CROSS-CULTURAL HUMAN RIGHTS REVIEW

Klatt N and Böhret I, 'WOMEN'S RIGHTS IN CHILDBIRTH DURING THE COVID-19 PANDEMIC: A comparison of WHO guidelines to policies, recommendations, and practices in the US and Germany' (2021) 3 *Cross-cultural Human Rights Review* 1-41
DOI: http://doi.org/10.52854/cchrr.51

RESEARCH ARTICLE

WOMEN'S RIGHTS IN CHILDBIRTH DURING THE COVID-19 PANDEMIC: A Comparison of WHO Guidelines to Policies, Recommendations, and Practices in the US And Germany

NIKOLINA KLATT* & INES BÖHRET**

ABSTRACT

Women's rights to respectful care in childbirth are often violated, especially during health emergencies. This article evaluates to which degree policies and recommendations implemented in response to the COVID-19 pandemic strengthen or violate women's rights in birth in Germany and the US. Therefore, recommendations and policies on a subnational level in Baden-Wuerttemberg and New York State are compared to the recommendations given by the WHO for a safe and positive childbirth experience during the COVID-19 pandemic. This article demonstrates that policies approved in New York have the potential to increase the options for birthing women and thus strengthen their rights. In contrast, little evidence was found for subnational policies in Baden-Wuerttemberg that aimed to safeguard women's rights at birth. This article concludes that women's rights in birth must be supported at the federal, state, and institutional level to ensure respectful and safe birth experiences, even in times of pandemics.

KEY WORDS

Women's rights; childbirth; COVID-19; public health emergencies; respectful maternity health care; WHO guidelines

* Nikolina Klatt is a Master of Public Policy candidate at the Hertie School of Governance in Berlin.
Her research interests include gender equality, democracy research, climate security, and transatlantic relations.
Email: Nikolina.d.klatt@gmail.com

** Ines Böhret holds an M.Sc. in Global Health and an M.A in Caritas Science and Value-based Management.
She works as a project coordinator for health system strengthening at the German Institute for Medical Mission and has been involved in the CoronaNet Project as a Research Assistant since the beginning of the Pandemic.
Email: ines.boehret@gmail.com

** We would like to express our gratitude to the anonymous reviewer for their very lucid insights and helpful comments.

1. INTRODUCTION

The right of birthing women to dignified, respectful care is vulnerable and often violated, especially during public health emergencies. Women's right to respectful maternity care (RMC), such as the right to autonomy and freedom from harm, is grounded in international and multinational human rights instruments and has been stressed in the Charter on the Universal Rights of Childbearing Women.[1] The WHO defines RMC as care that is "organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth."[2] Shakibazadeh et al. define RMC further as "an approach to care that emphasizes the fundamental rights of women, newborns, and families, and that promotes equitable access to evidence-based care while recognizing the unique needs and preferences of both women and newborns."[3] Thus, RMC is a fundamental human right of pregnant and birthing women.

However, recent reports uncovered the high prevalence of mistreatment and abuse during childbirth.[4] Furthermore, responses to previous health emergencies demonstrated little awareness for structural gender inequalities, thus increasing the

[1] Such as Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing (White Ribbon Alliance, 'Respectful Maternity Care: The universal rights of childbearing women' (2011) <https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf> accessed 24 July 2020).

[2] WHO, 'WHO recommendations on intrapartum care for a positive childbirth experience' (2018) 3 <https://www.bgbl.de/xaver/bgbl/media/A9C4EB06627ADB727D0BC61BAEDA2DC9/bgbl113s3458_21893.pdf> accessed 3 June 2020.

[3] E. Shakibazadeh and others, 'Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis' (2018) 125(8) BJOG : an international journal of obstetrics and gynaecology 932, 933.

[4] Meghan A Bohren and others, 'How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys' (2019) 394(10210) The Lancet 1750.

risk for human rights violations.[5] For example, it has been argued that the current COVID-19 pandemic constitutes a risk factor for gender violence in the form of obstetric violence such as: verbal degradations; denial of care during childbirth; disregard of a woman's needs, and pain; invasive practices; physical violence; unnecessary use of medication; forced and coerced medical interventions.[6] Therefore, it is crucial to define international standards that guarantee women's rights in childbirth through RMC independent of the given circumstances.

International institutions have indeed formulated recommendations and guidelines on women's intrapartum care. As part of the United Nations, the World Health Organization (WHO) is an international institution that provides standards and recommendations on health issues. One of its core functions is to develop global guidelines ensuring the appropriate use of evidence in health care.[7] For example, guidelines on intrapartum care were created for clinical practice and list recommendations of interventions or options that should be implemented for a positive health outcome.[8] Thereby, the WHO aims for a global perspective by focusing on a human-rights-based approach to care and considers a diverse set of medical care and the various determinants of health. Thus, even though those recommendations are non-binding, they should be applied in practice for the best health outcome in childbirth. Furthermore, they support human rights in healthcare by defining evidence-based care.[9]

In response to the COVID-19 pandemic, the WHO published several recommendations and guidelines that affect women's care during birth and underline women's fundamental rights. An infographic was published on women's rights to a safe and positive childbirth experience, regardless of their COVID-19 infection

[5] Ibid; Davies, Sara, E. and Belinda Bennet, 'A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies' (2016) 92(5) International Affairs 1041.

[6] Michelle Sadler, Gonzalo Leiva and Ibone Olza, 'COVID-19 as a risk factor for obstetric violence' [2020] Sexual and reproductive health matters.

[7] WHO, 'WHO Guidelines' (2021) <https://www.who.int/publications/who-guidelines> accessed 6 January 2021.

[8] WHO (n 2).

[9] WHO, 'Human rights and health' (2017) <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> accessed 12 January 2021.

status.[10] In this document, the WHO refers to five key recommendations that have already been part of the WHO guidelines on intrapartum care published in 2018.[11] Namely (1) being treated with respect and dignity, (2) having a companion of choice, (3) clear communication by maternity staff, (4) appropriate pain relief strategies, and (5) mobility in labor and birth position of choice. By framing these five standards as women's rights, the WHO used a human-rights-based approach. Furthermore, within their interim guidance on clinical management of COVID-19[12] and their Q&A section on pregnancy and childbirth during the pandemic,[13] the WHO lists two other recommendations: (6) performing cesarean sections only when medically justified and in line with women's preferences and (7) prioritized testing for pregnant women with symptoms of COVID-19. The recommendation on performing cesarean sections only with medical indication is supported by the WHO statement from 2015.[14] However, the focus on women's preferences next to obstetric indicators illustrates a shift towards women-centered care and reproductive rights.

Like previous WHO guidelines, these seven recommendations have the potential to affect and shape public policies and practices. A WHO guideline is "any information product developed by WHO that contains recommendations for clinical practice or public health policy."[15] Thus, recommendations and proposed solutions to medical issues made by the WHO can be endorsed and adopted by a government as

[10] WHO, 'All women have the right to a positive childbirth experience whether or not they have a confirmed COVID-19 infection' (n.d.). <https://www.who.int/reproductivehealth/publications/emergencies/Pregnancy-3-1200x1200.png?ua=1> accessed 6 June 2020.

[11] WHO (n 2).

[12] WHO, 'Clinical management of COVID-19' (2020) <https://www.who.int/publications/i/item/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected> accessed 6 June 2020.

[13] WHO, 'Q&A: Pregnancy, childbirth and COVID-19' (2020) <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth> accessed 3 June 2020.

[14] WHO, 'WHO Statement on Caesarean Section Rates' (2015) <https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1> accessed 3 June 2020.

[15] WHO (n 7) n.p.

public policies (e.g., ban on tobacco use in response to lung cancer).[16] Public health policies are used to react to long-term health issues as well as emerging challenges such as public health emergencies. Mid-March 2020, when COVID-19 was declared a pandemic, most countries started to take up preventive measures and other government responses in order to control the spread of the novel virus. More than 50,000 public policies regarding different aspects of the pandemic, such as lockdown and quarantine, in more than 195 countries have been issued in response to COVID-19, as shown by the comprehensive dataset of Cheng et al.[17] Given the extensive use of policymaking and the duty of governments to ensure women's rights, it is of interest to which extent the WHO recommendations have been integrated into these new national and subnational policies.

National expert societies also influence public policies and practices. Thomas Dye famously defined public policy as "anything a government chooses to do or not to do,"[18] emphasizing that public policies are deliberate and conscious decisions made by governments to achieve a particular goal. However, public policy is often not only shaped by elected governments but by "scientific and technical advisers, public opinion, and pressure groups."[19] For example, national expert associations aim to influence public health policies in addition to the WHO. Organizations such as ACOG or DGGG typically represent their perspectives in political committees and councils.[20] During the COVID-19 pandemic, ACOG was involved in advising the government of NYS regarding policies for pregnant women.[21] DGGG in Germany or ACOG in the US also create and regularly update guidelines with recommendations to medical issues

[16] Michael Howlett and Ben Cashore, 'Conceptualizing Public Policy' in Isabelle Engeli and Christine R Allison (eds), *Comparative Policy Studies* (Palgrave Macmillan UK 2014).

[17] Cindy Cheng and others, 'COVID-19 Government Response Event Dataset (CoronaNet v.1.0)' [2020] Nat Hum Behav 1 <https://www.nature.com/articles/s41562-020-0909-7#Ack1> .

[18] Thomas R Dye, *Understanding public policy* (Prentice-Hall 1972) 2.

[19] Miquel Porta and John M Last, *A Dictionary of Public Health* (vol 1, Oxford University Press 2018).

[20] DGGG, 'Übersicht [Overview]' (2021) <https://www.dggg.de/ueber-die-dggg/uebersicht/> accessed 6 January 2021; ACOG, 'About' (2021) <https://www.acog.org/about> accessed 8 January 2021.

[21] New York State COVID-19 MaternityTask Force, 'Recommendations to the Governor to Promote Increased Choice and Access to Safe Maternity Care During the COVID-19 Pandemic' (2020) <https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/042920_CMTF_Recommendations.pdf> accessed 21 August 2020.

linked to intrapartum care.[22] Like the WHO recommendations, they are an essential tool to support medical practitioners in their decision-making as they refer to the current state of the art in science.[23] Therefore, it is also worth investigating to which extent the WHO recommendations were reflected in recommendations made by expert societies.

Despite the importance of WHO guidelines for women's rights in childbirth, little research has been conducted on how they have been integrated into guidelines and policies on national and subnational level. In the face of the novelty of COVID-19, there have already been attempts to collect extensive data on women with COVID-19 during pregnancy, childbirth, and the postpartum period.[24] Yet, these datasets primarily focus on clinical management. Also, efforts have been made to collect and report evidence of mistreatment and disrespect of birthing women[25] and advocate for human rights in childbirth during the pandemic.[26] These reports refer to the WHO guidelines. Yet, recommendations made by expert societies and national and subnational policies were only partially assessed in the reports on maternity care during the pandemic. This article addresses this shortcoming by evaluating to which degree policies implemented in response to the COVID-19 pandemic strengthen or

[22] DGGG, 'Leitlinienprogramm [Guideline Program]' (2021) <https://www.dggg.de/leitlinien-stellungnahmen/leitlinien/> accessed 12 January 2021; ACOG, 'Clinical Information' (2021) <https://www.acog.org/en/Clinical> accessed 12 January 2021.

[23] Bundesärztekammer, 'Verbindlichkeit von Richtlinien, Leitlinien, Empfehlungen und Stellungnahmen [Binding nature of guidelines, directives, recommendations and statements]' (n.d.) <https://www.bundesaerztekammer.de/richtlinien/> accessed 22 December 2020.

