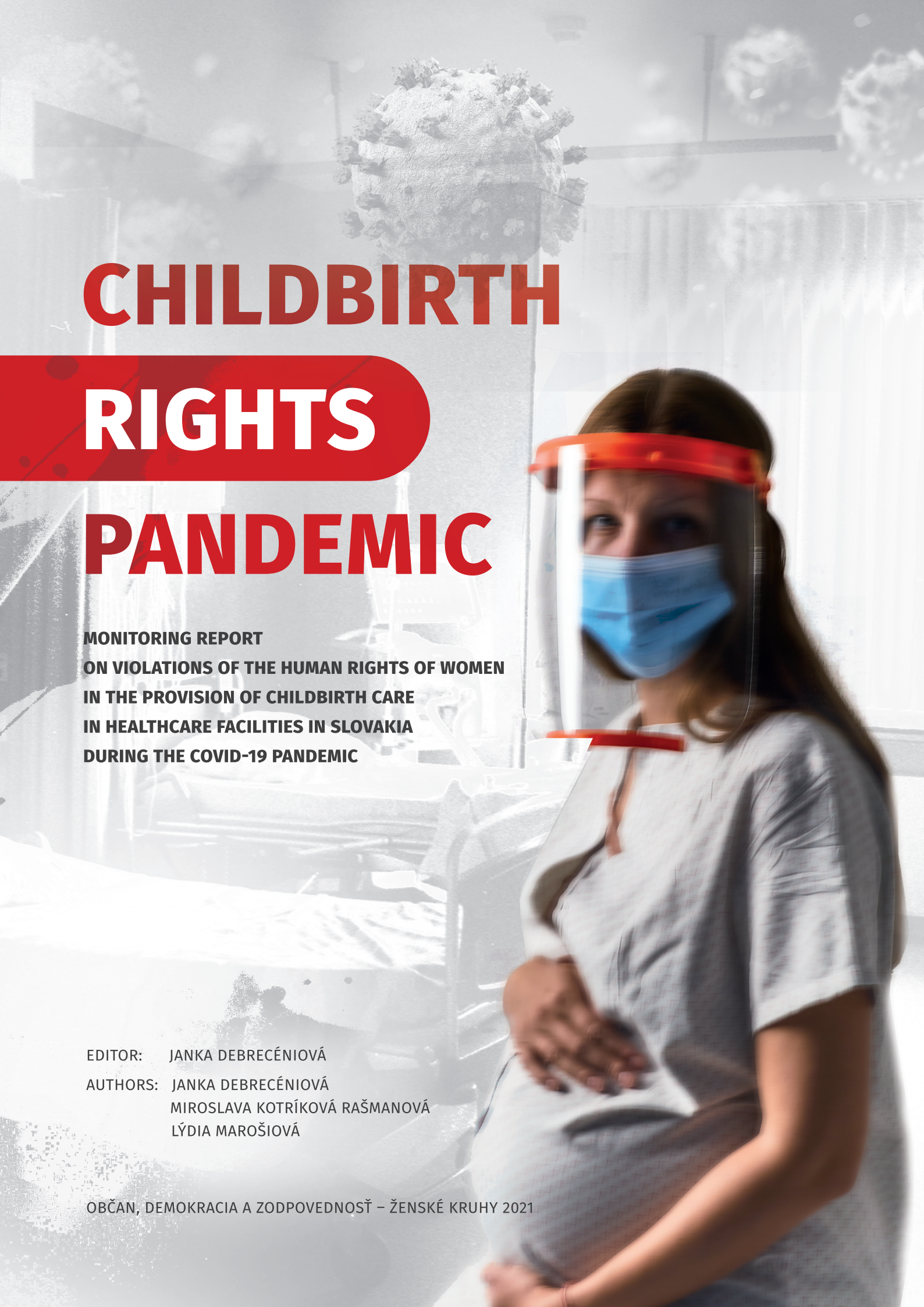
CHILDBIRTH RIGHTS PANDEMIC

MONITORING REPORT ON VIOLATIONS OF THE HUMAN RIGHTS OF WOMEN IN THE PROVISION OF CHILDBIRTH CARE IN HEALTHCARE FACILITIES IN SLOVAKIA DURING THE COVID-19 PANDEMIC



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During the COVID-19 Pandemic

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Janka Debrecéniová, Miroslava Kotríková Rašmanová, Lýdia Marošiová

August 2020

Introduction

In early March 2020, Slovakia, a Central European country with about 5.5 million inhabitants, reported the first cases of coronavirus disease 2019 (COVID-19). The response of the Slovak government was a rapid one. On 12 March 2020, the government declared a state of extraordinary situation[1], and on 15 March 2020 the government declared a state of emergency[2]. These decisions, combined with numerous measures adopted by the government, governmental and other public bodies and various other institutions that jointly led to a strict lockdown, resulted in keeping the numbers of COVID-19 cases very low. By 13 June 2020, the day until which the state of emergency officially lasted, Slovakia had only had 1545 cases of persons who had tested positive for COVID-19[3], out of whom only a few had been hospitalised.

However, the measures and other steps that were undertaken in Slovakia during the initial phase of the COVID-19 pandemic (not necessarily with a clear and existing legal basis and not necessarily meeting the legal requirements of necessity, proportionality and non-discrimination) also had numerous negative impacts on various groups. One of the groups that was seriously negatively affected was pregnant women and women giving birth after the outbreak of the pandemic.

One of the first indicators that the human rights of women in childbirth would be seriously endangered under the guise of the anti-epidemic measures was a general ban on visits in hospitals throughout Slovakia, which was adopted on 6 March 2020.[4] Numerous hospitals immediately began interpreting this measure as enabling a ban on birth companions. Many women were thus deprived not only of an important component of their right to private and family life and their right to health[5], but also of the so much needed component of public control that is essential in all systems of unequal power

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1 Decision of the Government of the Slovak Republic No 111 of 11 March 2020, available at: https://rokovania.gov.sk/RVL/Material/24585/1 (last visited on 27 July 2020).

2 Decision of the Government of the Slovak Republic No 114 of 15 March 2020, published in the official Collection of Laws of the Slovak Republic (further on as 'Coll.') under No 45/2020 Coll.

3 See https://www.health.gov.sk/Clanok?covid-19-13-06-2020-vysledky (last visited on 27 July 2020).

4 Decision of the Public Health Authority of the Slovak Republic No OLP/2405/2020 of 6 March 2020, available at: https://www.ruvzpp.sk/aktuality-a-novinky/uvz-sr-verejna-vyhlaska-vo-veci-nariadenia-opatrenia-na-predchadzanie-vzniku-a-sireniu-prenosneho-ochorenia-covid-19 (last visited on 27 July 2020).

5 There is evidence suggesting that the presence of a birth companion of a woman's choosing makes childbirth shorter and reduces the likelihood of caesarean section and instrumental vaginal delivery. The WHO recommends the presence of a companion of choice for all women throughout labour and childbirth, including during the COVID-19 pandemic. See WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva : World Health Organization, 2018, pp 29 – 30, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020). See also WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

relations that are closed, monopolised, and rich in systemic human rights violations, such as the childbirth care system in Slovakia.

At the same time, the websites of hospitals and/or their parent companies began presenting statements from their leading medical authorities who were themselves promoting procedures in childbirth for the COVID-19 pandemic period that had no basis in scientific evidence or that were in conflict with the existing WHO recommendations.[6] Examples of the procedures promoted by Slovak medical authorities included the routine exercise of instrumental vaginal delivery in cases of women with COVID-19 in order to shorten the second stage of labour and reduce the risk of infecting the hospital staff[7], as well as a routine separation of newborns from their mothers with positive COVID-19 tests or with symptoms of the disease, either until a negative COVID-19 test, or for 14 days (in case of the mothers with positive COVID-19 tests).[8]

It was this setting in which Občan, demokracia a zodpovednosť (Citizen, Democracy and Accountability (CDA)) and Ženské kruhy (Women's Circles), two women's rights NGOs based in Slovakia that promote, *inter alia*, the rights of women in childbirth, began monitoring the ways in which prenatal and childbirth care were being provided during the COVID-19 pandemic in healthcare facilities in Slovakia. The aim of the monitoring, carried out between 6 March 2020 and 30 June 2020 by using various fact-finding methods, was to identify and document any violations of the human rights of women that potentially occurred in connection with the provision of prenatal and childbirth care during the initial phase of the COVID-19 pandemic in Slovakia, in particular during the period between early March 2020 and the end of June 2020 (this approximate period is sometimes also called the 'first wave' of the pandemic in Slovakia).

During this period, 50 maternity wards providing state-guaranteed healthcare covered by health insurance were in operation in Slovakia. Given that state borders were, for women wishing to give birth abroad, closed in practice for most of the duration of the state of emergency, and given that Slovakia does not guarantee any kind of childbirth care other than that provided in hospitals, women who gave birth during the pandemic had no other option but to go to one of these 50 birthing facilities if they wanted to be

6 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

7 Podcast of the Košice-Šaca hospital: *Interview of 20 March 2020 with MUDr. Erik Dosedla, PhD., MBA, the head of the Gynaecology and Obstetrics Clinic at the Košice-Šaca hospital*, at 10:09 – 10:30 minutes of the record, available at: https://youtu.be/K6UrG9SH46o (last visited on 27 July 2020).

8 See, for example, a podcast on the ProCare and Svet zdravia companies' (the latter owning several hospitals with maternity wards in Slovakia) website: *Zdravý podcast #6: Majú bábätká nosiť rúško?* [Healthy Podcast #6: Should Babies Wear Face Masks?] An interview with MUDr. Mária Vasilová, the main expert of the ProCare and Svet zdravia network for the field of neonatology and at the same time the head of the Department of Neonatology at the Humenné hospital, at 13:00 – 14:10 minutes of the record, available at: https://www.procare.sk/podcasty (last visited on 27 July 2020).

assisted by a health professional (and in any case, other options extant during times of open borders are available only to a few privileged women).

The system of childbirth care in Slovakia is a highly medicalised and male-dominated one. Obstetric male authorities determine the nature of care provided both in individual healthcare facilities (in the overwhelming majority of cases, men are the heads of obstetric departments and obstetric clinics and make the decisions on the ways childbirth care is to be provided), and at the state level (male medical professors and other male experts determine the nature and content of both medical education and further medical professional training). Midwives are employed in all maternity wards, but in practice, they do not provide childbirth care independently but under the leadership of obstetricians; in actuality, midwives do not assist the labouring women but the obstetricians, and are in fact subordinate to them in the workplace hierarchies. There are no guidelines on birth care adopted on the state level that would incorporate the latest scientific knowledge and evidence-based medicine and the essential human rights requirements on which childbirth care must be based.

