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COVID-19 as a risk factor for obstetric violence

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The new coronavirus outbreak is challenging health systems around the world, requiring quick adjustments and accommodations in order to face the pandemic. During the last decade, the widespread problem of abuse and disrespect of women during childbirth was placed on the global public health agenda.[1] The concept of obstetric violence highlighted that these abuses are a form of gender violence which has been validated and perpetuated within biomedical systems.[2] In 2018, WHO recommendations on intrapartum care for a positive childbirth experience elevated "the concept of experience of care as a critical aspect of ensuring high-quality labour and childbirth care and improved woman-centred outcomes, and not just complementary to provision of routine clinical practices."[3]

These were all good advances, but what happens during serious public health threats, such as the COVID-19 pandemic we are going through? In the midst of the outbreak, in many hospital settings around the world which had improved the quality of maternity care, childbirth rights and standards of care are receding. We argue that some of the restrictions and interventions being implemented in childbirth due to the COVID-19 outbreak are not necessary, not based on scientific evidence, are disrespecting human dignity and are not proportionate to achieve the objective of limiting the spread of the virus. They therefore constitute obstetric violence, and include unnecessary interventions done without medical indications (such as caesareans or instrumental deliveries), prohibition of companionship during labour, immediate separation and isolation from the newborn, and the prevention of breastfeeding.

The first reports of COVID-19 infection cases in pregnant women came from China. In some of the first published papers, all babies were delivered by caesareans without giving convincing reasons for such intervention. In a review of the 108 cases published in Chinese and English until April 4th, the caesarean rate for pregnant mothers who were COVID positive was 92%.[4] The reason given for most was "fetal distress," however, this was not clarified in the reports, so we think some of those surgeries were likely to have been unnecessary or avoidable, and might have been scheduled due to fear within the COVID scenario. It is unlikely that 92% of those 108 women were in a condition that justified caesarean section, or that the women wished to have the procedure.

On 3rd March, Favre et al suggested the following for pregnant women with confirmed infection: "Whenever possible, vaginal delivery via induction of labour, with eventual instrumental delivery to avoid maternal exhaustion, should be favored to avoid unnecessary surgical complications in an already sick patient," giving no evidence to support that instrumental delivery avoids maternal exhaustion.[5] The paper also stated that to date, there was no evidence of vertical transmission of COVID-19 during pregnancy and only one reported case of suspected perinatal transmission. Nonetheless, it recommended the isolation of newborns of mothers positive for COVID-19 for at least 14 days, or until viral shedding cleared, time during which breastfeeding was not recommended. The United States Centers for Disease Control and

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Prevention (CDC) also recommended separating newborns until the mother was no longer considered contagious, until their update on 4th April. The guidelines had a big impact and spread quickly among Spanish speaking countries – for example, the document by Favre et al was quickly translated and published in Spanish.[6]

Such recommendations can potentially harm women and newborns. There is strong evidence to support that: the induction of labour implies a higher chance of emergency caesarean section; and caesarean section and instrumental delivery are related to a reduction in exclusive breastfeeding and are considered risk factors for postnatal depression and post-traumatic stress disorder following childbirth.[7,8] Also, the isolation of newborns and prevention of breastfeeding may lead to long-term consequences and could be harmful if applied to the general population.[9,10] Isolation of the newborn can disrupt infection prevention mechanisms; disrupt newborn physiology; stress mothers; interfere with the provision of maternal milk to the infant; disrupt innate and specific immune protection; disrupt breastfeeding and its benefits and double the burden on the health system by providing care for women and babies separately.[11]

The WHO guidelines for COVID-19 clinical management published on 13th March recognise these dangers and clearly state that all pregnant women, including those with confirmed or suspected COVID-19 infection (and taking into account the severity of the maternal condition), should have access to woman-centred, respectful, skilled care. The mode of birth should be individualised and caesarean section undertaken only when medically justified. After birth, women should be enabled to practice skin-to-skin contact, rooming-in with their newborn and breastfeeding, whether they or their infants have suspected, probable, or confirmed COVID-19.[12] Despite these WHO recommendations, the rights of women and newborns are being infringed. Protocols that should only be applied when women are in severe condition due to the infection are forced upon many, and in some contexts, upon every woman and infant, which has been reported and denounced by international midwife and human rights associations.[13,14] This is the case for most Latin American countries: Human Rights in Childbirth reports that in many maternity units across Brazil, Argentina and Uruguay, there has been prohibition of companionship during labour and birth.[14] A regional webinar on 22nd May showed examples in the countries mentioned, plus Paraguay, Ecuador and Chile, in all of which the rights of women and newborns at birth are being infringed.[15] While acknowledging that in many contexts health workers face precarious conditions, without adequate protection, exposed to longer and more demanding hours and fearing for their own health, efforts should be focused on how to cooperate to avoid infection and at the same time avoid causing harm to women and newborns.