[24] Burnet Institute, 'Rapid review of maternal health recommendations related to the COVID-19 pandemic' (2020) <https://www.burnet.edu.au/projects/435_rapid_review_of_maternal_health_recommendations_related_to_the_covid_19_pandemic> accessed 6 June 2020; Cochrane Pregnancy and Childbirth, 'COVID-19 review of national clinical practice guidelines for key questions relating to the care of pregnant women and their babies' (2020) <https://pregnancy.cochrane.org/news/covid-19-review-national-clinical-practice-guidelines-key-questions-relating-care-pregnant> accessed 6 June 2020.

[25] Human Rights in Childbirth, 'Human Rights Violations in Pregnancy, Birth and Postpartum during the COVID-19 Pandemic' (2020) <http://humanrightsinchildbirth.org/wp-content/uploads/2020/05/Human-Rights-in-Childbirth-Pregnancy-Birth-and-Postpartum-During-COVID19-Report-May-2020.pdf> accessed 6 June 2020.

[26] Human Rights in Childbirth, 'HRiC informs European Parliament Action on Maternity Care during COVID-19' (2020) <http://humanrightsinchildbirth.org/index.php/2020/04/23/hric-informs-european-parliament-action-on-maternity-care-during-covid-19/> accessed 6 June 2020.

violate the rights of birthing women with regards to the recommendations given by the WHO for a positive childbirth experience. The objective is to analyze and discuss how the WHO recommendations have been integrated into guidelines, policies, and practices before and during the pandemic to indicate how and when women's rights are enforced or violated.

Therefore, the relevant laws, policies, as well as expert guidelines, and situation reports from two subnational regions, one in the United States and one in Germany, are compared and their implementation evaluated. Given the novelty of the COVID-19 disease, the amount of scientific literature on the implementation of recommendations was limited. Hence, grey literature like reports by maternal initiatives, newspapers, and hospital websites were consulted to determine in which regard and to which degree the different recommendations and policies have been implemented. It must therefore be noted that evidence is still scarce and often limited to anecdotal reports.

New York State (NYS) in the US and Baden-Wuerttemberg (BW) in Germany were chosen to be investigated. They represent two subnational regions that were both hit by a large number of COVID-19 infections as one of the first states in two of the most industrialized countries world.[27] Thus, they each respectively reacted to the upcoming challenges in childbirth as one of the first states. This article examines policies on a state level because both countries are federalized into states. It is acknowledged that the two countries differ in various aspects: the US and Germany have different health care and insurance systems, and both chose different approaches to maternal health care in general and policies regarding COVID-19.[28] NYS and BW

[27] Paul Blickle and others, 'Coronavirus-Karte für Deutschland: Coronavirus in Deutschland und der Welt – alle Zahlen im Überblick [Coronavirus Map for Germany: Coronavirus in Germany and the World - All Figures at a Glance]' *Die Zeit* (11 January 2021) <https://www.zeit.de/wissen/gesundheit/coronavirus-echtzeit-karte-deutschland-landkreise-infektionen-ausbreitung?utm_referrer=https%3A%2F%2Fwww.google.com%2F> accessed 12 January 2021; Corinne N Thompson and others, 'COVID-19 Outbreak - New York City, February 29-June 1, 2020' (2020) 69(46) MMWR Morb Mortal Wkly Rep 1725 <https://www.cdc.gov/mmwr/volumes/69/wr/mm6946a2.htm>.

[28] Cheng and others (n 17) Roosa Tikkanen and others, 'What Is Status of Women's Health? U.S. vs. 10 Other Countries | Commonwealth Fund' (2018) <https://www.commonwealthfund.org/publications/issue-briefs/2018/dec/womens-health-us-compared-ten-other-countries> accessed 15 July 2020.

have a different number of inhabitants (around 19 million in NYS[29] and 11 million in BW[30]) and are demographically different (NY has a primarily urban population and is ethnically more diverse than BW).

While the pandemic had a substantial impact on many aspects of reproductive rights, such as abortion service and maternal health care in general, this paper investigates intrapartum care and women's rights during hospital-based childbirth. As the pandemic affects not only the treatment of birthing women infected with the virus, the research refers to all childbearing women in hospital settings during this pandemic. Most women in the US and Germany give birth in hospitals, and most policies and recommendations regarding childbirth during the pandemic focus on hospital-based births.[31] Thus, policies and recommendations that have been published between March and the end of June 2020 and affect the rights of birthing women in hospital settings are included in this study.

This paper is influenced by an understanding of health as a continuum that incorporates physiological, psychological, and social wellbeing and is affected by personal resources, and risk factors, and social determinants of health. Furthermore, a human rights perspective focusing on women's rights has been applied due to the female-centered nature of the topic. Particularly, a feminist epistemological approach has been chosen. This is by acknowledging that maternity care and narratives of birth are embedded in socio-structural inequities and that patriarchal structures commonly influenced obstetrics in Western countries.[32] Thus, throughout the discussion, narratives of birthing

[29] U.S. Census Bureau, 'QuickFacts: New York' (2019) <https://www.census.gov/quickfacts/NY> accessed 9 January 2021.

[30] Statistisches Landesamt Baden-Württemberg, 'Baden-Württemberg: 11,1 Millionen Einwohner [Baden-Wuerttemberg: 11.1 million inhabitants]' (2020) <https://www.statistik-bw.de/Presse/Pressemitteilungen/2020016> accessed 9 January 2021.

[31] Kohler, Stefan & Bärnighausen and Till, 'Entwicklung und aktuelle Versorgungssituation in der Geburtshilfe in Baden-Württemberg: Bericht für den Runden Tisch Geburtshilfe in Baden-Württemberg [Development and Current Care Situation in Obstetrics in Baden-Württemberg: Report for the Round Table on Obstetrics in Baden-Wuerttemberg]' (2018) <https://sozialministerium.baden-wuerttemberg.de/fileadmin/redaktion/m-sm/intern/downloads/Downloads_Runder-Tisch-Geburtshilfe/Bericht_Entwicklung-Versorgungssituation-Geburtshilfe-BW_2018.pdf> accessed 12 July 2020.

[32] Jessica C A Shaw, 'The Medicalization of Birth and Midwifery as Resistance' (2013) 34(6) Health Care for Women International 522.

women and their rights are critically examined, and women's voices were included.

This article is structured into four chapters. The first chapter introduces the WHO's seven recommendations on birthing rights during the COVID-19 pandemic. The second chapter presents the results of comprehensive research of national and subnational policies, as well as recommendations by expert associations relating to these recommendations. These results refer to the status quo ante to acknowledge the inherent differences and emphasize the similarities between both countries and the policies and recommendations put in place in response to the COVID-19 crisis. The third chapter discusses the results within four key components of respectful maternity care: dignity, support, information, and choice, by briefly referring to the situation on a global scale and reviewing the situation in the US and Germany. This article concludes in the fourth chapter, arguing that the response to the current pandemic has, in some places, violated fundamental birthing rights by exacerbating existing shortcomings while at the same time raising awareness of the vulnerabilities of women's rights in birth.

Notably, this article found great differences between NYS and BW before COVID-19 as well as in response to the pandemic. The COVID-19 pandemic has shed light on prevalent shortcomings in maternity care, such as a lack of human resources or birthing options and, in some instances, increased existing vulnerabilities. New York State marks a special case within the US as it reacted quickly on a subnational policy level to upcoming issues regarding maternal health and birth in particular. In comparison, Baden-Wuerttemberg had been aiming to improve maternity care prior to the outbreak, yet did not explicitly consider women's rights in birth in their response to COVID-19. Thus, while the pandemic and the response towards it have the potential to exacerbate existing shortcomings in maternity care, there is a chance that increased awareness of the significance of respectful and dignified care may lead to long-term structural improvements.

2. POLICIES AND GUIDELINES REGARDING INTRAPARTUM CARE

This chapter provides an overview of the seven recommendations for a positive childbirth experience made by the WHO. Furthermore, it presents to which extent these recommendations are integrated into general and COVID-19-related

governmental laws, policies, recommendations, and guidelines by expert associations in the US and Germany.

2.1 TREATMENT WITH RESPECT AND DIGNITY

Respectful maternity care (RMC) has been defined by the WHO in their guidelines on intrapartum care, published in 2018:[33] It entails

> "care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth." (p.3)

In Germany, women have the right to maternal health care, and expert societies acknowledge the importance of women-centered care. Women are legally entitled to receive medical care and midwifery assistance during pregnancy, delivery, and postpartum.[34] Furthermore, laws are in place to guarantee confidential maternity care[35] and choice of place of delivery (e.g., hospital, birth center, home).[36] While the national health goal on prenatal, intrapartum, and postpartum care, published before the WHO recommendations in 2017, does not explicitly refer to respect and dignity, it underlines the importance of women-centered care.[37] This notion is supported by the German Midwifery Association, which highlights the right to respectful and individual maternity care in their position paper for good obstetrics.[38]

[33] WHO (n 2).

[34] 24d SGB V Ärztliche Betreuung und Hebammenhilfe [§ 24d SGB V Medical Care and Midwifery] 20 December 1988 (Federal Republic of Germany).

[35] Gesetz zum Ausbau der Hilfen für Schwangere und zur Regelung der vertraulichen Geburt [Law on the expansion of assistance for pregnant women and on the rgeulation of confidential birth] 2013 (Federal Republic of Germany).

[36] '§ 24f Delivery [§ 24f Entbindung]', *Social Security Code (SGB V) Fifth Book of the Statutory Health Insurance [Sozialgesetzbuch (SGB V) Fünftes Buch Gesetzliche Krankenversicherung* (1988).

[37] Kooperationsverbund gesundheitsziele.de, 'Nationales Gesundheitsziel: Gesundheit rund um die Geburt' [National health goal: Health around birth] (2017) accessed 4 June 2020.

[38] Deutscher Hebammen Verband, '12 Thesen für eine gute Geburtshilfe [12 theses for good obstetrics]' [2017].

Within the US, the right to respectful maternal care is formulated more explicitly by governmental bodies and expert societies. New York City has issued standards for respectful care at birth to inform, educate and support people giving birth, explicitly stating the "human right to respectful, safe and quality care during the birthing experience."[39] Although it is not a legally binding document, it can empower women to receive respectful care by informing them of their rights. The document includes information about support during labor and delivery, quality of care, communication, informed consent, and decision-making. The ACOG acknowledges the importance of "treating all childbearing women with kindness, respect, dignity, and cultural sensitivity, throughout their maternity care experiences" (n.p.).[40] The organization underlines similar key points as the overall WHO recommendations for maternal health care: communication, shared decision-making, teamwork, and data-driven quality improvement initiatives.

During the COVID-19 pandemic, no policies or recommendations could be found that directly refer to respectful and dignified care in both countries. However, it can be argued that policies that require birthing women to wear a face mask in labor and delivery and calling for interventions without medical indication conflict with key principles of RMC. For example, masks and unnecessary interventions can be considered mistreatment and harm towards birthing women.[41] Thus, policies and recommendations on mask-wearing are discussed within this section.

While no WHO statement could be found regarding mask-wearing during labor and delivery, several other societies called for masks during birth to prevent the spread of COVID-19. Professional societies from the US, Canada, UK, and Oceania recommend wearing surgical masks for suspected or known COVID-19 positive

<https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Gesundheit/Broschueren/Nationales_Gesundheitsziel_Gesundheit_rund_um_die_Geburt.pdf> accessed 4 June 2020.

[39] NYC Health, 'New York City Standards for Respectful Care at Birth' [n.d.], 2 <https://www.acog.org/practice-management/patient-safety-and-quality/clinical-information/quality-patient-care-in-labor-and-delivery-a-call-to-action> accessed 21 August 2020.