Earlier work of CDA and of Women's Circles documented very serious violations on the part of healthcare facilities in Slovakia regarding human rights that are particularly affected by the provision of childbirth services. The particular rights where violations were identified include the right to be treated with respect and dignity; the right to health, including to sexual and reproductive health; the right to information; the right to the protection of private and family life and to the provision of healthcare solely on the basis of informed consent; the right to equality and non-discrimination; the right not to be subject to violence, torture, and other cruel, inhuman and degrading treatment; and the right to enjoy the benefits of scientific progress and its application. CDA's and Women's Circles' previous work also casts light on some of the systemic aspects that cause and/or accompany these violations and that include the education and training of healthcare personnel, the absence of national-level guidelines on the provision of childbirth care, power and hierarchical relations among the healthcare personnel, the organisation of work in birthing facilities, the misunderstanding of the informed consent concept by the personnel, and the misunderstanding of the concept of human rights in general.[9]

9 See DEBRECÉNIOVÁ, J. (ed.); BABIAKOVÁ, K. – DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – KRIŠKOVÁ, Z. – SEKULOVÁ, M. – ŠUMŠALOVÁ, S.: *Ženy – Matky – Telá: Ľudské práva žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku*. [Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, 2015. Also available at: http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf (last visited on 27 July 2020). An English summary is available at: http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf (last visited on 27 July 2020). See also DEBRECÉNIOVÁ, J. (ed.); DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – HREŠANOVÁ, E. – KRIŠKOVÁ, Z. – LAFFÉRSOVÁ, Z. – SEKULOVÁ, M.: *Ženy – Matky – Telá II: Systémové aspekty porušovania ľudských práv žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku*. [Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, Ženské kruhy, 2016. Also available at: http://odz.sk/wp-content/uploads/ZMT2_systemove_apekty_v6_w.pdf (last visited on 27 July 2020). An English summary is available at: http://odz.sk/en/wp-content/uploads/ZMT2_SUMMARY_EN_final.pdf (last visited on 27 July 2020).

There is no doubt that the COVID-19 pandemic is an emergency situation under which States need to carry out specific measures to protect public health. These measures may restrict or suspend certain human rights, but the conditions for the adoption and implementation of these limitations are very strict.

First, not all human rights can be restricted or suspended in times of emergencies. In the case of certain fundamental rights, such as the right to life or the right not to be subject to torture or other cruel, inhuman or degrading treatment, no derogation can be made.

Second, States' obligations associated with the core content of economic and social rights including the right to health remain in effect even during situations of emergency. Sexual and reproductive health services, which include pregnancy- and childbirth-related care, are essential services and the State must ensure their provision even during the COVID-19 pandemic. This does not only concern providing the healthcare as such but also services connected therewith, such as the relevant health- and healthcare information.

Third, where States can limit some rights in situations of emergencies, strict requirements must be met. The restriction in question must be legal, which means, *inter alia*, that it must have a basis in a particular provision of the national legal order (in Slovakia, the Constitutional Act No 227/2002 Coll. on the security of the State in times of war, war state, state of extraordinary situation and state of emergency, as amended, represents such a basis). It must also be necessary, proportional, and it cannot be discriminatory. It must be strictly temporary in nature.[10] Responses to the pandemic should be based on

10 For more information on the legal framework for human rights limitations during emergency situations, see: International Covenant on Civil and Political Rights, Article 4; International Covenant on Economic, Social and Cultural Rights, Article 4; THE OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS: *Emergency Measures and COVID-19: Guidance*. 27 April 2020. Available at: https://www.ohchr.org/Documents/Events/EmergencyMeasures_COVID19.pdf (last visited on 27 July 2020); HUMAN RIGHTS COMMITTEE: *General Comment No. 29: States of Emergency (Article 4)*. CCPR/C/21/Rev. 1/Add. 11, 31 August 2001. Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2f21%2fRev.1%2fAdd.11&Lang=en (last visited on 27 July 2020); COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN: *Guidance Note on CEDAW and COVID-19*. Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT/CEDAW/STA/9156&Lang=en (last visited on 27 July 2020); COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: *Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights*. E/C.12/2020/1, 17 April 2020, mainly paras 2, 3, 8, 10 – 18. Available at: https://undocs.org/E/C.12/2020/1 (last visited on 27 July 2020); COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: *General comment No. 3: The nature of States parties obligations (Art. 2, par. 1*). 14 December 1990, paras 10 – 11. Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCESCR%2fGEC%2f4758&Lang=en (last visited on 27 July 2020); COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: *General comment No. 14: The right to the highest attainable standard of health*. E/C.12/2000/4, 11 August 2000, paras 43 – 44. Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en (last visited on 27 July 2020); COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: *General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*. E/C.12/GC/22, 4 March 2016, para 49. Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en (last visited on 27 July 2020).

the best available scientific evidence to protect public health.[11] Emergency measures and powers of state bodies adopting them should not be abused.[12] The inherent dignity of all people must be respected and protected.[13]

11 See COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: *Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights*. E/C.12/2020/1, 17 April 2020, para 10. Available at: https://undocs.org/E/C.12/2020/1 (last visited on 27 July 2020); and see COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: *General comment No. 25 (2020) on science and economic, social and cultural rights (article 15 (1) (b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights)*. E/C.12/GC/25, 30 April 2020. Available at: https://undocs.org/E/C.12/GC/25 (last visited on 27 July 2020).

12 See, for example, COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: *Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights*. E/C.12/2020/1, 17 April 2020, para 11. Available at: https://undocs.org/E/C.12/2020/1 (last visited on 27 July 2020).

13 See, for example, *ibid*, para 12.

1. Aims and Methods of the Monitoring

The aim of the monitoring was to collect data and place on record how healthcare was provided, from the perspective of relevant human rights obligations, to pregnant women and women in childbirth in healthcare facilities in Slovakia during the initial phase of the COVID-19 pandemic in the country (in particular, during the period between early March 2020 and the end of June 2020). The monitoring was thus also aimed at determining whether the human rights of women in childbirth had been violated in healthcare facilities in Slovakia during this period and, where applicable, how. Another aim was to investigate the specificities of any violations that could be ascribed to the measures (not) adopted during the pandemic.

CDA and Women's Circles carried out fact-finding research between 6 March 2020 and 30 June 2020, using various methods to gather and analyse data from numerous sources in order to get the most complex picture possible. In particular, CDA and Women's Circles:

- conducted an internet survey on women's experiences with pregnancy- and childbirth-related healthcare during the pandemic;
- compiled reports and records of individual women who were seeking advice or counselling from Women's Circles (by phone or the internet), or from CDA in some cases, or who wrote comments concerning their pregnancy- and childbirth-related healthcare experience during the pandemic under Women's Circles' Facebook posts;
- monitored (on an *ad hoc* basis) the information provided by (public and private) healthcare facilities/owners of private healthcare facilities, and by their representatives, in relation to the provision of pregnancy and childbirth healthcare during the pandemic, mainly through hospital and other websites and through social networks, but also through printed and electronic media;
- kept records of the official communication of the Ministry of Health of the Slovak Republic with CDA and Women's Circles regarding the provision of pregnancy and childbirth care during the COVID-19 pandemic;[14]
- monitored the official website of the government of the Slovak Republic, of the Ministry of Health of the Slovak Republic, and of the Public Health Authority of the Slovak Republic, in particular the sections related to COVID-19;[15]

14 A letter from the Ministry of Health of the Slovak Republic sent to CDA and Women's Circles on 3 April 2020 (on file with the authors), as a response to their *Appeal for compliance with healthcare standards in childbirth during the COVID-19 pandemic* (available also at: http://odz.sk/en/appeal-for-compliance, last visited on 27 July 2020); a letter of the Ministry of Health of the Slovak Republic of 6 April 2020, addressed to Women's Circles (on file with the authors). The letter is also available at https://zenskekruhy.sk/wp-content/uploads/2020/04/List-%C3%BAradn%C3%BD-Odbor-%C5%BDENSK%C3%89-KRUHY-2.pdf (last visited on 27 July 2020).

15 See https://korona.gov.sk, https://www.health.gov.sk/Clanok?Hlavna-sprava-COVID-19, and http://www.

– monitored the media in cases where the media published articles and broadcasted news or stories relating to the provision of pregnancy- and childbirth-related services during the pandemic.

The internet survey on women's experiences with pregnancy- and childbirth-related healthcare represents the main source that informed this report. Therefore, the findings presented in this report are to a large extent based on first-hand testimonies of women about their lived experience.

The survey was carried out through an online questionnaire designed jointly by CDA and Women's Circles for women to report on their experiences with healthcare related to their pregnancy and childbirth during the COVID-19 pandemic.

The target group of the online questionnaire was comprised both of women who had given birth in Slovakia during the initial phase of the COVID-19 pandemic (from the beginning of March 2020 until 22 June 2020, when the collecting of the questionnaires for the purpose of this report was closed) and of women who had been pregnant during this period, regardless of whether they had given birth by the time of the submission of the questionnaire or not.

The online questionnaire was designed and partly processed with the use of Google Forms (freely accessible version). The questionnaire contained both closed-ended, or semi-closed-ended questions, and open-ended questions.

The questionnaire was placed on the website www.spolusmevbezpeci.sk/covid-19[16] (the website is administered by Women's Circles, with this particular section having been designed jointly by Women's Circles and CDA) and also on the Facebook profile of Women's Circles. Women's Circles also sent out a link to the questionnaire via their newsletter. The respondents were thus, with a high degree of probability, mainly women associated with the grassroots movement of Women's Circles, even though any woman who was meeting the target group criteria could choose to participate in the questionnaire.

This report, in its parts relating to the outcomes of the internet survey, covers 184 respondents who gave birth or were pregnant between the beginning of March 2020 and 22 June 2020 and who submitted the questionnaire between 25 May 2020 and 22 June 2020 (the period in which the data from the internet survey were collected).

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uvzsr.sk/index.php?option=com_content&view=category&layout=blog&id=250&Itemid=153 (last visited on 27 July 2020).