In Spain and Chile, childbirth protocols during the pandemic have been updated and rectified to align to the WHO guidelines. Nonetheless, as members of civil society organisations for women's rights in childbirth in both countries, we are receiving daily notices of pregnant women whose labour was speeded up unnecessarily (scheduled induction of labour, routine oxytocin, instrumental births); whose only option for birth was scheduled caesarean; who were denied a companion during labour and birth; who were routinely separated from their newborns; and who were not allowed to breastfeed.[16,17]

The measures implemented are not strictly necessary and are not based on evidence. They are disrespectful of human dignity, denying women's rights. Worse, they are causing harm, stress and fear, as many pregnant women are not only afraid of contracting COVID, but also of being coerced into unnecessary obstetric interventions, or separated from their partners and newborns during and after labour. All these are likely to cause long impact effects on maternal and infant mental health.

Unfortunately, we carry a history of decades – even centuries – of harmful biomedical childbirth practices that are not evidence-based and have proved difficult to change in practice. The COVID-19 scenario reminds us of the fragility of the advances in the rights of these groups. Rather than being an effective response to COVID-19, these harmful practices are a breach of women's human rights and a cloaked manifestation of structural gender discrimination.[14] The current backlash in women's human rights during childbirth during this pandemic is a perfect example of how little it takes for health systems to infringe on the rights of mothers and their babies. We have yet to see if these harmful practices will or will not be of limited duration, but we fear a regression in the achievement of positive birth experiences for women, newborns and families around the world.

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References

1. WHO. Statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. Geneva: World Health Organization; 2015.
2. Sadler M, Santos M, Ruiz-Berdún D, et al. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reprod Health Matters. 2016;24 (47):47–55. DOI:10.1016/j.rhm.2016.04.002
3. WHO. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018.
4. Zaigham M, Andersson O. Maternal and perinatal outcomes with COVID-19: a systematic review of 108 pregnancies. Acta Obstet Gynecol Scand. 2020;99(7):823–829. DOI:10.1111/aogs.13867
5. Favre G, Pomar L, Qi X, et al. Guidelines for pregnant women with suspected SARS-CoV-2 infection. Lancet Infect Dis. 2020 Mar 3: pii. DOI:10.1016/S1473-3099(20)30157-2
6. Martinez-Portilla RJ, Goncé A, Hawkins-Villarreal A, et al. A Spanish-translated clinical algorithm for management of suspected SARS-CoV-2 infection in pregnant women. Lancet Infect Dis. 2020 Apr 9. DOI:10.1016/S1473-3099(20)30285-1
7. Davey MA, King J. Caesarean section following induction of labour in uncomplicated first births: a population-based cross-sectional analysis of 42,950 births. BMC Pregnancy Childbirth. 2016;16:92. DOI:10.1186/s12884-016-0869-0
8. Dekel S, Ein-Dor T, Berman Z, et al. Delivery mode is associated with maternal mental health following childbirth. Arch Womens Ment Health. 2019;22 (6):817–824. DOI:10.1007/s00737-019-00968-2
9. Schmid MB, Fontijn J, Ochsenbein-Kölble N, et al. COVID-19 in pregnant women. Lancet Infect Dis. 2020 Mar 17. DOI:10.1016/S1473-3099(20)30175-4
10. Smith H. Impact of COVID-19 on neonatal health: Are we causing more harm than good? Eur J Midwifery. 2020;4 (April):9. DOI:10.18332/ejm/120245
11. Stuebe A. Should infants be separated from mothers with COVID-19? First, do no harm. Breastfeed Med. 2020;15 (5):351–352. DOI:10.1089/bfm.2020.29153.ams
12. WHO. Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected. Interim guidance 13 March 2020. WHO/2019-nCoV/clinical/2020.4 Available from: https://apps.who.int/iris/handle/10665/331446
13. International Confederation of Midwives. Women's rights in childbirth must be upheld during the coronavirus pandemic. Available from: https://www.internationalmidwives.org/assets/files/news-files/2020/03/icm-statement_upholding-womens-rights-during-covid19-5e83ae2ebfe59.pdf
14. Human Rights in Childbirth. Human rights violations in pregnancy, birth and postpartum during the COVID-19 pandemic. San Francisco (CA): Human Rights in Childbirth; 2020, May 6.
15. Webinar Experiencias de Parto Respetado en el contexto de la Pandemia de Covid-19 en Latinoamérica. May 22. UNER; Facultad de Ciencias de la Salud. Available from: https://www.youtube.com/watch?v=h8RkISLxsSQ
16. El Parto es Nuestro. El Parto es Nuestro denuncia mala praxis por COVID19; [cited 2020 Apr 20]. Available from: https://www.elpartoesnuestro.es/blog/2020/04/05/el-parto-es-nuestro-denuncia-mala-praxis-por-covid19
17. Observatorio de Violencia Obstétrica Chile. Declaración pública sobre Covid-19 y nacimientos en Chile; [cited 2020 Apr 12]. http://ovochile.cl/declaracion-publica-sobre-covid-19-y-nacimientos-en-chile/