[40] ACOG, 'Quality Patient Care in Labor and Delivery: A Call to Action' (2011) <https://www.acog.org/practice-management/patient-safety-and-quality/clinical-information/quality-patient-care-in-labor-and-delivery-a-call-to-action> accessed 21 August 2020.

[41] Kıymet Y Çalik, Özlem Karabulutlu and Canan Yavuz, 'First do no harm - interventions during labor and maternal satisfaction: a descriptive cross-sectional study' (2018) 18(1) BMC pregnancy and childbirth 415.

birthing women once they are admitted to the hospital to reduce the infection risk.[42] It was recognized that masks for birthing women can be obstructive during labor and delivery; one paper recommended shortening the second stage by operative vaginal delivery, "as active pushing while wearing a surgical mask would be unfeasible."[43] Given that the authors therein did not refer to the risks of operative vaginal delivery, it is suggested that they seemingly accept potential harm towards birthing women and newborns[44] as a necessity in times of pandemics. The International Society of Ultrasound in Obstetrics and Gynecology includes the recommendation of masks for all women (not based on their suspected or known COVID-19 infection) and the benefits of operative vaginal delivery in their interim guidance, which gave it international prominence.[45] However, other expert associations do not make similar recommendations regarding operative deliveries, even in cases of known infection, but refer to standard clinical indications instead.[46]

There were a lack of German national or subnational policies referring to mask-wearing at birth. According to a regional daily newspaper, the national health ministry in Germany does not require birthing people to wear masks,[47] and in Baden-Wuerttemberg, none of the policies include mandatory mask-wearing of birthing women.[48] The Robert Koch Institute (RKI), the governmental institute for disease

[42] Melissa E Bauer and others, 'Obstetric Anesthesia During the COVID-19 Pandemic' (2020) 131(1) Anesthesia and analgesia 7.

[43] H. Yang, C. Wang and L. C Poon, 'Novel coronavirus infection and pregnancy' (2020) 55(4) Ultrasound in obstetrics & gynecology : the official journal of the International Society of Ultrasound in Obstetrics and Gynecology 435, 436.

[44] Royal College of Obstetricians and Gynaecologists, 'Operative Vaginal Delivery: Green–top Guideline No. 26' (2011) <http://humanrightsinchildbirth.org/wp-content/uploads/2020/05/Human-Rights-in-Childbirth-Pregnancy-Birth-and-Postpartum-During-COVID19-Report-May-2020.pdf> accessed 6 June 2020.

[45] L. C Poon and others, 'ISUOG Interim Guidance on coronavirus disease 2019 (COVID-19) during pregnancy and puerperium: information for healthcare professionals - an update' (2020) 55(6) Ultrasound in obstetrics & gynecology : the official journal of the International Society of Ultrasound in Obstetrics and Gynecology 848.

[46] Bauer and others (n 45).

[47] S. Horsch, 'Coronavirus: Müssen Mütter bei der Geburt Maske tragen? [Coronavirus: Do mothers need to wear mask at birth?]' *Merkur* (13 May 2020) <https://www.merkur.de/politik/coronavirus-muessen-muetter-bei-geburt-maske-tragen-13761018.html#idAnchComments> accessed 6 June 2020.

[48] E. Weisenburger, 'Maskenpflicht im Kreißsaal: "Bei allen Frauen kommt der Punkt, an dem sie die Maske herunterreißen" [Duty to wear masks in the delivery room: "With all women, there comes a point when they tear the mask off"]' Bruchsaler Rundschau (21 May 2020).

control and prevention, recommends "the wearing of medical mouth and nose protectors by patients in situations where contact or encounter with other people is likely, as far as this can be tolerated" [n.p. translated by author].[49] However, it remains unclear whether the level of tolerance is also defined with respect to childbearing women. Thus, some institutions implement the recommendation to wear masks when experienced as tolerable by the woman,[50] while others indicate that mask-wearing during labor is mandatory, even for asymptomatic birthing women, to protect the hospital's staff.[51] The German Midwifery Association criticized the mandatory wearing of masks during labor and delivery.[52] Nevertheless, no statement in favor or opposition could be found by other expert societies.

In the US, no public policy was found, but expert societies made clear recommendations focusing on birthing women. The ACOG advises mask-wearing within a hospital setting or birth center if the laboring woman is infected with COVID-19.[53] However, they do not recommend wearing a mask in the setting of the second stage of labor and instead emphasize the importance of appropriate personal

<https://bnn.de/lokales/bruchsal/maskenpflicht-im-kreisssaal-bei-allen-frauen-kommt-der-punkt-an-dem-sie-die-maske-herunterreissen> accessed 6 June 2020.

[49] Robert Koch Institut, 'Erweiterte Hygienemaßnahmen im Gesundheitswesen im Rahmen der COVID-19 Pandemie [Enhanced healthcare hygiene measures under the COVID-19 pandemic]' (2020) <https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/erweiterte_Hygiene.html> accessed 6 June 2020.

[50] St. Joseph Stift, 'Informationen zum Coronavirus für Schwangere [Information on coronavirus for pregnant women]' (2020) <https://www.sjs-bremen.de/informationen-zum-coronavirus-fuer-schwangere.html> accessed 6 June 2020.

[51] Weisenburger (n 50).

[52] Deutscher Hebammen Verband e.V. 'Stellungnahme des DHV zur Maskenpflicht im Kreißsaal [Statement of the DHV on the compulsory wearing of masks in the delivery room]' (2020) <https://www.hebammenverband.de/aktuell/nachricht-detail/datum/2020/05/18/artikel/stellungnahme-des-dhv-zur-maskenpflicht-im-kreisssaal/> accessed 6 June 2020.

[53] Lisa Hollier, 'Coronavirus (COVID-19), Pregnancy, and Breastfeeding: A Message for Patients' (2020) <https://www.acog.org/patient-resources/faqs/pregnancy/coronavirus-pregnancy-and-breastfeeding#Would%20it%20be%20safer%20to%20have%20a%20home%20birth> accessed 21 August 2020.

protective equipment (PPE) for medical staff.[54] Regarding interventions, they state that operative vaginal delivery should only be performed if medically necessary.[55]

2.2 COMPANION OF CHOICE

Having a companion of choice refers to continuous support during labor and delivery and is one of the key evidence-based recommendations by the WHO to ensure a positive birth experience.[56] A support person during labor has been found to offer comforting touch, encouragement, and praise and can have a positive and protective impact on physical and mental wellbeing.[57] However, the WHO's Guideline Development Group emphasized that policymakers are often reluctant to implement this recommendation in clinical practice.[58]

Indeed, in Germany, no policy or guideline could be found that explicitly refers to a companion of choice, yet in the US, the right to a companion in birth is emphasized on different levels. The ACOG recommends continuous support during labor as it improves the outcome for women.[59] This support goes beyond nursing staff's care and explicitly lists doulas who support women during childbirth and other non-medical support persons such as partners and family members. Information provided by New York City regarding standards for respectful care at birth explicitly states that the birthing woman deserves to have the support person(s) of her choice present during labor and delivery.[60]

Policies made in response to the COVID-19 pandemic on national, subnational, and institutional levels have been diverse regarding a companion of choice. While most policymakers seem to have allowed one non-symptomatic birth companion,

---

[54] ACOG, 'COVID-19 FAQs for Obstetrician-Gynecologists, Obstetrics' (2020) <https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics> accessed 21 August 2020; Hollier (n 56).

[55] ACOG (n 57).

[56] WHO (n 2).

[57] ibid.

[58] ibid.

[59] ACOG, 'ACOG Committee Opinion: Approaches to Limit Intervention During Labor and Birth' [2017] <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2019/02/approaches-to-limit-intervention-during-labor-and-birth.pdf> accessed 21 August 2020.

[60] NYC Health (n 42).

others restrict the mobility of birth companions or prohibit any birth partner.[61] These restrictions are in line with the recommendation of various professional associations, which suggest the limitation of birth companions or no access of symptomatic support persons.[62]

In Germany, there is no standardized approach, and individual institutions have often made decisions regarding companions directly at birth. A temporary national ban on visitors in hospitals from March 17 until mid-May in 2020 was implemented and enforced on an institutional level.[63] However, some states indicated that this policy did not apply to the situation of birth.[64] In Baden-Wuerttemberg, the ministry of social affairs and integration underlined that "related persons should be able to visit their relatives in need of care if there is a risk of physical and psychological damage through social isolation" [translated by author].[65] Nevertheless, no governmental statement on the issue of companionship in birth could be found. Thus, similar to other states in Germany, hospitals were free to decide whether this policy applies to birthing partners or not.[66] In response to the lack of political commitment, key expert associations of midwives, gynecologists, and obstetricians referring to the WHO recommendations demanded regulation on the state level.[67] They emphasized

[61] Cochrane Pregnancy and Childbirth (n 24).

[62] Bauer and others (n 45).

[63] Land Brandenburg, 'Kabinett beschließt Rechtsverordnung zur Eindämmung der Corona-Pandemie [Cabinet adopts legal regulation to contain corona pandemic]' (2020) <https://www.brandenburg.de/cms/detail.php/bb1.c.661751.de> accessed 15 July 2020; Deutsche Welle, 'Corona: Krankenhäuser isolieren sich [Corona: Hospitals isolate themselves]' (16 March 2020) <https://www.dw.com/de/corona-krankenh%C3%A4user-isolieren-sich/a-52792245> accessed 15 July 2020.

[64] Motherhood e.V. 'Infoblatt zur aktuellen Situation in der Geburtshilfe [Information sheet on the current situation in obstetrics]' (n.d.) <https://www.mother-hood.de/fileadmin/user_upload/Medien/Dokumente/MH_Corona_L%C3%A4nderverordnungen_Bes ucherregeln_20200525.pdf> accessed 3 June 2020.

[65] Ministerium für Soziales und Integration Baden-Württemberg, 'Besuchsverbote in Krankenhäusern und Pflegeheimen werden schrittweise gelockert [Visiting bans in hospitals and nursing homes will be gradually eased]' (2020) n.p. <https://www.baden-wuerttemberg.de/de/service/presse/pressemitteilung/pid/besuchsverbote-in-krankenhaeusern-und-pflegeheimen-werden-schrittweise-gelockert/> accessed 12 July 2020.

[66] Motherhood e.V. (n 67)

[67] Deutscher Hebammen Verband, 'Gebären in Corona-Zeiten: Frauen nicht alleine lassen [Giving birth in Corona times: Not leaving women alone]' (2020)

the importance of a birth companion for the mental and physical health of the birthing person as well as for the family. While at least the state of Rhineland-Palatinate responded by urging hospitals to allow a companion of choice,[68] hospitals in most states retained power in decision-making. This was illustrated by one court case in which a hospital in Saxony successfully claimed its householder's right to prohibit access to birthing partners.[69] The government in Baden-Wuerttemberg did not respond to the concerns raised by experts, and while some hospitals allowed visitors, others continued to ban companions at birth.

In the US, expert societies' clear recommendation to allow one support person was transformed into an executive order in NYS. Both the CDC and the ACOG recommend limiting visitors to pregnant women in hospitals, including support persons during birth to those essential for the pregnant individual's wellbeing.[70] The CDC also states this for women who have known or suspected COVID-19 infections.