16 As a part of the international campaign *Safer Together: Respectful Maternity Care in COVID-19*. The Slovak version https://spolusmevbezpeci.sk/covid-19 is based on a toolkit provided by the author of the international version, the White Ribbon Alliance. The goal of the campaign is to uphold rights, promote innovative approaches to maternity care, and save lives during the COVID-19 pandemic worldwide.

Out of the 184 respondents who took part in the survey, 110 had given birth and 74 were still pregnant at the time of submitting the questionnaire.

The data from the internet survey were processed through a qualitative analysis of data (in the case of the open-ended questions), and through the Google Form's statistical analysis of data (in the case of the closed-ended questions).

The approach used in this internet survey was a heuristic one to keep the questionnaire open to the wide variety of women's experiences. Further, it incorporated the 'no strain' principle, i.e., women were free to decide whether or not to respond to matters of a highly personal or intimate nature. Therefore, women could decide not to answer any of the internet survey questions while still remaining as participants. For this reason, the overall numbers of responses to each individual internet survey question vary. The varying amounts of responses are also caused by the fact that respondents who had not given birth by the time of submitting the questionnaire did not answer sections related to childbirth and to the stay in post-natal units.

The data submitted by the respondents of the internet survey as well as the outcomes are fully anonymous. Some women, however, left us their contact information and agreed to provide additional information if needed (again under full anonymity guarantees).

Some of the outcomes of the internet survey that are contained further in this report are illustrated by graphs and by the actual statements of some of the survey respondents.

2. Outcomes of the Monitoring

Generally speaking, the monitoring confirmed violations that are consistent with those that had been documented in the previous research of CDA and Women's Circles regarding the human rights of women in the provision of childbirth services by healthcare facilities in Slovakia. At the same time, the present monitoring appears to demonstrate that the COVID-19 era and the measures (not) adopted under its duration may be enabling new violations and/or intensification of those that previously existed.

2.1. Prenatal Healthcare Findings, Including Provision of Information Connected to Childbirth

Out of the 183 respondents of the internet survey who responded to the questions on prenatal check-ups, 13 per cent reported that the number of their routine prenatal check-ups (recommended by the healthcare system and covered by health insurance) was reduced with the pandemic. Some women reported that their gynaecologists were not working due to being on sick leave and that it was impossible to find a substitute carer. Some of the planned check-ups were simply cancelled.

> *"I missed one counselling session and two important check-ups because my doctor was on vacation when the quarantine was declared. He hadn't appointed a substitute. I was so upset I wanted to leave – but all other doctors refused to take me in as a new patient."* (respondent JPTTT)

Almost 16 percent of the 183 respondents reported that their planned examinations or tests were cancelled or postponed, or that their frequency was reduced. This concerned not only CTG monitoring that, in Slovakia, normally begins with in the 37th week of pregnancy, but also other procedures, including testing for gestational diabetes, foetal screening, regular check-ups concerning the haematology treatment of one particular pregnant woman, or check-ups of a pregnant woman in her high-risk pregnancy.

> *"Every counselling session was short and quick, held once in four weeks, though I have a high-risk pregnancy and was supposed to go* [to a counselling session] *every two weeks."* (respondent JTTTTT)

> *"My haematology check-ups were cancelled…"* (respondent TT)

Some of the hospitals also published information via their websites regarding the reduction of the healthcare services to be provided to pregnant women during the COVID-19 pandemic. For example, the Martin hospital announced that it would provide prenatal care only to those women with pathological and risk pregnancies, with the exception of CTG monitoring that would also be provided to women with physiological pregnancies, but only from the 40th week of pregnancy onwards. The hospital also added that it

would provide ultrasound examinations only to women with pregnancies with a high suspicion of foetal defects.[17] Similarly, the Banská Bystrica hospital stated that it would not provide prenatal care to women with physiological pregnancies, with the exception of CTG monitoring in such cases where a woman had completed the 40th week of pregnancy but whose gynaecologist was not able to provide it.[18]

Pregnant women participating in the internet survey also reported that they were not allowed to come to their prenatal check-ups with their partners or other companions. At the same time, some women reported that they did not get an appointment for an exact time but had to wait in the waiting room, sometimes for hours, with many other women in order to see a doctor. Women also reported having to wait in long queues in front of hospitals, in order to pass through general anti-epidemic screening (and one woman even reported having to wait in such a queue while experiencing labour pains).

> *"...* [we had to undergo the examination] *without partners and companions, but still there were sometimes up to 20 women in the waiting room. A couple of times I would wait as long as three hours for a check-up at the hospital."* (respondent JTO)

Women who took part in the internet survey also complained about a very acute lack of information that they needed for their preparation for childbirth and that they were expecting to get from the hospitals. Women reported that hospitals cancelled the prenatal courses that they had previously regularly offered and also the opportunity for women to visit the maternity ward, i.e., services that women had used to discuss their labour with the hospital staff in advance. At the same time, there was apparently no or little alternative for these reduced informational opportunities, e.g., by putting the information on the hospitals' websites.

> *"Unfortunately, before I was even able to take the* [antenatal] *course, everything had already been cancelled and restricted. I was offered no substitute or alternative. There was no information on the hospital's website. I was disappointed that I couldn't go and see the maternity ward and familiarise myself with the setting, and ask questions. I took a one-day preparatory course with a doula online."* (respondent TTTP)

In response to receiving the inquiries of women regarding insufficient information on pregnancy and childbirth care during the COVID-19 pandemic provided by individual hospitals, Women's Circles and CDA carried out the *ad hoc* monitoring of websites

17 Information obtained from the website of the Department of Gynaecology and Obstetrics Clinic of Martin University Hospital, https://www.unm.sk/gynekologicko-porodnicka-klinika, on 12 May 2020. A screenshot is on file with the authors.

18 Information obtained from the website of F. D. Roosevelt University General Hospital of Banská Bystrica, https://www.fnspfdr.sk/covid-19-opatrenia-a-odporucania/#porod, on 14 April 2020. A screenshot is on file with the authors.

of hospitals with maternity wards. The aim of the *ad hoc* monitoring was to find out whether hospitals with maternity wards in Slovakia (50 maternity wards altogether) made accessible, via their websites, sufficient information about pregnancy and childbirth care provided in the respective facilities under the COVID-19 pandemic.

The *ad hoc* monitoring showed the following situational findings:[19]

Approximately 40 per cent of the websites of hospitals with maternity wards incorporated information on pregnancy and childbirth care provided under the COVID-19 pandemic in the respective hospitals. However, in most of the cases, the information provided was only partial. There were only two cases (Skalica, Trenčín) where the information provided was relatively sufficient and of good quality.

Approximately half of the websites of hospitals with maternity wards provided information on general measures adopted by each of the hospitals in response to the COVID-19 pandemic, but the websites did not contain any specific information concerning pregnancy and childbirth care provided in the respective facilities during the pandemic.

In the case of four hospitals with maternity wards, their websites contained no COVID-19-related information whatsoever – i.e., neither any general information on healthcare provided in that particular hospital during the pandemic, nor any specific information on pregnancy and childbirth care provided therein under the pandemic.

2.2. Prohibition of a Birth Companion

The possibility of the presence of a birth companion of a woman's choice during labour and delivery is not only a human right but it is also a practice recommended by the WHO, including during the COVID-19 pandemic[20].

On 6 March 2020, the Public Health Authority of the Slovak Republic adopted a general ban on visits in hospitals.[21] Although a birth companion is not a 'visitor', numerous hospital managements interpreted this ban on visitors as also enabling a ban on birth

19 Printscreens of the relevant sections of the hospital websites are on file with Women's Circles and CDA.

20 See WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva : World Health Organization, 2018, p 29, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020), and see also WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

21 Decision of the Public Health Authority of the Slovak Republic No OLP/2405/2020 of 6 March 2020, available at: https://www.ruvzpp.sk/aktuality-a-novinky/uvz-sr-verejna-vyhlaska-vo-veci-nariadenia-opatrenia-na-predchadzanie-vzniku-a-sireniu-prenosneho-ochorenia-covid-19 (last visited on 27 July 2020).

companions, and banned these companions in their respective hospitals.[22] This was happening in spite of the fact that the Ministry of Health of the Slovak Republic had placed on its website a translation of the WHO recommendations of 18 March 2020 on pregnancy, childbirth, and breastfeeding under the COVID-19 pandemic that emphasise having a companion of choice present during delivery as a component of a safe and positive childbirth experience.[23]

One of the causes for the hospitals to ban birth companions so easily and arbitrarily was almost certainly the fact that the Ministry of Health did not publish clear and unambiguous rules on pregnancy and childbirth care during the COVID-19 pandemic that would be in accordance with human rights requirements and recommendations of international health professional bodies. Additionally, the Ministry of Health practically encouraged healthcare providers to violate rights and to act in an arbitrary manner. For example, in a letter addressed to CDA and Women's Circles, the Ministry stated that "*although we understand the need for the presence of a companion during childbirth, in the current situation of the COVID-19 pandemic, it is essential to follow and respect the guidelines and instructions of healthcare workers* [in Slovakia] *and the orders of the Main Public Health Officer* [of the Slovak Republic] *in each particular healthcare setting, for the reason of preserving the health of persons to whom healthcare is provided, and also of the healthcare workers*."[24] In another letter sent to Women's Circles', in response to their request for information regarding, *inter alia*, the possibility for women to have a birth companion during the COVID-19 pandemic, the Ministry explicitly asked women to accept the present situation, without reflecting on the fact that the human rights of women were at stake: *"It is therefore necessary that women realize their own responsibility, as the situation unfortunately does not allow for full provision of all available options, and that they accept certain measures (such as the absence of a birth companion or wearing masks). It is for the safety of all of us."*[25]

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22 For example the hospital in Banská Bystrica (https://www.fnspfdr.sk/covid-19-opatrenia-a-odporucania/#porod, a statement of 14 April 2020, last visited on 1 May 2020), Bratislava University Hospital (https://www.unb.sk/vsetko-o-covid-19, https://www.unb.sk/1781-sk/oznam-pre-buduce-mamicky, a statement of 23 March 2020, last visited on 1 May 2020), the Košice-Šaca hospital (https://www.nemocnicasaca.sk/o-nemocnici/novinky/200507-otec-pro-porode.html, a statement of 7 May 2020 by which the hospital was renewing the possibility of having a birth companion, last visited on 11 May 2020), the hospital in Levice (https://www.nemocnicalevice.sk/index.html, https://www.nemocnicalevice.sk/o-nemocnici/novinky/200402-gynekologia.html, a statement of 2 April 2020, last visited on 1 May 2020), the hospital in Prievidza-Bojnice (http://www.hospital-bojnice.sk/aktuality/oznam-porodnice.html?page_id=8692, a statement of 7 May 2020 by which the hospital was renewing the possibility of having a birth companion, last visited on 16 July 2020), and the hospital in Trnava (http://www.fntt.sk/index.php/o-nemocnici/aktuality/105-aktuality/602-gynekologycko-porodnicka-klinika-informuje-rodicky, a statement of 18 March 2020, last visited on 16 July 2020). All screenshots to the listed links are on file with the authors.

