Written evidence from Birthrights (COV0024)

Overview

Birthrights is the UK charity that champions respectful care for women during pregnancy and childbirth by protecting human rights.

Pregnant and labouring individuals are a vulnerable and unique group with a fundamental human right to dignity and respectful care. Their rights to make choices about their care and the circumstances of their births are protected under Article 8 of the European Convention on Human Rights (ECHR): the right to a private and family life.

In recent months hundreds of individuals have contacted our advice line with serious concerns about their maternity care. We are particularly concerned about:

- **The impact of service suspensions and other temporary changes to maternity services**
- **The impact on women from disadvantaged and vulnerable groups**
- **Restrictions on birth partners**

There has been an exemplary response to the crisis by many NHS Trusts which rapidly adjusted 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 have not taken evidence-based or rights-respecting decisions in line with national guidance. We have seen many Trusts applying policies in a blanket way and **not considering exceptions based on women's individual circumstances**, as required by human rights law.

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. Whilst we understand that decisions faced by Trusts are not easy, we are concerned that decision-making has not always been **proportionate** or **transparent**: an issue we raised with NHS England and Improvement in April. [1]

We believe that the restrictions that have been imposed on maternity care, and a failure to communicate them in a timely manner, risk compromising the safety of women and babies and causing serious trauma and psychological damage to pregnant women and their partners.

" 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 yet to see a systematic lifting of restrictions in maternity services in England, despite the significant easing of social Covid-19 control measures.

It will be vital that the impact of restrictions on birthing individuals' experiences and outcomes are thoroughly evaluated. For example, we are concerned by emerging evidence from one Trust that stillbirth rates have risen (very) significantly during the pandemic.[2]

What needs to be done?

[1] https://www.birthrights.org.uk/wp-content/uploads/2020/04/Letter-to-NHSE-re-transparency.pdf
[2] https://jamanetwork.com/journals/jama/fullarticle/2768389

Decisions must be made with the **human rights of birthing people** and partners front-and-centre[3] and restrictions to maternity services must be **proportionate** to the real risks. Decision-making must involve service user voices.

Restrictions must be regularly reviewed and **lifted as soon as possible**.

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. Appropriate support must be offered to those in need, including women facing disadvantage.

Impact of temporary changes to maternity services

Women's rights to make choices about where and how they give birth is protected by Article 8 of the ECHR. Restrictions can only be imposed if they are necessary and proportionate. Where restrictions are imposed, individual exceptions must be considered on a case-by-case basis. They must be proactively considered where they may comprise reasonable adjustments for women under the Equality Act 2010. We are still hearing far too many cases where this is not happening.

During the pandemic, many NHS Trusts **suspended midwifery-led services including home birth** and centralised maternity care on labour wards. We heard from women who did not feel safe attending hospital because of the risk of infection or restrictions on birth partners. Some gave birth at home alone instead.

Some Trusts stopped **respecting women's requests for elective c-sections**. Whilst Trusts may classify these caesareans as "maternal request" many women were seeking them because of long term physical and mental health conditions. One woman in Oxford with a serious genetic medical condition which had led to the death of a relative in childbirth was told she would only be offered an induction.

For much of the pandemic we had concerns about **access to pain relief**. A number of Trusts **suspended the use of birth pools** for all women in labour without sufficient evidence to support their restriction. Without pain relief, there is a risk that women will experience inhuman and degrading treatment, in breach of Article 3 of the ECHR.

Impact on women facing disadvantage

Restrictions, including those which are evidence-based, are likely to have had a disproportionate effect on women facing multiple disadvantage. Women from these groups already face significant barriers to respectful care. [4] This has been exacerbated during the pandemic.

More women have been left **giving birth with no birth partner to provide emotional and advocacy support**.

Access to interpretation services – highly variable in normal circumstances yet vital for giving legal informed consent – appears to have been worse. A number of **vulnerable women have not been offered any interpretation support**, and telephone interpretation is harder to use than face-to-face. Inadequate or ineffective 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. Information about maternity service changes and restrictions in languages other than English has not always been available.

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[3] https://www.birthrights.org.uk/how-to-run-a-safe-and-effective-maternity-service-during-a-pandemic/

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

Women facing disadvantage have faced additional barriers to **access to maternity care** due to data poverty and the move to online and telephone services.

These barriers have been exacerbated in some areas by the **loss of continuity of carer**, which has resulted in some Trusts losing contact with the most vulnerable women they care for. This model of care (in which women see the same midwife or small team) is associated with significant health and emotional benefits[5] and is a key part of NHS work to reduce existing inequalities in maternity outcomes for women facing disadvantage and women from Black, Asian and mixed ethnic backgrounds.[6]

Birth partners

An individual's right to companionship of her choice during labour is a vital aspect of respectful maternity care. Prohibiting birth partners is a serious infringement of women and their partners' Article 8 rights to family life.

All NHS Trusts have imposed restrictions on visitors to hospital during the pandemic. Some Trusts initially prevented women from having a partner at all during labour, although these decisions were reversed following guidance from the Royal College of Obstetricians and Gynaecologists. However many Trusts continue to impose restrictions, even as restrictions in other areas of life are being lifted, including:

- **Partners not permitted to attend antenatal appointments and scans**, which can reveal that a baby has died or is suffering from abnormalities. Some but not all Trusts are permitting partners to join scans by video.
- **Women prevented from having a birth partner with them during an induction on antenatal wards**, leaving women alone during a difficult and physically demanding experience and a real risk that they will give birth without their partner.
- **Partners not being allowed to join an individual in labour until they are in established labour leading to some women feeling coerced into having a vaginal examination.**
- **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.

We have heard that exceptions are not being made for women even when they are in a particularly vulnerable situation, including women who were not allowed visitors or time to make memories after their babies had died. Families with sick newborns have faced restricted neonatal visiting.

Whilst most women are now able to be supported by a birth partner during active labour, we are concerned that the initial crisis response by some Trusts was to restrict support altogether.

We are also concerned that restrictions are not being lifted in a timely manner, and that they may be re-introduced should the NHS come under additional Covid-19 pressure in future.

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[5] A 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: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full

[6] https://www.npeu.ox.ac.uk/mbrrace-uk/reports