<https://www.hebammenverband.de/aktuell/nachricht-detail/datum/2020/04/17/artikel/gebaeren-in-corona-zeiten-frauen-nicht-alleine-lassen/> accessed 7 June 2020; Deutsche Gesellschaft für Gynäkologie und Geburtshilfe, 'DGGG empfiehlt: Väter bei der Geburt zulassen – auch in Zeiten der Corona-Pandemie [DGGG recommends: Allow fathers at birth - even in times of corona pandemic]' (2020) <https://www.dggg.de/presse-news/pressemitteilungen/mitteilung/dggg-empfiehlt-vaeter-bei-der-geburt-zulassen-auch-in-zeiten-der-corona-pandemie-1195/https://www.dggg.de/presse-news/pressemitteilungen/mitteilung/dggg-empfiehlt-vaeter-bei-der-geburt-zulassen-auch-in-zeiten-der-corona-pandemie-1195/> accessed 7 June 2020; Deutsche Gesellschaft für Psychosomatische Frauenheilkunde und Geburtshilfe, 'Bei Geburten sind auch in der Corona-Krise die Partner gefragt [During birth partners are also in demand in the Corona crisis]' (2020) <https://www.presseportal.de/pm/143189/4560419> accessed 7 June 2020.

[68] Landesregierung Rheinland Pfalz, 'Information der Landesregierung zum aktuellen Stand hinsichtlich des Coronavirus: Anwesenheit von Begleitpersonen bei der Geburt [Information from the state government on the current status of coronavirus: presence of accompanying persons at birth]' (2020) <https://msagd.rlp.de/de/service/presse/detail/news/News/detail/information-der-landesregierung-zum-aktuellen-stand-hinsichtlich-des-coronavirus-anwesenheit-von-be/> accessed 7 June 2020.

[69] Haufe Online Redaktion, 'Väter sind wegen Corona bei der Geburt ihrer Kinder ausgesperrt [Fathers are locked out during birth of their children because of Corona]' (2020) <https://www.haufe.de/recht/familien-erbrecht/vaeter-werden-wegen-corona-bei-der-geburt-ihrer-kinder-gesperrt_220_513984.html> accessed 7 June 2020.

[70] Cdc,'Considerations for Inpatient Obstetric Healthcare Settings'(2020) <https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare guidance.html#anchor_1582067955833> accessed 21 August 2020; ACOG (n 57).

Since the beginning of the COVID-19 pandemic in New York State, the situation regarding support persons has been rapidly changing. On March 18, 2020, the New York State Department of Health (NYSDOH) issued guidance for hospitals stating that all visitation should be suspended.[71] This guidance was further specified on March 21, 2020, when the NYSDOH issued recommendations from the CDC regarding visitation in birthing hospitals, allowing one support person essential to patient care throughout labor, delivery, and the immediate postpartum period.[72] Shortly after, on March 28, 2020, this recommendation was turned into an executive order by the Governor of New York, ensuring all public and private hospitals in the state to allow the attendance of one support person to accompany a woman in labor and delivery as well as the immediate postpartum period.[73] This executive order was extended by another on April 29, 2020, to ensure a support person's attendance also during recovery of childbirth and to declare doulas as an essential part of the support team of a laboring woman, thus allowing them to be present during labor and delivery.[74]

2.3 CLEAR COMMUNICATION BY MATERNITY STAFF

Clear communication includes the use of simple and culturally acceptable language and the support of women's capacities, knowledge, and choice.[75] It thereby refers to

[71] Cuomo, Andrew, M. Zucker, Howard, A. and Sally Dreslyn, 'Health Advisory: COVID-19 Guidance for Hospital Operators Regarding Visitation' (2020) <https://coronavirus.health.ny.gov/system/files/documents/2020/03/covid19-hospital-visitation-guidance-3.18.20.pdf> accessed 21 August 2020.

[72] Cuomo, Andrew, M. Zucker, Howard, A. and Sally Dreslyn, 'Pregnancy and COVID-19 Resources for Health Care Providers' (2020) accessed 21 August 2020.

[73] Cuomo, Andrew, M. 'Executive Order No. 202.12: Continuing Temporary Suspension and Modification of Law Relating to the Disaster Emergency' (2020) <https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.12.pdf> accessed 21 August 2020; Cuomo, Andrew, M. 'Executive Order No. 202.13: Continuing Temporary Suspension and Modification of Law Relating to the Disaster Emergency' (2020) <https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.13.pdf> accessed 21 August 2020.
Cuomo, Andrew, M. 'Executive Order No. 202.25: Continuing Temporary Suspension and Modification of Law Relating to the Disaster Emergency' (2020) <https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.25.pdf> accessed 21 August 2020.

[74] New York State COVID-19 Maternity Task Force (n 21).

[75] WHO (n 2).

one of the key recommendations on intrapartum care for a positive childbirth experience by WHO.[76] For example, the provision of information in an appropriate way and the communication of risks and benefits are the foundation for informed decision-making.[77] In Germany, policies and recommendations support clear communication in maternity care. Informed consent, which entails clear communication, is part of civil rights.[78] The importance of clear communication and shared decision-making was underlined in the national health goal for physiological childbirths with a low intervention rate and within the recently published action plan to improve maternity care in Baden-Wuerttemberg.[79] For example, new evidence-based guidelines on vaginal birth, cesarean section, and labor induction are currently being developed.[80] Furthermore, the proposition for good obstetrics by the German Midwifery Association covers the aspects of privacy, confidentiality, and informed choice.[81]

The right to be informed and to consent or dissent to a medical procedure or treatment is also supported on a legal basis in the US. New York State law requires every hospital to annually publish their data on birth-related events and procedures such as the number of vaginal or cesarean births, use of operative vaginal delivery, and other related statistics.[82] Furthermore, hospitals must provide every childbearing

[76] Ibid.

[77] Amy M DeBaets, 'From birth plan to birth partnership: enhancing communication in childbirth' (2017) 216(1) American journal of obstetrics and gynecology 31.e1-31.e4.

[78] Bundesamt für Justiz, '§ 630d BGB' (2013) <https://www.gesetze-im-internet.de/bgb/__630d.html> accessed 7 June 2020.

[79] Bundesministerium für Gesundheit, 'Nationales Gesundheitsziel [National Health Goal]: Gesundheit rundum die Geburt' [2017] <https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Gesundheit/Bro schueren/Nationales_Gesundheitsziel_Gesundheit_rund_um_die_Geburt.pdf> accessed 12 July 2020; Katja Stahl and others, 'Maßnahmenplan mit Empfehlungen zur Verbesserung der Situation der Geburtshilfe in Baden-Württemberg' (2019) <https://sozialministerium.baden-wuerttemberg.de/fileadmin/redaktion/m-sm/intern/downloads/Downloads_Runder-Tisch-Geburtshilfe/RTG_Massnahmenplan-OptiMedis_April-2019.pdf> accessed 12 July 2020.

[80] Stahl and others (n 82).

[81] Deutscher Hebammen Verband, '12 Thesen für eine gute Geburtshilfe [12 theses for good obstetrics]' (n 41).

[82] New York State Senate, 'Information for maternity patients' (n.d.) <https://www.nysenate.gov/legislation/laws/PBH/2803-J> accessed 21 August 2020

patient with a brochure called "Maternity Information" regarding the hospital's rates of selected procedures, including the definitions and explanations of these procedures.[83] Thereby, this ensures birthing women are informed about the procedures and their occurrences at a specific hospital. The information provided by New York City regarding standards for respectful care at birth also explicitly states the legal right to informed consent enabling women to know and make informed decisions about their medical procedures. This information includes accurate, judgment-free explanations and information about procedures, tests, treatments, or drugs, as well as any risks, benefits, and alternative procedures by the health care provider.[84] Notwithstanding, there is no consensus on a standard informed consent process before vaginal delivery[85] as it is generally regarded as a "natural physiological process that by definition is not a medical treatment."[86]

During the COVID-19 pandemic, clear communication was emphasized in NYS, yet in the context of BW and Germany, no COVID-19 specific policies or recommendations could be found that directly refer to communication, information, and choice. In NYS, the COVID-19 Maternity Task Force was created specifically for pregnant and birthing women. They made recommendations to the NYSDOH regarding messaging and education in the form of a campaign that should emphasize the safety of and rebuild confidence in maternity care at all certified birthing facilities. Furthermore, the Task Force recommended that the campaign should explain infection control practices in each type of birthing facility and increase patient understanding of different levels of maternity care and types of birthing facilities, as well as how to work with a provider to select the appropriate patient-centered delivery.[87]

---

[83] New York State Department of Health, 'Maternity Information: Childbirth Services' [n.d.] <https://www.health.ny.gov/publications/2901.pdf> accessed 21 August 2020.

[84] NYC Health (n 42).

[85] Mokerrum F Malik, Awoniyi O Awonuga and Cheryl B Iglesia, 'Informed Consent for Vaginal Delivery: Is It Time to Revisit the Shared Decision-Making Process?' (2016) 61(3-4) The Journal of reproductive medicine 153.

[86] Kavin Senapathy, 'Giving Birth Made Me Question the Informed Consent Process During Childbirth' *SELF* (14 May 2018) n.p. <https://www.self.com/story/informed-consent-in-childbirth> accessed 21 August 2020.

[87] New York State COVID-19 MaternityTask Force (n 21) n.p.

2.4 APPROPRIATE PAIN RELIEF STRATEGIES

Depending on a woman's preferences, the WHO recommends epidural analgesia, opioid analgesia, relaxation techniques, and manual techniques for healthy pregnant women requesting pain relief during labor.[88] Preferred pain relief strategies highly depend on socio-cultural factors, and experiencing choice and control in pain relief strategies has been found to influence the satisfaction with birth.[89]

The right to appropriate pain relief is only indirectly supported by German laws and recommendations. While the right to health and pain relief is not embedded in the German constitution, it can be argued that it is recognized by committing itself to the 'human rights' in Article 1 of the constitution and the right to life and physical integrity in Article 2. A recently updated guideline by the German Society of Anaesthesiology and Intensive Care Medicine (DGAI) and the DGGG refer to the indication and appropriate use of standard medical pain relief strategies.[90] However, no official guidelines on pain relief strategies that include non-medical methods could be found.

In the US, no public policies in regard to pain relief in birth could be found, yet expert societies recommend the use of varying pain relief methods. The ACOG generally recommends the use of multiple nonpharmacologic and pharmacologic techniques to reduce pain during labor; this includes, for example, oral hydration, positions of comfort, and epidural anesthesia.[91]

During the COVID-19 pandemic, some pain relief methods have been discouraged by expert societies in Germany and the US. There are no German policies regarding pain relief; however, one professional association recommends suspending the use of nitrous oxide as pain relief due to increased aerosolization and the spread

[88] WHO (n 2).

[89] Ibid.

[90] D. Bremerich and others, 'Die geburtshilfliche Analgesie und Anästhesie. S1-Leitlinie der Deutschen Gesellschaft für Anästhesiologie und Intensivmedizin in Zusammenarbeit mit der Deutschen Gesellschaft für Gynäkologie und Geburtshilfe [Obstetrical analgesia and anaesthesia. S1 guideline of the German Society for Anaesthesiology and Intensive Care Medicine in cooperation with the German Society for Gynaecology and Obstetrics]' [2020] <https://www.awmf.org/uploads/tx_szleitlinien/001-038l_S1_Die-geburtshilfliche-Analgesie-und-Anaesthesie_2020-03.pdf> accessed 15 July 2020.