23 See the website of the Ministry of Health of the Slovak Republic at https://www.health.gov.sk/Clanok?Hlavna-sprava-COVID-19 (last visited on 27 July 2020), in connection with WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

24 Letter from the Ministry of Health of the Slovak Republic sent to CDA and Women's Circles on 3 April 2020. On file with the authors.

25 Letter of the Ministry of Health of the Slovak Republic of 6 April 2020, addressed to Women's Circles. The letter

On 11 May 2020, the Public Health Authority of the Slovak Republic issued new recommendations connected to visits and companionship in hospitals and to the treatment of women and newborns in childbirth during the period of the COVID-19 pandemic. The recommendations reiterated the general prohibition of visits in hospitals, but explicitly established an exception for one companion of a woman during labour and post-natal care, provided there is prior approval by the healthcare facility, and the companion uses protective equipment, follows hygienic end epidemiologic rules, and enters the hospital through the general screening process for identifying persons with COVID-19 symptoms.[26]

Although the conditions for women in childbirth with regard to their right to be accompanied by a person of their choosing were somewhat less unfavourable with the adoption of these recommendations, they were still problematic because the final decision as to whether a birthing woman could have a companion or not was left to the hospitals. During the fact-finding, we came across cases where hospitals retained the bans on birth companions despite these recommendations,[27] and there were also examples where women could only be accompanied by their (male) partners and not by any other persons of their choice, e.g., doulas[28]. In any case, the Public Health Authority document was issued as a mere *recommendation* and not a directive, which could further encourage hospitals toward arbitrary practices. We also assume that the requirement for the companion to enter the hospital through the general screening process could separate the woman from her companion for an extended length of time and even prevent efficient companionship.

Our internet survey showed that in a majority of the cases (61 out of 87 women who had given birth and who responded), a childbirth companion was prohibited altogether. Further, according to the responses to a multi-item question, in 8 (out of 82) cases, only the father of the child was allowed to serve as companion; in 9 cases (out of 86), only

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is also available at https://zenskekruhy.sk/wp-content/uploads/2020/04/List-%C3%BAradn%C3%BD-Odbor-%C5%BDENSK%C3%89-KRUHY-2.pdf (last visited on 27 July 2020).

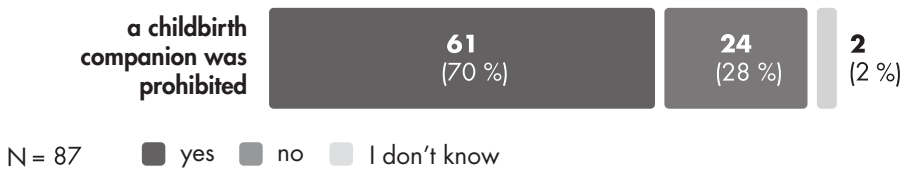
26 ÚRAD VEREJNÉHO ZDRAVOTNÍCTVA SLOVENSKEJ REPUBLIKY: *Odporúčania pre sprievod, návštevu pacientov a návštevu kňaza pre vykonávanie duchovných služieb pacientom počas epidemického výskytu ochorenia COVID-19 v zdravotníckych zariadeniach* [Recommendations for Companions, Visitors of Patients and for the Visits by Priests Providing Clerical Services to Patients During the Epidemic Occurrence of the COVID-19 Disease in Healthcare Facilities], OE/3976/92429/2020. Úrad verejného zdravotníctva Slovenskej republiky, 11 May 2020, available at: https://www.ruvztv.sk/wp-content/pdf_downloads/covid_19/odporucania_hlavneho_hygienika_sr_navsteva_sprievod_pacienta_v_zz.pdf (last visited on 27 July 2020).

27 For example the hospital in Čadca. A woman who wanted to give birth at the Kysuce Region Hospital and Polyclinic of Čadca but was denied a birth companion wrote to Women's Circles via their Facebook account (the communication is on file with Women's Circles).

28 An example of this case was a hospital, which, three days after the Public Health Authority issued its recommendations, insisted that the companion must be the (male) partner of the woman concerned. This information was obtained from a CDA's client who was planning to give birth in this hospital, accompanied by her doula, and CDA was assisting her with drafting an official request to the hospital.

the husband/partner of the woman was allowed; and in only 16 (out of 88) cases, the (one) companion could be any person of a woman's choice. In merely 3 (out of 87) cases, a woman could be accompanied by two persons of her choice.

Graph No. 1 **Did the hospital provide you with the possibility to have a childbirth companion, and if so, who was eligible as a companion?**



Women who took part in the internet survey perceived very negatively the inability to have a companion of their choice present. They felt alone and abandoned, lacked the support and help of a close person in the process of their labour as such, lacked the possibility of sharing such a deep, life-changing personal and emotional moment with a close person, but also lacked a buffer, intermediary and a negotiator with the hospital staff, which is often one of the roles a companion in Slovak hospitals has in protecting and pursuing the rights of women in childbirth. Many women felt that the inappropriate care they received from the hospital staff, including the disinterest and ignorance they were subject to, was (partially) rooted in the forced absence of birth companions.

> *"They sent my husband home (and not very politely) as soon as he'd dropped me at an exam room. I was very upset he couldn't be with me during the birth. It is very demanding to go through it alone. I was really annoyed that there was no possibility to have him tested* [for COVID-19] *or wrap him in some kind of a spacesuit, they showed no effort to arrange it so that he could stay there without being a risk to the staff. My husband and I were both healthy."* (respondent JTTST)

> *"They threw my husband out, saying he could not stay during labour – visits were prohibited, of course. It made me really uncertain, and the whole time I spent in the maternity ward was a very bad experience."* (respondent JT)

> *"I'm really sad I couldn't have the doula and my partner with me during labour. I was alone there, feeling quite lonely and unable to assert my wishes. The staff didn't treat me the way I believe a woman giving birth deserves to be treated, they didn't give me enough information about all interventions, there were moments when they left me alone in pain, and I even screamed for help. I just simply wanted somebody to hold my hand, but nobody came. They only came when they wanted to. If not for the pandemic, I wouldn't have been alone there and I would've felt safer."* (respondent OT)

> *"I spent seven days in the hospital; my husband just dropped me off alone in front of the hospital and came to pick me up a week later. I was stressed out and alone the whole time."* (respondent JTO)

Our previous research had shown that in Slovak hospitals, a companion often fulfils some of the hospital staff's roles or substitutes them to some extent. For example, a companion is often the only person to support a labouring woman in going through her contractions during the first stage of labour. Our recent internet survey confirmed, in the case of some components of childbirth care, the tendency for hospital staffs to rely on women's companions. At the same time, the survey revealed that the hospitals and their personnel did not always reflect on the lack of complexity and continuity of care provided in maternity wards, and did not always adopt compensatory measures to balance the missing components of care caused by the companion bans.

Women described cases when they were left alone for the entire first stages of their labours, without any assistance by the hospital staff (one of the respondents described being left alone in a shower, with a strong urge to push developing soon after). Another woman described a case when the staff did not help her climb onto the birthing table, and some women reported that they were not allowed skin-to-skin contact with their babies directly after delivery, with the justification that a companion who is normally helping with such a contact is not present (due to the ban).

Women also described cases of arriving to maternity units in the midst of labour pains and finding no one to help them with their belongings or to support them physically. There was even a case of a woman who, after having had a caesarean section, was not assisted by any member of the staff with her baby and her luggage when leaving the hospital while her husband was forced to wait outside.

> *"... ALONE, without help, I crawled up onto the birthing table, already in contractions."* (respondent JTTST)

> *"*[In the hospital where I gave birth] *bonding after birth is only allowed in the presence of a companion, and since companions were banned, there was no bonding."* (respondent TTO)

> *"I couldn't have a companion with me during the birth; when I was discharged after the birth, my partner could not even help me with the baby and bags to leave the hospital. After a C-section, I hauled the baby and my stuff through the hospital alone, my husband could only wait for me at the entrance."* (respondent JTTS)

The ban on birth companions also led to a case where a woman from the internet survey travelled long distance (more than 150 km) to give birth in a hospital where a birth companion was allowed. In another case reported in the internet survey, a respondent

decided to give birth at home in spite of the fact that the State does not provide any healthcare in cases of homebirths.

> *"Before we conceived, my husband and I had discussed the fact that he wanted to be at the childbirth, and it was my strong wish, too... We'd decided on a private facility. But in March* [2020] *they banned companions from even entering the building...* [A]*s a result, in order for my husband to be present at our son's birth, we went to a state maternity hospital 156 km away."* (respondent JJST)

Women also noted in the internet survey that they experienced unkind treatment if they insisted on having a birth companion – or that staff treatment of their birth companion, if one was present (e.g., at the stage of admitting the woman concerned to the hospital), was unkind.

Women participating in the internet survey also reported that if a hospital had a ban on birth companions, the ban was asserted very strictly. For example, as also stated above, a particular woman was not allowed to be walked to and from the maternity ward, or, in another case, a partner could not bring clean face masks to a woman after childbirth to have them exchanged. There was even a case of a woman and her partner who both presented with negative COVID-19 tests to the maternity ward staff, yet the partner was not allowed to accompany the labouring woman. At the same time, however, women perceived the ban as unequally applied (there was a case where, at a hospital admission, one woman could be accompanied by her partner and another could not).

Women who participated in the internet survey also complained that despite the ban on companions, there were many strangers moving around the obstetric department (one case), unjustifiably high numbers of staff attending individual women during their childbirths, and insufficient hygienic and epidemiological measures (see further chapter 2.7) being applied. Given all this, the women concerned did not perceive the bans on companions as legitimate and justified.

