding. Both parents are welcome to visit the Neonatal Intensive Care Unit (NICU).

About Birthrights

Birthrights is the UK's only organisation dedicated to improving women's experience of pregnancy and childbirth by promoting respect for human rights. We believe that all women are entitled to respectful maternity care that protects their fundamental rights to dignity, autonomy, privacy and equality. We provide advice and legal information to women, train healthcare professionals to deliver rights-respecting care and campaign to change maternity policy and systems.

Read more at: <https://www.birthrights.org.uk/>

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