[91] ACOG, 'ACOG Committee Opinion' (n 62).

of the virus.[92] Recommendations regarding the use of nitrous oxide have been altered in the US as well: according to the ACOG, nitrous oxide can still be offered to birthing women who have been tested negative for COVID-19 but for women with suspected, unconfirmed negative, or confirmed positive cases it may be suspended.[93] However, the recommendation regarding the suspension of nitrous oxide was not shared by other societies, stating that it can be used as there is no evidence of aerosol-generating procedures causing an increased risk of infections.[94] Additionally, it has been recommended by the Society for Obstetric Anesthesia and Perinatology (SOAP) to place epidural analgesia early, as in the case of an emergency cesarean delivery, it may reduce the need for general anesthesia.[95] This has also been recommended by other national societies from the UK, Canada, Australia, and New Zealand.[96]

2.5 MOBILITY IN LABOR

According to the WHO, "encouraging the adoption of mobility and an upright position during labor in women at low risk is recommended."[97] Choosing the birthing position can act as a coping mechanism for pain, reduces obstetric complications and interventions, and may shorten the duration of labor.[98]

---

[92] Berufsverband der Frauenärzte e.V. 'FAQ für schwangere Frauen und ihre Familien zu spezifischen Risiken der COVID-19-Virusinfektion [FAQ for pregnant women and their families on specific risks of COVID-19 virus infection]' (2020) <https://www.bvf.de/aktuelles/gbcog-mitteilungen/meldung/news/faq-fuer-schwangere-frauen-und-ihre-familien-zu-spezifischen-risiken-der-covid-19-virusinfektion/> accessed 8 July 2020; Deutscher Bundestag, 'Die Grundrechte' (2010) <https://www.bundestag.de/parlament/aufgaben/rechtsgrundlagen/grundgesetz/gg_01-245122> accessed 3 July 2020.

[93] ACOG (n 57).

[94] Bauer and others (n 45).

[95] SOAP, 'Interim Considerations for Obstetric Anesthesia Care Related to COVID19 - SOAP' (2020) <https://soap.org/education/provider-education/expert-summaries/interim-considerations-for-obstetric-anesthesia-care-related-to-covid19/> accessed 21 August 2020.

[96] Bauer and others (n 45).

[97] WHO (n 2) 4.

[98] Saffie Colley and others, 'Women's perception of support and control during childbirth in The Gambia, a quantitative study on dignified facility-based intrapartum care' (2018) 18(1) BMC Pregnancy Childbirth 413.

In the US, mobility in labor is supported by the ACOG, while no recommendation could be found for Germany. The ACOG recommends that "no one position needs to be mandated nor proscribed" for most people giving birth.[99] They state that it is normal for birthing women to assume many different positions as no one position has been proven best. Furthermore, care providers can support frequent position changes during labor to enhance maternal comfort and promote optimal positioning of the fetus, as long as they do not hinder monitoring and there are no complications. Nevertheless, there were no recommendations or policies found regarding the COVID-19 pandemic and mobility in both countries.

2.6 CESAREAN SECTION

The WHO recommends in their infographic on women's rights during the pandemic "that cesarean sections should only be performed when medically justified. The mode of birth should be individualized and based on a woman's preferences alongside obstetric indications."[100] This recommendation is supported by the WHO statement from 2015, in which the short- and long-term risks of cesarean sections are highlighted.[101]

Expert societies in both countries highlight the risks of cesarean sections and emphasize their limited use for medical indications. The ACOG issued guidance regarding the safe prevention of primary cesarean delivery.[102] According to the guidance, cesarean delivery is recommended for specific medical conditions to prevent maternal and infant morbidity and mortality. The DGGG in Germany published a new guideline for cesarean sections in 2020, which stresses the need for medical indication and individualized decisions.[103]

[99] ACOG, 'ACOG Committee Opinion' (n 62) n.p.

[100] WHO (n 13) n.p.

[101] WHO (n 14).

[102] ACOG and SMFM, 'Obstetric Care Consensus' (2014) <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery.pdf> accessed 21 August 2020.

[103] DGGG, 'Leitlinienprogramm [Guideline Program]: sectio caesarea' (2020) <https://www.awmf.org/uploads/tx_szleitlinien/015-084k_S3_Sectio-caesarea_2020-06_1_02.pdf> accessed 3 July 2020.

At this time, there is no evidence for vertical transmission of COVID-19.[104] In neither Germany nor the US are public policies in place considering cesarean sections in case of COVID-19 infection.[105] Instead, expert societies in both countries cautioned against cesarean sections solely based on women's COVID-19-positive status.[106] For example, the ACOG states that cesarean sections should not be deemed necessary because of COVID-19 alone; they should still be based on obstetric (fetal or maternal) indications and not solely on infection status.[107] This is in line with guidance by other international and national expert societies such as the FIGO or RCOG, which support the recommendation by the WHO to conduct cesarean sections only when medically indicated.[108]

2.7 TESTING

The WHO makes special recommendations regarding testing pregnant women for COVID-19 and states that these women should be prioritized for testing if they show symptoms of an infection. These recommendations are mainly based on the need for specialized care among COVID-positive women[109] rather than on the implications for general maternal care of their known COVID-status. However, the WHO also acknowledges that testing protocols and eligibility vary depending on location.[110]

No clear information on the prioritization of pregnant women could be found in Germany. When analyzing official websites of German governmental organizations, no evidence was found for the prioritization of pregnant and birthing

[104] Nan Yu and others, 'Clinical features and obstetric and neonatal outcomes of pregnant patients with COVID-19 in Wuhan, China: a retrospective, single-centre, descriptive study' (2020) 20(5) The Lancet Infectious Diseases 559.

[105] Heike Le Ker, 'Covid-19: Was bedeutet eine Coronainfektion der Mutter für das Neugeborene?' *Der Spiegel* (1 April 2020) <https://www.spiegel.de/wissenschaft/mensch/covid-19-was-bedeutet-eine-corona-infektion-der-mutter-fuer-das-neugeborene-a-0b46905e-11d9-401a-b249-9f9c53707ee4> accessed 7 June 2020.

[106] Ärzte Zeitung, 'Coronavirus rechtfertigt keine Kaiserschnitte! [Coronavirus does not justify a C-section!]' *Ärzte Zeitung* (19 March 2020) <https://www.aerztezeitung.de/Politik/Coronavirus-rechtfertigt-keine-Kaiserschnitte-407832.html> accessed 7 June 2020.

[107] ACOG (n 57).

[108] Burnet Institute (n 24); Bauer and others (n 45).

[109] WHO (n 13).

[110] Ibid.

women in testing for COVID-19. However, according to the WHO Regional Office for Europe, Germany took steps to ensure the testing of all women who went into labor and made sure that positive-tested women and their newborns were isolated together.[111] Also, no recommendations by expert associations were found.

In NYS, testing is recommended by the COVID-19 Maternity Task Force and was implemented through waving cost-sharing for COVID-19 tests.[112] The Maternity Task Force recommends "universal COVID-19 testing for all pregnant individuals and for all support persons accompanying pregnant individuals at birthing facilities."[113] Knowing the COVID-19 status of a birthing patient has consequences for their treatment in the hospital, during birth, and possibly for their health and mental wellbeing. A negative test result can lead to decreased anxiety. A positive test result can lead to an immediate separation of the birthing woman and her newborn,[114] even though this is in opposition to the "Breastfeeding Mothers' Bill of Rights" of New York.[115]

2.8 SUMMARY

Before discussing the implications of the seven recommendations, the two following tables present the various policies and recommendations in reference to the WHO guidance and aims to give a brief overview of the policies and recommendations that were presented above.

[111] WHO Europe, 'Coronavirus and pregnancy – preserving maternal health across the European Region' (2020) <https://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/news/news/2020/6/coronavirus-and-pregnancy-preserving-maternal-health-across-the-european-region> accessed 14 August 2020.

[112] Cuomo, Andrew, M. Zucker, Howard, A. and Dreslyn (n 75).

[113] New York State COVID-19 MaternityTask Force (n 21).

[114] Irin Carmon, ''They Separated Me From My Baby'' *The Cut* (7 April 2020) <https://www.thecut.com/2020/04/coronavirus-newborns-hospitals-parents.html> accessed 21 August 2020.

[115] New York State Department of Health, 'Breastfeeding Mothers' Bill of Rights' [n.d.] <https://www.health.ny.gov/publications/2028.pdf> accessed 21 August 2020.

Table 1 WHO recommendations for positive childbirth during the COVID-19 pandemic and related policies in New York and Baden-Wuerttemberg as of June 2020

WHO Recommendation	**Policies**			
	New York		**Baden-Wuerttemberg**	
	pre-pandemic	during COVID-19	pre-pandemic	during COVID-19
Treatment with respect and dignity (1)	yes	no	indirect	no
Companion of choice (2)	yes	yes	no	no
Clear communication (3)	yes	no	yes	no
Appropriate pain relief (4)	no	no	indirect	no
Mobility in labor (5)	no	no	no	no
Cesarean section with indication (6)	no	no	no	no
Prioritized testing (7)	not applicable	yes	not applicable	no

Table 1 underlines that in New York, more policies have been published regarding the WHO recommendations, both pre-pandemic and in response to COVID-19. In comparison, little evidence for supporting policies could be found on the subnational level in Germany, and no measures in response to the pandemic integrate the WHO guidelines. The policy activity index on the national level regarding COVID-19 has been similar in both countries.[116] Thus, these differences indicate that within NYS policymaking, at least some aspects of maternal health and women's rights in birth have been considered during the pandemic, as compared to BW government responses.

[116] Cheng and others (n 17).

Table 2 WHO recommendations for positive childbirth during the COVID-19 pandemic and related guidelines and recommendations by leading expert associations for New York and Baden-Wuerttemberg as of June 2020

WHO Recommendation	**Guidelines and Recommendations**			
	New York		**Baden-Wuerttemberg**	
	pre-pandemic	during COVID-19	pre-pandemic	during COVID-19
Treatment with respect and dignity (1)	yes (ACOG)	yes, no masks during pushing (ACOG)	yes (German Midwifery Association)	yes, no masks during pushing (RKI / German Midwifery Association)
Companion of choice (2)	yes (ACOG)	yes (ACOG)	no	yes (German Midwifery Association)
Clear communication (3)	yes (ACOG)	yes (Maternity Task Force)	yes (Baden-Wuerttemberg roundtable on obstetrics)	no
Appropriate pain relief (4)	yes (ACOG)	yes, no nitrous oxide and early epidural (ACOG and SOAP)	yes, medical methods (DGGG and DGAI)	yes, no nitrous oxide (Association of Gynaecologists)
Mobility in labor (5)	yes (ACOG)	no	no	no
Cesarean section with indication (6)	yes (ACOG)	yes (ACOG)	yes (DGGG)	yes (DGGG)
Prioritized testing (7)	not applicable	yes (Maternity Task Force)	not applicable	no

Table 2 shows that expert associations in both countries predominantly give very similar recommendations. However, the professions involved were different, as in the US, mostly ACOG publishes recommendations, while in Germany, the German Midwifery Association is very active, followed by the DGGG. This can be explained by socio-cultural differences in the approach to birth. While in Germany, midwives need to be present at clinical births,[117] whereas the vast majority of women in the US are cared for by obstetricians.[118]

3. WOMEN'S RIGHTS IN BIRTH DURING THE COVID-19 PANDEMIC

To examine whether and how birthing rights have changed during the first four months of the COVID-19 pandemic, the results of our analysis of policies and recommendations are discussed within four key components of RCM, namely, dignity, support, information, and choice. Thus, the individual recommendations made by the WHO, such as pain relief strategies or testing, are discussed within the relevant topics of respectful maternity care. We briefly refer to the situation on a global scale and then reflect on the situation in New York State and Baden-Wuerttemberg.