> *"*[There was a] [c]*omplete ban* [on companions, even] *despite the fact that my husband had been in a voluntary quarantine a month prior to the birth and had a protective suit at his disposal."* (respondent TJ)

> *"I expected they would allow my partner to the admission office at least because I had met another woman at a counselling session who had come to the admission office with her husband in such a way."* (respondent OT)

A lack of justification and proportionality, and an overall illegitimacy of the ban on birth companions can also be inferred from other fact-finding sources used in the monitoring. For example, the monitoring of the hospital websites revealed a case where a hospital justified the ban by its inability to provide sufficient anti-epidemic measures while at the same time preserving privacy for the women concerned (the hospital used the argument that even in cases of uncomplicated delivery, five members of the hospital staff are

generally present in a 20-square-metre delivery room, so meaningful distancing could not be maintained; and also the argument that after delivery, women and their newborns were to share rooms with other women and their newborns).[29] Paradoxically, the same hospital publicly called upon the partners of pregnant and birthing women (whom they perceived as a potential health threat) to donate blood to the hospital.[30]

In the few cases reported in the internet survey where a companion was allowed, the conditions were very strict and sometimes even completely inadequate. For example, one hospital maintained the rule that once a single companion was already present in the obstetric unit, no other woman could have one. In another case, a companion could not leave the room where the labour was taking place – otherwise they would not be allowed to return.

> *"Once* [a companion] *left the room, they couldn't come back.* [My partner] *had to leave after the birth, he couldn't walk me to the hospital room. Visits were prohibited, and yet many strangers were walking freely up and down the ward anyway. Some fathers could even enter the rooms, bring things, too. It was not very objective and impartial regarding who could or could not bring things or come for a 'visit'."* (respondent JDT)

2.3. Lack of Informed Consent with Provided Healthcare

Our previous research reveals a very high number of cases of childbirth care that are not based on the informed consent of the women concerned, with many cases of interventions carried out even without the knowledge of the women in question, and/or even against their explicit refusal. The childbirth care system's approach to informed consent is generally a very formalistic one, heavily relying solely on informed consent forms signed by women in labour upon their arrival in the hospital or at latter stages of their labours.[31]

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29 This explanation was contained on the website of the Koch Sanatorium in Bratislava at http://www.sanatoriumkoch.sk/?nazov=novinky&j=1&news_id=106 (a statement of 25 April 2020, visited on 1 May 2020; a screenshot is on file with the authors).

30 The Koch Sanatorium in Bratislava and its call addressed to future fathers to donate blood to the hospital, both via its website (see http://www.sanatoriumkoch.sk/?nazov=novinky&j=1&news_id=109, a statement of 27 April 2020, last visited on 27 July 2020) and via a TV advertisement (the advertisement was broadcasted repeatedly by the TA3 TV).

31 See for example DEBRECÉNIOVÁ, J. (ed.); BABIAKOVÁ, K. – DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – KRIŠKOVÁ, Z. – SEKULOVÁ, M. – ŠUMŠALOVÁ, S.: *Ženy – Matky – Telá: Ľudské práva žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku.* [Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, 2015, pp 85 – 93 and pp 189 – 191. Also available at: http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf (last visited on 27 July 2020). See also DEBRECÉNIOVÁ, J. (ed.); DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – HREŠANOVÁ, E. – KRIŠKOVÁ, Z. – LAFFÉRSOVÁ, Z. – SEKULOVÁ, M.: *Ženy – Matky – Telá II: Systémové aspekty porušovania ľudských práv žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku.* [Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, Ženské kruhy, 2016, pp 106 – 117, pp 124 – 132, and pp 247 – 251. Also available at: http://odz.sk/wp-content/uploads/ZMT2_systemove_apekty_v6_w.pdf (last visited on 27 July 2020).

Our internet survey carried out during the COVID-19 pandemic confirms all of these earlier findings, and the pandemic seems to have even perpetuated the systemic pitfalls in relation to the duty to provide healthcare solely on the basis of informed consent.

> *"They only asked [me] to sign the papers."* (respondent JST)

> *"'Sign these forms, please,' and there was no one asking about anything else, they just went on carrying out their routine."* (respondent JOD)

> *"I don't remember them having asked for my consent to anything."* (respondent JSTTT)

> *"I was surprised that a nurse at the admission office asked me about ten times if I had told the truth in the questionnaire (whether I'm a COVID suspect) and that it wasn't enough to fill in that questionnaire while already being in labour pains. My husband had brought me in and, since he's a foreigner, the nurse decided that we were a definite risk – which she also directly confirmed with her questions. I had to repeat two or three times that during the whole of my pregnancy (approximately a year), WE HADN'T BEEN ANYWHERE AND NOBODY HAD VISITED US AND THAT I'M TELLING THE TRUTH! That was quite awkward."* (respondent JOJ)

'Informed consent' forms remain the major way of 'informing' women about labour and about the potential interventions to be undertaken – 76 out of 86 of the internet survey respondents who had given birth reported explicitly that they were asked to sign the form upon their arrival in the hospital. Numerous women reported that they were not given any additional explanation, that they were filling in the informed consent forms during contractions, or that they were even urged to sign the forms without being given the opportunity to acquaint themselves with the content.

> *"They were filling in the questionnaire* [with me] *while I was having contractions. I didn't consent to getting a cannula, but they told me that I HAD TO, and since I had no companion with me and I already felt the need to push, I complied."* (respondent DN)

Only 42 out of 83 of the internet survey respondents reporting about their childbirth experience stated that the staff asked for their consent in the case of each intervention the staff intended to undertake, and 15 out of 59 women stated that they were never asked for any kind of consent in the case of any intervention that was to be carried out. Women often reported that interventions were simply carried out without any prior information being provided about the interventions by the staff (and some women learned about the fact that a particular intervention had been done to them only after reading medical documentation; carrying out interventions without the knowledge of the woman concerned implies an automatic absence of her informed consent); that women had to actively ask about what was happening; or that women were simply notified about what was to happen/had just happened. There were also cases where interventions were

carried out against women's express refusal (mainly interventions like the application of a cannula or of oxytocin, or episiotomy), and cases where women were intimidated or manipulated into these interventions (oxytocin, episiotomy, the Kristeller manoeuvre).

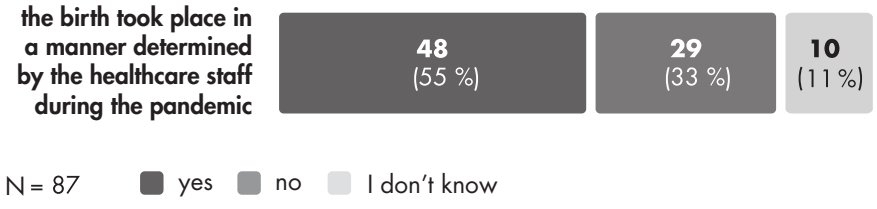
> *"They asked me if they could give me this or that. With other interventions, they just more or less told me that they were going to do it."* (respondent TTTP)

> *"I told the doctor that I didn't want any artificial hormones or drugs or an episiotomy and that I wanted to leave everything to nature. They took me straight to the delivery room. First, they tried to persuade me that they would give me a glucose IV infusion. I said I didn't want it. But I was thirsty and because they'd refused to give me water I eventually agreed to the infusion. The doctor said the episiotomy would be necessary. I replied that it would not have to be if I could just deliver while laying on my side. The midwife told me it was IMPOSSIBLE to deliver like that… and they performed the episiotomy. I read in my discharge report they had given me oxytocin as well. Allegedly for the placenta. Even though they'd known I didn't want it. When I went to ask the doctor about it, he said I had delivered without oxytocin and they had only administered it because of the placenta, and that I should keep calm… I'm angry that they didn't tell me beforehand and that I only learnt about it when I read the discharge report. The doctor did various things when I was in labour and I always had to ask what he was going to do or what he had done. He didn't say anything without being asked. Except for the episiotomy."* (respondent OT)

The lack of respect for informed consent and the women's autonomous will can also be seen in the outcomes on the ways in which the staff did (not) take into account the women's wishes and had (not) even been asking about them. In the internet survey, 48 out of 86 women who had given birth reported that the course of the labour and delivery was determined by the hospital staff, and only 49 out of 82 women reported that their most imperative wishes were fulfilled.

Graph No. 2 **How did the childbirth proceed in terms of your (oral or written) wishes (a birth plan)?**

Answer to the statement:

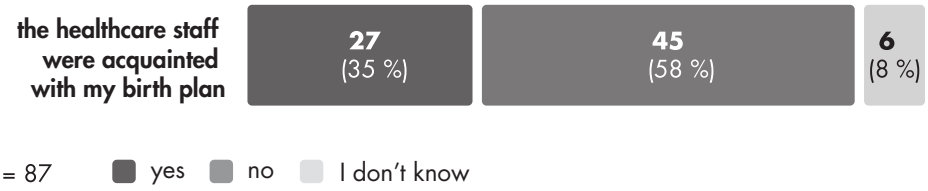


The data obtained from the internet survey, however, do not only show that hospital personnel are not willing to fulfil women's wishes, but they also show that hospital personnel are not even interested in them. Out of 78 women who had given birth, only

27 reported that the healthcare staff became acquainted with the women's birth plans, and 51 reported the opposite, or were not sure. A number of women also reported that no one had asked about their wishes – for example, there were cases where a woman did not have a written birth plan but had ideas about their childbirth and thought/expected that the hospital staff would be asking about them, which did not happen. Some women also reported that the hospital personnel did not even stick to the procedures that the maternity ward unit had declared to follow on its website.

Graph No. 3 **How did the childbirth proceed in terms of your (oral or written) wishes (a birth plan)?**

Answer to the statement:



According to the women participating in the internet survey, the wishes and procedures the hospital staff were disrespectful of the most include mainly: the women's wish not to be given oxytocin; their refusal of episiotomy or the Kristeller manoeuvre; their wish to choose the birthing position; their wish for skin-to-skin contact directly following delivery; and also the wish not to be separated later from their baby.