3.1 DIGNITY IN BIRTH

Even though RMC is considered a human right, global evidence indicates a high prevalence of mistreatment of women at birth. In a statement published in 2015, the WHO declared abuse, neglect, or disrespect during childbirth a "violation of women's fundamental human rights."[119] As with health care in general, maternity care and narratives of birth are embedded in socio-structural inequities and influenced by cultural aspects.[120] For example, it is argued that birth is often seen as a risky medical situation[121] that leads to unnecessary interventions and undermines women's choice

[117] Deutscher Hebammenverband e. V. 'Was machen Hebammen? [What are midwifes doing?]' (2018) <https://www.hebammenverband.de/beruf-hebamme/was-machen-hebammen/> accessed 14 August 2020.

[118] E. R Declercq and others, 'Listening to Mothers III Pregnancy and Birth' (2013) <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-iii-pregnancy-and-birth-2013.pdf> accessed 14 August 2020.

[119] WHO, 'The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO Statement' [2015], 1 accessed 23 May 2020.

[120] A. D Napier and others, 'Culture and health' (2014) 384(9954) The Lancet 1607 <https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61603-2.pdf> accessed 14 August 2020.

[121] Agneta Westergren and others, 'Autonomous and dependent-The dichotomy of birth: A feminist analysis of birth plans in Sweden' (2019) 68 Midwifery 56.

and autonomy.[122] Despite the efforts by the WHO and other organizations to stress the significance of RMC and to support the provision of such care, reports of violence and abuse during birth, e.g., in terms of unconsented care or discrimination, are frequent.[123]

In addition to the already existing abuse and mistreatment in birth, the COVID-19 pandemic has the potential to further limit dignity and respect at childbirth on a global scale. Some public response measures negatively affected RMC.[124] For example, maternity care units have been used for patients infected with COVID-19,[125] thereby putting additional pressure on maternity care resources and increasing the risk for limited access to care and obstetric violence.[126] In fact, mistreatment and violence have been reported on an international scale and include: forced interventions, giving birth alone, and being separated from the newborns immediately after birth.[127] For instance, women gave account that they were forced to wear masks even during intense contractions.[128] Recognizing the risks of infection for maternal staff, the principle of "Do No Harm" seems to be neglected in such situations, given the fact that unobstructed breathing is a key aspect of labor to reduce pain and support pushing.[129]

While German law and national recommendations aim to support RMC,[130] structural barriers and a lack of resources keep impeding women-centered and

[122] Shaw (n 32).

[123] Bohren and others (n 4).

[124] I. Böhret, 'The Impact of Government Responses to COVID-19 on Women´s Reproductive Health and Rights' (2020) <https://www.coronanet-project.org/data/reports finished/20200507_womensrights.html> accessed 7 June 2020.

[125] Cheng and others (n 17).

[126] Lucia Rocca-Ihenacho and Cristina Alonso, 'Where do women birth during a pandemic? Changing perspectives on Safe Motherhood during the COVID-19 pandemic' (2020) 2(1) J Glob Health Sci.

[127] Daniela Drandić and Fleur van Leeuwen, 'COVID-19: a watershed moment for women's rights in childbirth | Medical Anthropology Quarterly' [2020] Medical Anthropology Quarterly <http:// medanthroquarterly.org/2020/08/11/covid-19-a-watershed-moment-for-womens-rights-in-childbirth/> accessed 14 August 2020; Human Rights in Childbirth (n 25).

[128] A. Richter-Trummer, 'Tag der Frauengesundheit: "Ich musste mit Maske gebären und dufte mein Baby nicht berühren" [Women's Health Day: "I had to give birth wearing a mask and wasn´t allowed to touch my baby"]' *meinbezirkat* (28 May 2020) <https://www.meinbezirk.at/c-lokales/ich-musste-mit-maske-gebaeren-und-dufte-mein-baby-nicht-beruehren_a4079370> accessed 6 June 2020.

[129] Deutscher Hebammen Verband e.V. (n 55).

[130] Bundesministerium für Gesundheit (n 82).

dignified care during birth.[131] Baden-Wuerttemberg has taken steps to improve the situation for birthing women by approaching economic and structural issues that exacerbate staff shortage. A roundtable on obstetrics was created in 2017 to address regional bottlenecks in the supply of maternity care.[132] In the last ten years, the birth rate increased in Baden-Wuerttemberg while at the same time, eleven maternity hospitals and two of ten birthing centers have been closed.[133] During the pandemic, this reduction of labor and delivery units might have led to a decrease in choice as more women aimed to give birth in a non-clinical setting.[134] Furthermore, staff shortage is a crucial challenge in the provision of region-wide maternity care, and in 2019 the roundtable published several resolutions to improve working conditions for maternity care staff and increase women's self-determination.[135] However, there is no evidence yet as to when and how these resolutions have been implemented. During COVID-19, maternity care staff were faced with extreme working conditions, for example, due to a lack of protective equipment.[136] The roundtable on obstetrics could have acted as an advising body for the subnational government to mitigate the negative impacts of the pandemic on women in birth and maternal care staff. Yet, no statements or activities by the roundtable could be found and the committee had its last meeting in October 2020.[137]

---

[131] Roses Revolution (n 135).

[132] Ministerium für Soziales und Integration Baden-Württemberg, 'Runder Tisch Geburtshilfe [Round table on obstetrics]: Bessere Rahmenbedingungen für Geburtshilfe und Hebammenversorgung [Better framework conditions for obstetrics and midwifery care]' (2019) <https://sozialministerium.baden-wuerttemberg.de/de/gesundheit-pflege/runder-tisch-geburtshilfe/> accessed 12 July 2020.

[133] Kohler, Stefan & Bärnighausen and Till (n 31).

[134] QUAG, 'Geburtenzahlen in Deutschland [Birth numbers in Germany]' (2021) <https://www.quag.de/quag/geburtenzahlen.htm> accessed 17 May 2021.

[135] Ministerium für Soziales und Integration Baden-Württemberg, 'Beschlüsse des Runden Tisches Geburtshilfe am 10. Mai 2019 [Decisions of the Obstetrics Round Table on 10 May 2019]' (2019) <https://sozialministerium.baden-wuerttemberg.de/fileadmin/redaktion/m-sm/intern/downloads/Downloads_Runder-Tisch-Geburtshilfe/Runder-Tisch-Geburtshilfe_Beschluesse_10-05-2019.pdf> accessed 12 July 2020.

[136] Deutscher Ärzteverlag GmbH, Redaktion Deutsches Ärzteblatt, 'COVID-19: Veto zur Hausgeburt [COVID-19: Veto on home birth]' (2020) <https://www.aerzteblatt.de/nachrichten/111827/COVID-19-Veto-zur-Hausgeburt> accessed 17 May 2021.

[137] Landesregierung Baden Wuerttemberg, 'Runder Tisch Geburtshilfe zieht positive Bilanz [Round table on obstetrics takes positive stock]' (2020). <https://www.baden-

Previous efforts on national and subnational level to ensure RMC have been partially pushed back during the pandemic. The German government failed on a national and state level to ensure the right to dignified care in childbirth through human-rights-based policymaking. Specific measures such as mask-wearing are implemented even though they might increase harm for birthing women and newborns. For example, according to reports, at least one mother has been traumatized due to her experience of giving birth while wearing a mask.[138] While in Austria, a neighboring country, the health ministry explicitly advises against masks for birthing women due to associated health risks,[139] German national or subnational ministries fail to provide clear guidance for hospitals and birthing women. The general uncertainty of policies in place has led to rising anxiety and fear of birth.[140] Such harmful effects could have been at least partially prevented by adopting measures that support women's rights in birth.

In the US, dignity in birth is supported by aiming to reduce unnecessary interventions. The ACOG gives clear recommendations on limiting interventions during labor and birth,[141] as unnecessary interventions exacerbate the risk of non-respectful care and mistreatment. However, mistreatment at birth is arguably prevalent in the US, and according to a study by Vedam et al.,[142] 17.3% of women reported experiencing one or more types of mistreatment, such as being shouted at,

---

wuerttemberg.de/de/service/presse/pressemitteilung/pid/runder-tisch-geburtshilfe-zieht-positive-bilanz/> accessed 17 May 2021.

[138] Bernhard Lohr, 'Geburt in Corona-Zeiten: Traumatisierte Mütter [Birth in Corona times: Traumatised mothers]' *Süddeutsche Zeitung* (6 May 2020) <https://www.sueddeutsche.de/muenchen/landkreismuenchen/landkreis-muenchen-geburt-corona-1.4899536> accessed 6 June 2020.

[139] Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz, 'Gesundheitsministerium: Mund-Nasen-Schutz während der Geburt wird nicht empfohlen [Ministry of Health: Mouth and nose protection during birth is not recommended]' (2020) <https://www.ots.at/presseaussendung/OTS_20200509_OTS0037/gesundheitsministerium-mund-nasen-schutz-waehrend-der-geburt-wird-nicht-empfohlen> accessed 6 June 2020.

[140] Landtag Rheinland Pfalz, *Ausschuss für Gesundheit, Pflege und Demografie [Committee on Health, Care and Demography]: Öffentliche 43. Sitzung am Donnerstag, dem 4. Juni 2020, 10.00 Uhr, per Videokonferenz [43rd public meeting on Thursday, 4 June 2020, 10.00 a.m. by videoconference]* (2020).

[141] ACOG, 'ACOG Committee Opinion' (n 62).

[142] Saraswathi Vedam and others, 'The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States' (2019) 16(1) Reprod Health 77.

scolded, or threatened, and being ignored, refused, or receiving no response to requests for help.[143] Women of color are especially at risk as the rates of disrespect, abuse, and discrimination within the health care system are consistently higher. This leads to poorer outcomes for birthing women of color and their newborns,[144] which is particularly alarming as they are disproportionately affected by an extremely high and continuously rising maternal mortality rate in the US.[145] According to a CDC report, the maternal death rate for black women was more than 2-fold higher than white women: 37.3 deaths per 100,000 live births.[146]

During COVID-19, it is suggested that mistreatment in NYS may have increased, given the Maternity Task Force aim to reduce the risk of additional maternal deaths. There have been reports of birthing women "being pushed" into inductions and cesarean deliveries.[147] Furthermore, the maternal death rate is forecasted to rise. A study by Putra et al.[148] projects an increase in maternal mortality rate in the US to at least 18.7 deaths per 100,000 live births. This is likely to affect birthing women of color even more as there have already been higher rates of hospitalization and death from COVID-19 infection reported for people of color.[149] The Maternity Task Force is trying to tackle racial disparity by putting a special

[143] Ibid.

[144] Molly R Altman and others, 'Information and power: Women of color's experiences interacting with health care providers in pregnancy and birth' (2019) 238 Social science & medicine (1982) 112491 <http://www.sciencedirect.com/science/article/pii/S0277953619304848>.

[145] Marian F MacDorman and others, 'Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues' (2016) 128(3) Obstetrics and gynecology 447.

[146] National Center for Health Statistics, 'National Vital Statistics Reports: Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018' (2020) 69(2) <https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69-02-508.pdf> accessed 25 August 2020.

[147] Sandhya Raman, 'COVID-19 amplifies racial disparities in maternal health' *Roll Call* (14 May 2020) <https://www.rollcall.com/2020/05/14/covid-19-amplifies-racial-disparities-in-maternal-health/> accessed 21 August 2020.

[148] Manesha Putra and others, 'Forecasting the Impact of Coronavirus Disease During Delivery Hospitalization: An Aid for Resources Utilization' [2020] American Journal of Obstetrics & Gynecology MFM 100127 <http://www.sciencedirect.com/science/article/pii/S2589933320300641>.