> *"Upon admission, they just gave me an informed consent* [form] *to sign, that was it. They didn't even ask me about doing an episiotomy, which I didn't want to undergo, but they performed it anyway without my knowledge."* (respondent JJT)

> *"I thought the Kristeller manoeuvre was banned. That's why I didn't write in my birth plan that I didn't wish to have it. But during delivery, they told me that they had to help it a little and the nurse pushed on my belly even though I felt it was going well and I had enough strength to push."* (respondent TTTP)

> *"I asked for bonding, they promised: of course. Then they took him away as if we hadn't agreed on anything at all. When I asked them to give him back to me, they said, we would bring him right away. He came back all dressed 15 minutes later."* (respondent JT)

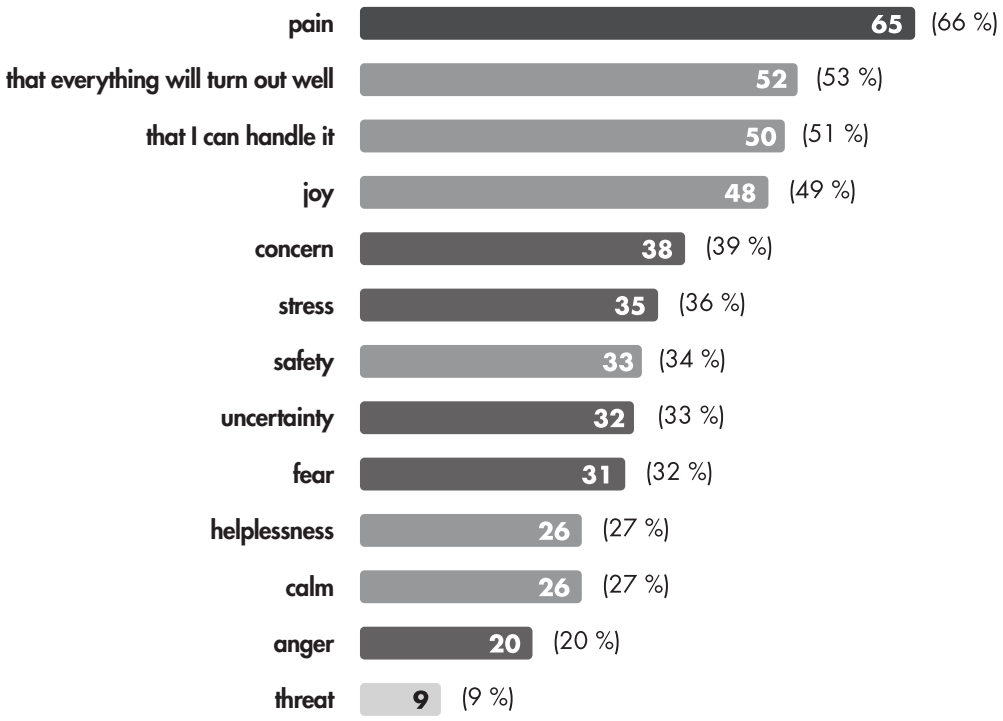
2.4. Feelings of Women During Labour and Delivery and the Dominance of Pain

When asked about their feelings during labour and delivery (a multiple-choice question, with 98 women responding), only one third of the internet survey respondents (34 per cent) stated that they felt safe, and only about half of them felt they could handle their childbirth (51 per cent), thought that everything would turn out well (53 per cent), or felt joyful (49 per cent). On the contrary, about one third of the women felt concern (39 per cent), stress (36 per cent), uncertainty (33 per cent) and fear (32 per cent), and more than one quarter felt helpless (27 per cent). A significant amount of the women felt angry (20 per cent), and a non-negligible number of them felt threatened (9 per cent).

The dominant feeling, though, was pain: it was reported by two thirds (66 per cent) of the 98 women who had responded in the internet survey.

Graph No. 4 **How did you feel and what did you experience during the childbirth?**

Multiple choice question (sum over 100 %)



N = 98

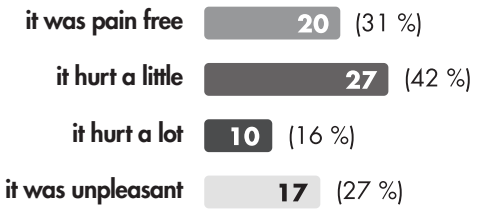
The fact-finding data are at the same time very indicative of insufficient efforts of hospitals and their staffs to relieve the pain of women in labour, delivery, or just following delivery, despite the WHO's emphasis on the need for appropriate pain relief strategies as a part of a safe and positive childbirth experience also during the COVID-19 pandemic, and the Slovak government's references to the WHO recommendations relating to pregnancy

and childbirth during the pandemic[32]. For example, some women who took part in the internet survey reported that no pain relief had been offered to them during labour except for the epidural analgesia. Women also reported cases when they were abandoned and left alone with their pain, including in the shower. Some women also described a lack of staff interest in the women's pain and pain relief after delivery. For example, one woman wrote in her online questionnaire that after a caesarean section, the staff forgot to give her pain relief and she was only given ordinary painkillers (and after 10 hours, when already suffering a high fever, she was given opiates).

The data obtained from the internet survey regarding pain are also very disturbing when it comes to the suturing of birth injuries, an intervention that two thirds of women (66 per cent out of 97 respondents) had experienced. Under a third of women who were sutured (31 per cent out of 64 responses) could state that the suturing was pain free, whereas almost 60 per cent reported that it was either slightly (42 per cent) or very (16 per cent) painful. Overall, for more than one quarter of respondents (27 per cent), suturing was unpleasant.

Graph No. 5 **If you gave birth vaginally and were sutured, what was your experience during the suturing procedure?**

Multiple choice question (sum over 100 %)



N = 64

Some of the women who experienced suturing also reported in their questionnaires that it had been carried out without pain relief, or with insufficient pain relief. There were also reports of (male) doctors joking while suturing.

Another disturbing outcome that has resulted from the internet survey was the high number of women who experienced other painful procedures during their labour or delivery. For example, 56 women (out of 94) experienced labour induction, 35 (out

32 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020), and the website of the Ministry of Health of the Slovak Republic at https://www.health.gov.sk/Clanok?Hlavna-sprava-COVID-19 (last visited on 27 July 2020). See also the response of the Ministry to an official request for information by Women's Circles – Letter of the Ministry of Health of the Slovak Republic of 6 April 2020 and its Annex 1 where the Ministry refers to, *inter alia*, the WHO COVID-19 guidelines, both available also at https://zenskekruhy.sk/vyjadrenie-mz-sr-k-porodnej-starostlivosti-pocas-epidemie (last visited on 27 July 2020).

of 95) experienced episiotomy, and 31 women (out of 95) underwent the Kristeller manoeuvre (the manoeuvre is not only not recommended by the WHO but is also prohibited in Slovak hospitals[33]).

Although the internet survey has not revealed cases of denial of the epidural analgesia to labouring women during the pandemic, other fact-finding methods used in our monitoring confirmed that there were cases when hospitals refused to provide the epidural to women in labour. For example, a head of an obstetric clinic explained in a TV interview that anaesthesiologists working for the hospital in question had said they would not provide an epidural if a partner of the woman in labour was present.[34] Two clients of Women's Circles also informed the organisation that epidurals were not available in the hospitals they were considering for their childbirth during the COVID-19 pandemic. In one case, the hospital did not provide the reason,[35] and in the other, the hospital informed the woman in writing that *"it is not possible to provide the epidural, due to the effort to minimise the contact of patients with other healthcare personnel and thus to prevent a potential spread of the* [COVID-19] *infection"*[36].

2.5. Lack of Skin-to-Skin Contact Directly Following Delivery and Separation of Women from Their Newborns in Hospitals

The WHO recommends that newborns without complications should be kept in skin-to-skin contact with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding, and that all newborns, including low-birth-weight babies who are able to breastfeed, should be put to the breast as soon as possible after birth

33 See WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva : World Health Organization, 2018, p 155, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020). See also HOLOMÁŇ, K. a kol.: *Vybrané kapitoly z pôrodníctva*. [Selected Chapters from the Field of Obstetrics]. Bratislava : Univerzita Komenského Bratislava, 2014, p 252, and ZÁHUMENSKÝ, J. – KORBEĽ, M. – KAŠČÁK, P.: Ruptúry hrádze 3. a 4. stupňa (odporúčané postupy). [Third and Fourth Degree Ruptures of the Perineum (Recommended Techniques)]. In: *Gynekológia pre prax*, 2015, p 197. And see DEBRECÉNIOVÁ, J. (ed.); DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – HREŠANOVÁ, E. – KRIŠKOVÁ, Z. – LAFFÉRSOVÁ, Z. – SEKULOVÁ, M.: *Ženy – Matky – Telá II: Systémové aspekty porušovania ľudských práv žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku*. [Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, Ženské kruhy, 2016, p 172, also available at: http://odz.sk/wp-content/uploads/ZMT2_systemove_apekty_v6_w.pdf (last visited on 27 July 2020).

34 A TV interview by the daily SME of 13 April 2020 with doc. MUDr. Jozef Záhumenský, PhD., the head of the 2nd Clinic of Gynaecology and Obstetrics at the University Bratislava Hospital in Ružinov, available at: https://video.sme.sk/c/22382276/rozhovory-zkh-zahumensky-a-porody-pocas-pandemie-video.html (last visited on 27 July 2020), at 05:50 – 06:00 minutes of the record.

35 The client wrote to Women's Circles via the organisation's Facebook account (the communication is on file with Women's Circles).

36 A screenshot of communication between a woman who approached Women's Circles and an obstetric unit of a hospital in Central Slovakia, on file with Women's Circles.

when they are clinically stable and the mother and the baby are ready. The WHO also recommends that the mother and baby should not be separated and should stay in the same room for 24 hours a day.[37]

For the period of the COVID-19 pandemic, the WHO has referred to these recommendations and emphasises their applicability also to the treatment of new mothers with confirmed or suspected COVID-19 infections. In particular, the WHO reiterates that close contact and early, exclusive breastfeeding helps a baby to thrive, and therefore women with COVID-19 or its symptoms should be supported in breastfeeding safely, with good respiratory hygiene, hold their newborns skin-to-skin, and share rooms with their babies, while washing hands before and after touching them and while keeping all surfaces clean.[38]

For both mothers and newborns, being in close contact is, apart from being a matter of health and wellbeing, also a matter of the right to privacy and to the protection of family life, and equally a matter of the right not to be subject to torture and cruel, inhuman, and degrading treatment.

In the internet survey, only about half (58 per cent) of the 97 women who responded to the question whether they had had skin-to-skin contact right after delivery, with a naked baby put on their naked breast and with this contact lasting for at least one hour, answered in the affirmative. The remainder responded either negatively (38 per cent), or that the question did not concern them (4 per cent).

> *"There was no* [skin-to-skin contact], *allegedly for personnel reasons."* (respondent JJD)

> *"I was not allowed any bonding because I had no companion with me (as they were not allowed). They put the naked baby on me right after I'd pushed her out, but just for a minute. Then they carried her away, examined her, dressed her and brought her back for another minute … and then took her away again immediately."* (respondent JTTST)

For many women from the internet survey who experienced skin-to-skin contact, this contact was not automatically provided but had to be sharply demanded. In some cases, the contact was not immediate (the staff took the newborn away to clean, check, measure, weigh, etc., and they often brought the baby back dressed with instructions not to undress it), or it lasted for a very short time only. Many women also reported that they were forced to wear masks while meeting their newborns right after delivery.

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37 See WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva : World Health Organization, 2018, pp 163 – 164, and the further references contained therein, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020).

38 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

> *"They brought the baby to me already dressed. I had asked for bonding and they'd promised."* (respondent JT)

> *"I had the skin-to-skin contact even after a C-section. I'd told the doctor in advance that it was my wish. He complied with it, but the contact only lasted for about five minutes."* (respondent JSN)

> *"Everything happened with a face mask on; they let me bond with her, but just for some 20 minutes max."* (respondent JJT)

The responses of women in the internet survey indicated unclear, often unsaid, and probably also fabricated reasons on the side of the health personnel for not enabling the skin-to-skin contact. Women's testimonies included information about the unwillingness of staff and their arbitrary exercise of power, staff arguments about a lack of health personnel or of space, and about the cold environs of the theatre[39].

The internet survey showed that one of the excuses by the staff for depriving women and their newborns of their right to have skin-to-skin contact was the argument that birth companions, who usually assist women and babies with this contact in Slovak hospitals, were prohibited. Therefore, in cases where a companion was banned, there was seemingly no one to assist the woman with the skin-to-skin contact. Apart from the fact that the practice of denying women and their newborns skin-to-skin contact and the explanation for its use are cruel and lacking in basic logic[40], both the denial of this basic right and the reason behind it also demonstrate the personnel's misunderstanding of their basic roles – to assist women and newborns in exercising their rights, and to support their health and wellbeing.

In Slovakia, the absence of skin-to-skin contact is very frequent in the case of caesarean sections, and our internet survey confirms this widespread malpractice. Only 4 out of 27 women from the survey who had given birth via a caesarean section confirmed that they had experienced skin-to-skin contact. The reasons for this harmful practice need further and in-depth exploration, but our internet survey indicates that apart from the general reasons for denying women the right to skin-to-skin contact that are mentioned above, this harmful practice seems to be so normalised and generally applied that not only had some of the women participating in the survey not had the information that the skin-to-skin contact after caesarean section was possible and recommended, but some of them

39 This argument is absurd not only from the point of view of the hospital staff disclosing that women are made to give birth in premises that are inappropriate and uncomfortable for them, but also because this explanation is in direct conflict with scientific knowledge on the functions of early skin-to-skin contact, which include the prevention of hypothermia. See WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva : World Health Organization, 2018, p 163, and the further references contained therein, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020).

40 It is the staff's role and responsibility to provide assistance to women and newborns, and hospitals cannot justify a denial of one right (the right to skin-to-skin contact) by a denial of another (the right to have a companion).

had actually been told by the hospital staff that skin-to-skin contact after a caesarean section was not possible.

Only three quarters (76 per cent) out of 91 respondents from the internet survey stated that they had their baby with them during the entirety of their stay in hospital after delivery. Overall, 24 of the respondent women experienced some separation, and 6 did not share a room with their baby at all while staying in the post-natal ward. In some cases, the reasons for the separation were allegedly spatial, but in other cases they remained completely unclear. One of the women, separated from her newborn for two days, reported that she had not been informed truthfully about the state of health of her baby and that the alleged reasons that caused the separation were exaggerated. Some women who delivered via a caesarean section also reported that they did not have their baby with them even 24 hours or longer after delivery.

> *"For 24 hours after the C-section they kept bringing me* [the baby] *to breastfeed. I didn't like this period because I couldn't* [stand up] *after the spinal block… but if my husband had been* [at the birth] *as planned, we could have been together… I'm most sorry about this. Then, when I could stand up already, I didn't give them my little one any more :)."* (respondent JJTTT)

The monitoring that we carried out has also revealed very serious and systemic separation of mothers from their premature babies who were being kept in intensive care. Misinterpreting the general ban on hospital visits of 6 March 2020[41], hospitals did not allow any contacts between babies who were kept in intensive care and their parents. Women's Circles were contacted by various women who, after having been released from hospital care after giving birth to a premature baby, had literally no chance of seeing, holding or breastfeeding their newborns. There was, for example, a very disturbing case of a woman who, after having given birth prematurely to a baby that needed intensive care, was forcibly released from hospital care, in order to vacate hospital beds for potential COVID-19 patients (who were very few at the time). By 3 May 2020, she had not been able to see her baby for six weeks.[42] Despite the cruel and harmful nature of these policies, media were often making celebrative reports of devoted and selfless hospital staff taking pictures and videos of newborn babies in intensive care who could not be with their mothers, due to the ban of 'visits', and sending them to parents.[43]

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41 Decision of the Public Health Authority of the Slovak Republic No OLP/2405/2020 of 6 March 2020, available at: https://www.ruvzpp.sk/aktuality-a-novinky/uvz-sr-verejna-vyhlaska-vo-veci-nariadenia-opatrenia-na-predchadzanie-vzniku-a-sireniu-prenosneho-ochorenia-covid-19 (last visited on 27 July 2020).

42 See https://zenskekruhy.sk/dlhe-tyzdne-bez-dietata (last visited on 27 July 2020). An English version of the testimony is available at https://zenskekruhy.sk/long-weeks-without-my-baby (last visited on 27 July 2020).

43 See, for example, a news report by the TV JOJ of 9 April 2020 called *Koronavírus a pôrody. Lekári posielajú mamičkám predčasniatok videá a fotky* [Coronavirus and Births: Doctors Sending Videos and Photos to Mummies of Preemies], available at: https://www.noviny.sk/koronavirus/524343-koronavirus-a-porody-lekari-posielaju-mamickam-predcasniatok-videa-a-fotky (last visited on 27 July 2020).

The recommendations of the Public Health Authority of the Slovak Republic of 11 May 2020[44], compared to its decision of 6 March 2020[45], already explicitly state that parents of hospitalised newborns should not be seen as visitors by hospitals, and emphasise that parents should, even during the COVID-19 pandemic, have the right to participate in the care of their children. However, at the same time, the recommendations stress that this possibility must be proportionate to the epidemic situation and that spatial arrangements of the premises of the departments for newborns and their possibilities to follow hygienic and epidemiological requirements should be taken into consideration. According to the Public Health Authority, it is up to the departments of newborns to judge whether these requirements can be met and under what conditions parents can be present.[46] Despite the recommendations' stressing that any limitations of the rights of parents to take part in the care for their children should only be adopted in the case of significant risk of COVID-19 spread[47], Women's Circles continued to receive further reports from individual women who had been released from hospitals while their babies were still admitted, and who were not even allowed to see their children.[48]

The internet survey has not documented any experience of women with COVID-19 or its symptoms who gave birth during the period monitored (which is by no means to say that there were no women with COVID-19, or women who developed COVID-19 symptoms, giving birth in Slovakia between March and June 2020). It is, however, worth noting that some hospitals and a company owning several hospitals adopted policies for cases in which a woman would test positive for COVID-19, or would have symptoms. In such cases, the baby would be separated, either until the mother became healthy or until there was proof of a negative test, or for 14 days.[49]

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44 ÚRAD VEREJNÉHO ZDRAVOTNÍCTVA SLOVENSKEJ REPUBLIKY: *Odporúčania pre sprievod, návštevu pacientov a návštevu kňaza pre vykonávanie duchovných služieb pacientom počas epidemického výskytu ochorenia COVID-19 v zdravotníckych zariadeniach* [Recommendations for Companions, Visitors of Patients and for the Visits by Priests Providing Clerical Services to Patients During the Epidemic Occurrence of the COVID-19 Disease in Healthcare Facilities], OE/3976/92429/2020. Úrad verejného zdravotníctva Slovenskej republiky, 11 May 2020, available at: http://www.ruvztv.sk/wp-content/pdf_downloads/covid_19/odporucania_hlavneho_hygienika_sr_navsteva_sprievod_pacienta_v_zz.pdf (last visited on 27 July 2020).

45 Decision of the Public Health Authority of the Slovak Republic No OLP/2405/2020 of 6 March 2020, available at: https://www.ruvzpp.sk/aktuality-a-novinky/uvz-sr-verejna-vyhlaska-vo-veci-nariadenia-opatrenia-na-predchadzanie-vzniku-a-sireniu-prenosneho-ochorenia-covid-19 (last visited on 27 July 2020).

46 ÚRAD VEREJNÉHO ZDRAVOTNÍCTVA SLOVENSKEJ REPUBLIKY: *Odporúčania pre sprievod, návštevu pacientov a návštevu kňaza pre vykonávanie duchovných služieb pacientom počas epidemického výskytu ochorenia COVID-19 v zdravotníckych zariadeniach* [Recommendations for Companions, Visitors of Patients and for the Visits by Priests Providing Clerical Services to Patients During the Epidemic Occurrence of the COVID-19 Disease in Healthcare Facilities], OE/3976/92429/2020, Section 4.1. Úrad verejného zdravotníctva Slovenskej republiky, 11 May 2020, available at: http://www.ruvztv.sk/wp-content/pdf_downloads/covid_19/odporucania_hlavneho_hygienika_sr_navsteva_sprievod_pacienta_v_zz.pdf (last visited on 27 July 2020).