[149] Cdc, 'Health Equity Considerations and Racial and Ethnic Minority Groups' (2020) <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fracial-ethnic-minorities.html> accessed 21 August 2020.

emphasis on this in one of their recommendations.[150] Furthermore, several executive orders were issued in NYS to expand access to maternal care during the COVID-19 pandemic. This includes authorizing midwives from out-of-state and Canada to practice, thus ensuring that sufficient personnel is available to provide maternity care.[151]

3.2 SUPPORT IN BIRTH

There is a wide variance in the number of people allowed to accompany a birthing woman and their level of engagement and responsibility in birth. Companionship during birth is considered standard in most countries. However, staff's concerns, limitations of resources, and cultural inclinations have previously been identified as implementation barriers.[152] For example, Oliveira et al.[153] explained that care professionals in Brazil often do not allow companions in the delivery room due to fear of confrontation. Thus, companionship in labor depends not only on women's individual wishes but also on socio-structural aspects.

During the COVID-19 pandemic, policies of social distancing and visitor restrictions in hospitals were common in many countries. While some countries such as Finland and the Czech Republic explicitly stated that the visitor ban does not apply to pregnant women, many women in other countries were not allowed to be accompanied by their partner of choice or a doula.[154] Such measures not only

[150] New York State COVID-19 MaternityTask Force (n 21).

[151] Cuomo, Andrew, M. 'Executive Order No. 202.11: Continuing Temporary Suspension and Modification of Law Relating to the Disaster Emergency' (2020) <https://www.governor.ny.gov/news/no-20211-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency> accessed 21 August 2020.

[152] Tamar Kabakian-Khasholian and Anayda Portela, 'Companion of choice at birth: factors affecting implementation' (2017) <https://www.mother-hood.de/fileadmin/user_upload/Medien/Dokumente/MH_Corona_L%C3%A4nderverordnungen_Bes ucherregeln_20200525.pdf> accessed 7 June 2020

[153] Virgínia J Oliveira and Cláudia M d M Penna, 'Discussing obstetric violence through the voices of women and health professionals' (2017) 26(2).

[154] Cheng and others (n 17).

undermined the protective and positive effects of birth support but also increased women's levels of stress and anxiety through uncertainty and isolation.[155]

In Germany, companionship during labor and delivery has become customary in the last decades, yet there is no respective law or policy, and the number of people allowed varies between hospitals. During the COVID-19 pandemic, some states clearly indicated that the national ban on hospital visitors does not apply to the situation of birth. However, only one state was found, which urged hospitals to allow a companion of choice.[156] No official statement was found on behalf of BW, and several hospitals (temporarily) banned birth partners during the COVID-19 pandemic or allowed companionship only during the expulsive phase of vaginal birth.[157] Thus, many women experienced most of the birthing process and hospital-based recovery without their companion of choice. Consequently, many women reported having been without continuous support since midwives are typically responsible for more than one laboring person, and sick leave due to COVID-19 further deteriorated this situation.[158]

Furthermore, German media narratives showed little awareness of the women's right to a companion of choice. Instead, the prohibition of companions in birth was referred to as an interference with the rights of fathers-to-be instead of women's right to receive support. For example, one newspaper in Baden-Wuerttemberg quoted a head physician stating: "It is a weighing up of goods, […] whether one endangers the health of the employees or the father's right to be present at the birth" [translated by author].[159] While many women choose the father-to-be to

[155] L. Oja, 'Sexual and Reproductive Rights in Time of the Covid-19 Pandemic: Reflections and Notes' (2020) <https://www.liirioja.com/srhr-writings> accessed 23 April 2020.

[156] Landesregierung Rheinland Pfalz (n 71).

[157] Motherhood e.V. 'Hinweise und Empfehlungen für Schwangere zu Corona [Notes and recommendations for pregnant women on Corona]' (2020) <https://www.mother-hood.de/sichere-geburt/informationen-fuer-eltern/hinweise-und-empfehlungen-fuer-schwangere-zu-corona.html> accessed 7 June 2020.

[158] Kirsten Achtelik, 'Grünen-Politikerin über Geburtshilfe: „Ein Recht auf Begleitung" [Green politician on obstetrics: "A right to company"]' *TAZ* (4 May 2020) <https://taz.de/Gruenen-Politikerin-ueber-Geburtshilfe/!5682816/> accessed 7 June 2020.

[159] Maximilian Müller, 'Freudenstadt: Chefärzte verteidigen Väter-Verbot im Kreißsaal [Freudenstadt: Chief physicians defend ban on fathers in delivery room]' *Schwarwälder Bote* (10 April 2020) n.p. <https://www.schwarzwaelder-bote.de/inhalt.freudenstadt-chefaerzte-verteidigen-vaeter-verbot-im-kreisssaal.43ea73ee-d0bd-47b3-a13a-21a66177fdb1.html> accessed 4 July 2020.

accompany the birth, such narratives are still at odds with women-centered care. Emphasizing the fathers' right to be present can be considered as a patriarchal narrative, which fails to acknowledge the need and right of birthing women to receive support from whomever they wish to accompany them.

In the US, most birthing women bring a companion of choice, and NYS aimed to ensure this kind of support during the pandemic. Hospitals usually allow one support person in the operating room during a cesarean section and at least two, including a doula, during a vaginal birth in the labor and delivery room.[160] Despite the NYSDOH's guidance issued at the beginning of the COVID-19 pandemic, two major private hospital networks issued hospital policies stating that no support person was allowed to accompany laboring women. Similar to institutional policies made by German hospitals, it was argued that this could help protect mothers and newborns from infections.[161] Those two hospital networks, New York-Presbyterian Healthcare System and Mount Sinai Health System, accounted for over 26,000 births in New York County out of 227,014 total birth in New York in 2017.[162]

Private hospitals' fast-paced changes made at the beginning of the pandemic show the vulnerability of women's rights during childbirth. Although it is clearly recommended by numerous organizations and city policies such as New York City, women's right to be accompanied by their support person of choice were increasingly violated. This practice has been swiftly put to an end by the executive order of the Governor of New York as described above, but in the days between March 23 and 28 in 2020, some women in private hospitals were not accompanied during childbirth.[163]

[160] Mount Sinai West, 'Giving Birth at Mount Sinai West: A planning guide to a rewarding pregnancy, labor, delivery, and postpartum experience' [n.d.] <https://www.mountsinai.org/files/MSHealth/Assets/MSW/MSW-Giving-Birth.pdf> accessed 21 August 2020 NewYork-Presbyterian, 'Labor & Delivery FAQs' (2020) <https://www.nyp.org/womens/services/pregnancy-and-maternity-care/labor-and-delivery/frequently-asked-questions> accessed 21 August 2020

[161] Christina Caron and Katie van Syckle, 'Some Pregnant Women in New York City Will Have to Deliver Babies Alone' *The New York Times* (24 March 2020) <https://www.nytimes.com/2020/03/24/parenting/coronavirus-labor-birth.html> accessed 21 August 2020.

[162] New York State Department of Health, 'Measure View: Total Births' (n.d.) <https://profiles.health.ny.gov/measures/all_state/16511> accessed 21 August 2020.

[163] Elizabeth Kim and Caroline Lewis, 'Expectant Mothers In NYC Face The Prospect Of Laboring Without Their Partners' *Gothamist* (24 March 2020) <https://gothamist.com/news/expectant-mothers-

The executive orders by the state do, however, ensure that birthing women can be supported both during childbirth and recovery, thus strengthening women's rights.

3.3 Information and Communication

The WHO describes informed choice and clear communication as fundamental elements of RMC.[164] Clear and effective communication is crucial for informed consent processes, feelings of control, and satisfaction with birth.[165] However, a lack of communication and limited information has been reported in different countries and contexts.[166] For example, in Germany, lack of clear communication has been mentioned as a contributing factor for traumatization and obstetric violence.[167]

Before the pandemic, BW aimed to improve clear communication, yet there was a lack of support for this aspect of RMC during COVID-19. The BW roundtable on obstetrics highlighted the need for comprehensive, evidence-based information and clear communication to strengthen women's self-determination and empowerment.[168] However, during COVID-19 German governments, both on the federal level as well as on the subnational level in BW, failed to underline the right to clear communication in public policies. Expert associations provided comprehensive guidelines for the prevention and management of COVID-19 in labor and delivery units, including clear

nyc-coronavirus-partners-covid-19> accessed 21 August 2020; Emily Bobrow, 'A Chaotic Week for Pregnant Women in New York City' *New Yorker* (1 April 2020) <https://www.newyorker.com/science/medical-dispatch/a-chaotic-week-for-pregnant-women-in-new-york-city> accessed 21 August 2020.

[164] WHO (n 2).

[165] Westergren and others (n 124).

[166] R. Brinkler and others, 'A survey of antenatal and peripartum provision of information on analgesia and anaesthesia' (2019) 74(9) Anaesthesia 1101; Birthrights, 'Dignity in Childbirth: Women's and midwives' experiences of dignity in UK maternity care' (2013) <https://birthrights.org.uk/wp-content/uploads/2013/10/Birthrights-Dignity-Survey-1.pdf> accessed 23 May 2020.

[167] B. Conradi, 'Willkommenskultur im Kreißsaal - Die Macht der Kommunikation beim Kinderkriegen [Welcome culture in the delivery room - The power of communication when having children]' (2018) <https://www.deutschlandfunkkultur.de/willkommenskultur-im-kreisssaal-die-macht-der-kommunikation.976.de.html?dram:article_id=416562> accessed 7 June 2020.

[168] Stahl and others (n 82).

recommendations for birthing women's care and treatment. Yet, no recommendation was found that highlighted the need for clear communication.[169]

Consequently, with birthing women's need for reliable information being largely ignored, this could arguably increase anxiety and fear of birth. The cancellation of prenatal courses due to COVID-19 prevention measures,[170] for example, may have led to an increased need for information. At the same time, uncertainty was caused by the often-changing recommendations and policies. This is all the more so considering that there was a lack of information regarding prioritized testing among pregnant and birthing women in Germany. Resultantly, some pregnant women feared attending public testing stations due to a perceived risk of infection.[171] Moreover, although individual hospitals had defined fixed procedures to test women and their companion of choice prior to delivery,[172] other hospitals recommended testing only for symptomatic women.[173] Such uncertainties and mixed approaches to testing are another example of the increased pressure placed on pregnant women, who are already at higher risk of experiencing psychological distress in a prolonged global pandemic.[174]

---

[169] DGGG, 'Empfohlene Präventionsmaßnahmen für die geburtshilfliche Versorgung in deutschen Krankenhäusern und Kliniken im Zusammenhang mit dem Coronavirus [Recommended preventive measures for obstetrical care in German hospitals and clinics in connection with coronavirus]' (2020) <https://www.dggg.de/fileadmin/documents/Weitere_Nachrichten/2020/COVID-19_DGGG-Empfehlungen_fuer_Kreissaele_20200319_f.pdf> accessed 3 July 2020.

[170] C. Spitz, 'Villingen-Schwenningen: Corona-Krise: Schwangere weichen auf Geburtshäuser aus _ Schwarzwälder Bote' *Schwarzwälder Bote :* [Corona crisis: Pregnant women turn to birth centers] (8 April 2020) <https://www.schwarzwaelder-bote.de/inhalt.villingen-schwenningen-corona-krise-schwangere-weichen-auf-geburtshaeuser-aus.32fb011f-38b0-41ab-97ec-01e4ff9ed3ff.html> accessed 14 August 2020.

[171] Redaktionsnetzwerk Deutschland, 'Corona und schwanger: Eine Mutter berichtet von ihren Erfahrungen [Corona and pregnant: A mother reports her experiences]' (16 May 2020) <https://www.rnd.de/familie/corona-und-schwanger-eine-mutter-berichtet-von-ihren-erfahrungen-B37Z7G3VQNFLFMHVPKDMOQGLHQ.html> accessed 8 July 2020.

[172] Ernst von Bergmann Klinikum, 'Ab sofort Begleitung im Familienzimmer nach der Geburt wieder möglich [From now on accompaniment in the family room after the birth is possible again]' (2020) <http://www.geburtinpotsdam.de/index.php?id=67> accessed 8 July 2020.

[173] City Praxen Berlin, 'Coronavirus - COVID-19 in der Schwangerschaft Gynäkologie und Geburtshilfe [Coronavirus - COVID-19 in pregnancy gynecology and obstetrics]' (2020) <https://frauenarzt-praxis-berlin-mitte.de/geburtshilfe/coronavirus-in-der-schwangerschaft/> accessed 8 July 2020.

[174] Suraj B Thapa and others, 'Maternal mental health in the time of the COVID-19 pandemic' (2020) 99(7) Acta obstetricia et gynecologica Scandinavica 817.

In the US, clear communication in maternity care and informed choice had already been insufficient prior to the pandemic. A survey study by Cheng et al.[175] examining birthing women's communication experiences found that over 40% were hesitant to ask their health care provider questions regarding their maternal care. Therefore, these women were not actively taking part in the decision-making process of their care, and what is even more alarming: "women who perceived pressure from clinicians for labor induction or cesarean delivery were more likely to undergo these procedures regardless of medical indication."[176] During the COVID-19 pandemic, the situation in NYS was similar to the one in BW. General communication and information in NYS regarding hospital policies have been nonuniform, and there were sudden shifts in plans and policies. Thus, next to the general need to improve communication and information in maternal health care, the significance of information for birthing women during a public health emergency needs to be acknowledged and addressed.

3.4 CHOICE IN BIRTH

Choice is a crucial part of a respectful and positive childbirth experience as it puts birthing women, to some extent, in control of the physiological process they are about to undergo. Choice can refer to the mode of delivery, position of labor, pain relief, and place of birth and is a key determinant of positive birth experiences.[177] However, many women report a lack of choice and control that contradicts their right to self-determination at birth.[178] Unconsented interventions, for example, are considered a form of obstetric violence.[179] The following paragraphs focus on choices that have been particularly affected by the pandemic, such as mode of delivery, pain relief, and birthing setting.

[175] Erika R Cheng and others, 'Communications Between Pregnant Women and Maternity Care Clinicians' (2020) 3(5) JAMA Network Open e206636.

[176] Ibid n.p.

[177] Amanda M Hardin and Ellen B Buckner, 'Characteristics of a positive experience for women who have unmedicated childbirth' (2004) 13(4) The Journal of Perinatal Education 10.

[178] Birthrights (n 181).

[179] European Commission (n 127).

Choice regarding the mode of delivery is important for women; however, it has been argued that many women are undergoing cesarean sections in the absence of medical indications or maternal requests.[180] According to the WHO, cesarean section rates higher than 10% within a population are often not associated with reductions in maternal and newborn mortality rates.[181]In both countries the rate of cesarean sections is above WHO's recommendations, with BW at 31.4% and NYS at 34,6%.[182] It is frequently argued that many cesarean sections are determined by structural and organizational factors instead of medical indications or maternal preferences.[183]

Concerning COVID-19, the WHO recommends that in case of an infection with COVID-19, cesarean sections should only be conducted if medically indicated and according to women's preferences.[184] When cesarean sections are framed as mandatory, women's right to give informed consent to a medical procedure is ignored. In Germany, at least one hospital had the (temporary) internal policy to conduct cesarean sections on all women infected with COVID-19.[185] Whether those women were informed about this policy prior to their delivery remains unclear. Experts criticized the approach of referring to COVID-19 infection as a general indication for surgical delivery.[186] There are no reports on hospitals in BW nor in New York that have had similar policies.

In the US and Germany, most births occur in hospitals, this is even though the hospital setting could lead to an increase in some specific risks, such as mistreatment, and in this case COVID-19 infection. In 2017 and 2015, respectively, the vast majority of births in NYS (97.5%) and BW (98,6%) took place in hospital settings.[187] Experiences of mistreatment have been found to differ significantly based on the place of birth: A

[180] Declercq and others (n 121).

[181] WHO (n 14).

[182] New York State Department of Health, 'Measure View: Cesarean Births' (n.d.) <https://profiles.health.ny.gov/measures/all_state/16575> accessed 21 August 2020.

[183] Die Techniker Schmerzmanagement, Pain management (2019) <https://www.tk.de/techniker/gesundheit-und-medizin/schwangerschaft-und-geburt/schmerzmanagement-2009566> accessed 15 July 2020.

[184] WHO (n 13).

[185] Ärzte Zeitung (n 109).

[186] Ibid.

[187] Marian F MacDorman and Eugene Declercq, 'Trends and state variations in out-of-hospital births in the United States, 2004-2017' (2019) 46(2) Birth (Berkeley, Calif) 279; Kohler, Stefan & Bärnighausen and Till (n 31).

study from 2019 showed that in the US, 5.1% of women gave birth at home in comparison to 28.1% of women who gave birth in a hospital setting report some form of mistreatment.[188] Furthermore, Putra et al. assert that the hospital setting poses a greater risk for women to get infected and increases the maternal mortality rate.[189] Thus, while hospitals may provide the best setting for high-risk patients,[190] out-of-hospital settings should be available for low-risk women who wish to give birth in a different setting.

However, women often have a limited choice of birth setting in NYS. New York City's standards for respectful care at birth include information about decision-making regarding where to give birth, whether at a hospital, birthing center, or at home.[191] Yet, alternative options are very rare. According to the American Association of Birth Centers, NYS only has three birth centers.[192] Births in one of these three centers make up 0.08% of all births.[193]

On the contrary, the accessibility of birthing options in Germany is slightly better, yet criticism on limitations of choice persists. In BW, there are eight birthing centers, three midwife-led labor wards, and the possibility of delivering at home or bringing an in-patient midwife to the hospital.[194] However, it is argued that this data still reflects a limited number of birthing centers and midwives offering home births in BW.[195] While the proportion of women who delivered their newborns at home or in birthing centers increased from 0.9% to 1,45% in the last decade,[196] there is only anecdotal evidence on the effects of the pandemic. Some hospitals in BW reported an increase in home births; others have not.[197] The interest in home births or in a birthing

[188] Vedam and others (n 155).

[189] Putra and others (n 161).

[190] Susan R Stapleton, Cara Osborne and Jessica Illuzzi, 'Outcomes of care in birth centers: demonstration of a durable model' (2013) 58(1) Journal of midwifery & women's health 3.

[191] NYC Health (n 42).

[192] American Association of Birth Centers, 'Find a Birth Center Near You' (n.d.) <https://www.birthcenters.org/search/custom.asp?id=2926> accessed 21 August 2020.

[193] MacDorman and Declercq (n 227).

[194] Hebammenverband Baden Wuerttemberg, 'Freie Wahl des Geburtsortes' (2019) <https://hebammen-bw.de/geburt/> accessed 15 July 2020.

[195] Selow (n 138).

[196] QUAG (n 146).

[197] Reinhold Wagner, 'Gebären in Corona-Zeiten: Nachgefragt bei Chefärzten und Experten der Kliniken in der Region [Giving birth in times of Corona]' (2018) <https://www.chilli-

center is likely linked to the ban of companions in hospitals and the perceived risk of infection with COVID-19.[198]

No public policies in BW could be found regarding the place of birth during the pandemic. Yet, official statements could be considered as having some potential to influence women's perception of choice. For example, on one occasion, a clinical director stated that choosing a home-birth during the pandemic shows lack of solidary, because a possible hospital transfer would require resources needed elsewhere.[199] The argument raised in this statement should be questioned, as the majority of out-of-hospital births (over 84%) do not require transfer to hospitals,[200] and thus might even relieve medical resources. Yet, perhaps more importantly, this statement suggests a new point in the discussion surrounding home births. While previously, discussions evolved primarily on the issue of individual risk, the accusation of lacking solidarity could potentially influence what women experience as legitimate choices when deciding on birth-setting.

Compared to BW, NYS expanded the choice for pregnant women. One of the recommendations the COVID-19 Maternity Task Force made regarding maternal choice was "to diversify birthing site options to support patient choice,"[201] which was directly issued as an executive order.[202] This allowed "for the immediate establishment of additional birthing surge sites operated by currently established licensed birthing hospitals and centers."[203] In the course of the expansion of birthing site options, two new midwife-led birthing centers were established to help ease hospitals' stress of caring for COVID-19 patients and increase birthing options.[204] The expansion of

freiburg.de/findefuchs/bauch-baby/gebaeren-in-corona-zeiten-nachgefragt-bei-chefaerzten-und-experten-der-kliniken-in-der-region/>.

[198] Deutsche Hebammen Zeitschrift, 'Corona lässt Interesse an Hausgeburten steigen [Corona drives up interest in home births]' (2020) <https://www.dhz-online.de/news/detail/artikel/corona-laesst-interesse-an-hausgeburten-steigen/> accessed 17 May 2021.

[199] Deutscher Ärzteverlag GmbH, Redaktion Deutsches Ärzteblatt (n 148).

[200] QUAG, 'Außerklinische Geburtshilfe in Deutschland - Qualitätsbericht 2019 Out-of-hospital obstetrics in Germany - Quality Report 2019]' (2019) <https://www.quag.de/downloads/QUAG_Bericht2019.pdf> accessed 17 May 2021.

[201] New York State COVID-19 Maternity Task Force (n 21) 4.

[202] Cuomo, Andrew, M. (n 77).

[203] New York State COVID-19 Maternity Task Force (n 21).

[204] Governor Andrew M. Cuomo, 'Governor Cuomo & COVID-19 Maternity Task Force Chair Melissa DeRosa Announce Increased Access to Midwife-Led Birth Centers Amid COVID-19 Pandemic' (2020).

birthing site options could potentially lead to a positive outcome regarding respectful care in childbirth. Out-of-hospital births can provide more choices for women, and it might mean fewer interventions that bear the risk of violence and unpleasant birthing experiences for women.

4. CONCLUSION

Even prior to this pandemic, many women worldwide lacked access to RMC and experienced disrespect, abuse, physical and psychological harm in their maternal care.[205] As with previous health emergencies, the current pandemic and the responses towards it bear the possibility to increase existing gender disparities and women's vulnerability.[206]

Women are generally disproportionally affected by preventive measures such as stay-at-home orders,[207] and pregnant women might be significantly impacted due to the fear for their unborn child; lack of preparation for birth; and increased anxiety about their intrapartum care due to continually changing policies. Furthermore, the lack of support and companionship, restricted provision of information, and limited choice regarding the delivery mode, are all in contradiction with RMC. Therefore, it is crucial to take women's rights regarding childbirth into account when issuing policies and recommendations, during the pandemic.

By using BW and NYS as a case study, this paper illustrated how women's birthing rights remain at great risk. While health emergencies put pressure on scarce resources and systems, response measures must not worsen already existing inequalities and vulnerabilities. Instead, women's rights in childbirth must be supported on federal, state, and hospital administration level and emphasized by expert societies to guarantee respectful and safe birth experiences even in times of pandemics.

<https://www.governor.ny.gov/news/governor-cuomo-covid-19-maternity-task-force-chair-melissa-derosa-announce-increased-access> accessed 21 August 2020.

[205] Bohren and others (n 4).

[206] Drandić and van Leeuwen (n 131).

[207] OHCHR, 'COVID-19 and Women´s Human Rights:: Guidance: What is the impact of COVID-19 on gender-based violence' (2020) <https://www.ohchr.org/Documents/Issues/Women/COVID-19_and_Womens_Human_Rights.pdf> accessed 14 August 2020.