47 *Ibid.*

48 The individual messages of the women concerned are on file with Women's Circles.

49 See, for example, a podcast at the ProCare and Svet zdravia companies' (the latter owning a couple of hospitals with maternity wards in Slovakia) website: *Zdravý podcast #6: Majú bábätká nosiť rúško?* [Healthy Podcast #6: Should Babies Wear Face Masks?] An interview with MUDr. Mária Vasilová, the main expert of the ProCare and Svet zdravia network for the field of neonatology and at the same time the head of the Department of Neonatology at the Humenné hospital, at 10:05 – 12:50 and 13:00 – 14:10 minutes of the record, available

2.6. The Obligation to Wear Face Masks During Labour and Delivery – an Anti-epidemic Requirement Put on Women

On numerous occasions during the period monitored, chief representatives of several maternity wards in Slovakia stated in media that wearing facial protection during labour and delivery was (more or less) compulsory, or highly recommended for women during childbirth. Some of these (male) obstetricians admitted that birthing women may have difficulties wearing it, and therefore some of the hospitals allegedly provided the option to use face shields or take the face masks off.[50] However, even in cases where the rare option to take the mask off did exist, it could not be relied upon automatically. The freedom to remove the mask might also be conditional upon, for example, the fact that the woman in question would not endanger other birthing women or the healthcare staff[51] – which might be difficult in cases when premises are shared between numerous women (which is the case of many maternity wards in Slovakia), or when a woman is assisted by the staff (which is also the reason why women go to hospitals to give birth and why maternity wards as such exist).

The internet survey showed that during labour and delivery, women were required, in a majority of the cases, to cover their nose and mouth (61 per cent out of 97 respondents reported about such a requirement, and the number could probably be even higher, but some women were not reporting on it since they had worn the face masks automatically, without waiting for the personnel's instructions, so they did not know whether masks were

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at: https://www.procare.sk/podcasty (last visited on 27 July 2020); DÓKUŠ, K.: *COVID-19 a gravidita* [COVID-19 and Pregnancy] (COVID-19 guidelines of the Revúca hospital relating to pregnancy and childbirth). Revúca: Nemocnica s poliklinikou, nezisková organizácia, available at: https://nsprevuca.sk/nspra/wp-content/uploads/2020/03/CoV19.pdf (last visited on 27 July 2020); Podcast of the Košice-Šaca hospital: *Interview of 20 March 2020 with MUDr. Erik Dosedla, PhD., MBA, the head of the Gynaecology and Obstetrics Clinic at the Košice-Šaca hospital*, at approximately the 6th minute of the record, available at: https://youtu.be/K6UrG9SH46o (last visited on 27 July 2020); website of the Kežmarok hospital, a statement of 23 April 2020, available at: https://nemocnicakezmarok.agel.sk/o-nemocnici/novinky/200423-simulovany-porod.html (last visited on 27 July 2020).

50 See, for example, interview with MUDr. Peter Kaščák, PhD., the head of the Gynaecology and Obstetrics Clinic at the Trenčín hospital, published in the magazine *Mama a ja* [Mama and Me] in May 2020, p 60; Facebook livestream of Trnava Faculty Hospital of 5 May 2020 with MUDr. Ivan Dečkov, the head of the Gynaecology and Obstetrics Clinic of that hospital, at approximately the 13th minute of the record available at: https://www.facebook.com/watch/live/?v=238091304207666 (last visited on 27 July 2020); video interview of 14 May 2020 with doc. MUDr. Igor Rusňák, PhD., the head of the 1st Gynaecology and Obstetrics Clinic at the Faculty of Medicine of the Slovak Medical University in Bratislava, at approximately 01:30 min. of the record available at: https://youtu.be/JVEW4NQaRrs (last visited on 27 April 2020); TV interview by the daily SME of 13 April 2020 with doc. MUDr. Jozef Záhumenský, PhD., the head of the 2nd Gynaecology and Obstetrics Clinic at the Bratislava University Hospital in Ružinov, at minutes 06:20 – 06:50 of the record available at: https://video.sme.sk/c/22382276/rozhovory-zkh-zahumensky-a-porody-pocas-pandemie-video.html (last visited on 27 July 2020); statements of MUDr. Petrenko, CSc., the deputy head of the 1st Gynaecology and Obstetrics Clinic of the Cyril and Methodius Hospital of Bratislava University Hospital, published in the magazine *Mama a ja* [Mama and Me] in May 2020, p 59.

51 See for example TV interview by the daily SME of 13 April 2020 with doc. MUDr. Jozef Záhumenský, PhD., the head of the 2nd Gynaecology and Obstetrics Clinic at the Bratislava University Hospital in Ružinov, minutes 06:20 – 06:50 of the record, available at: https://video.sme.sk/c/22382276/rozhovory-zkh-zahumensky-a-porody-pocas-pandemie-video.html (last visited on 27 July 2020).

required or not). Out of the women who wore some kind of mouth and nose protection, the vast majority used face masks, and only one woman wore a face shield.

More than one third (36 per cent) of the women reported that they had worn facial protection throughout the entirety of labour and delivery (out of the 73 women in the internet survey who responded to this question).

Many women reported in the internet survey that the face masks were unbearable especially during the pushing stage, as it was in general very uncomfortable, distracting, and made concentration much more difficult, and that it was making deep breathing very arduous or impossible (some of the women who had to wear face masks even reported that they felt they were going to collapse). Some women attempted to remove the masks for the pushing stage and succeeded, but there were also instances when the staff insisted on women wearing the masks also for the pushing stage. The same pattern occurred with regard to women wanting to take the masks off while meeting their baby for the first time during their skin-to-skin contact (some women were allowed to take their masks off or the removal of the mask was tolerated, but in some instances they were asked to put them back on).

> *"The lack of oxygen intake! One midwife kept telling me I should wear it over my nose and mouth."* (respondent JJST)

> *"I thought I would lose my breath and pass out. I was just about to faint."* (respondent TJ)

> *"I wore a face mask; I put one rubber band down from behind my ear during contractions and kept breathing sideways. But later I threw the mask away because I could no longer breathe through it, it was horrible. Somebody asked me once during the labour where my mask was, so I grabbed it and just literally threw it over my mouth – this was good for some five minutes and then I put it away again. Nobody told me anything after that."* (respondent JTJ)

The internet survey also showed that in an absolute majority of cases women were required to bring their own face masks (there was only one instance reported when a woman was given a mask by the hospital staff upon arrival), and the hospital was not exchanging them – neither during labour and delivery, nor during the subsequent stay in the hospital when face masks were still required. There was a case of a woman who, upon being moved to a post-natal ward, asked for a new face mask as hers was dirty with blood, but the staff told her they did not have any for her.

> *"I had to have my own face mask. I wore the same mask during my entire stay in the hospital, they didn't give me a chance to replace it, and anytime I told them that the mask was useless already, that I'd been wearing it for three days in a row, they would tell me I had to wear it anyway, and that I should have gotten another one by myself."* (respondent JJT)

2.7. Anti-epidemic Measures (Not) Carried Out by Hospitals

Although the hospitals were very strict on women regarding anti-epidemic measures, they were less strict on themselves. In some cases, some of the measures or steps undertaken did not have the potential to serve as effective prevention from the spread of the pandemic or as a safe and adequate protection of the women and babies in the hospitals' care from the COVID-19 disease.

During labour and delivery, health personnel were wearing face masks in 92 per cent of cases (98 responses altogether) only, and in the rest of cases they were either wearing them in some cases/situations only (5 per cent), or not at all (2 per cent). Even in cases where the staff wore face masks, some were not wearing them properly – e.g., by wearing them under their nose.

> *"*[A]*ll* [medical staff] *only wore face masks, they had no other protection."* (respondent TJ)

> *"Not all the nurses wore face masks during admission; during the birth, they did."* (respondent DTT)

> *"Not all medical staff wore face masks all the time* [and] *some wore them with their noses sticking out."* (respondent ON)

Apart from the face masks worn by the staff, some women reported they did not notice any other special anti-epidemic measures that would have been carried out by the hospitals in their labour wards. For example, the staff wore their usual hospital clothes; they did not wear protective gloves in a number of cases (and there was even a case of a woman who reported that not only had she been given an injection by a staff member with no protective gloves on their hands, but the staff member administering the injection touched the injection site with bare hands directly afterwards); they did not disinfect the premises or equipment in any additional ways, and few women also reported that the CTG monitor (the end in direct contact with women's skin) was not disinfected after every use (nor was the bed where the women lay during CTG monitoring).

There were 27 women (out of 91 women who responded on this item) reporting that during labour and delivery, they were not placed in a separate room with a door; further, 35 reported that they were compelled to share the labour premises with other women. Additionally, 28 women reported that they were moved between different rooms during labour and delivery, and 55 women reported that they were forced to share toilets with other women in labour.

Women reported strikingly high numbers of staff present during their labour and delivery (the staff members were usually not present continually, but were either changing shifts

or attending to a particular stage or intervention only, or just popping in). It was not unusual to read a report of 10 present staff members, and even more in some cases (especially, but not limited to, cases of caesarean sections). There were cases where the staff just popped in to have a chat with their colleagues, or a case of students of medicine present during suturing. It was quite common for healthcare staff not to have introduced themselves, so women often were unclear as to the identity of those present and felt highly confused regarding who was administering care.

> *"Several nurses, a doctor and anaesthesiologists kept moving around me all the time. I think the number of persons was not limited in any way."* (respondent STO)

> *"At first, a midwife was with me, then a doctor, and, eventually, there were seven to eight people around me, from an anaesthesiologist to the head of the department."* (respondent JJD)

> *"My husband and the doctor were with me while I was giving birth. Later on, during the birth of the placenta, a nurse and another doctor came in. Students came to have a look during suturing."* (respondent TTTP)

The findings described above not only show the persistence of violations of the right to privacy, the lack of respect for women's intimacy, dignity, and autonomy, and the lack of measures that make women in childbirth feel safe, respected, supported, and undisturbed that we have documented previously, but also the lack in ambition of the healthcare facilities to make women feel safe from COVID-19 transmission onto themselves and their babies.

The indication that the lack of this ambition on the part of the healthcare facilities might be systemic can also be seen from the way anti-epidemic and special hygiene measures were (not) applied in the post-natal units. The majority of the respondents (73 cases in total) shared their rooms in the post-natal units with one (49 respondents), two (21 respondents), or three other women (3 respondents). Only 36 respondents stayed in single rooms, and in most of the reported cases (75 per cent), they were asked to pay for these rooms. Women also reported they were forced to share toilets and showers.

Numerous women also emphasised the lack of hygiene in the post-natal units, and the missing hygiene equipment (antiviral gel/spray, but also ordinary soap).

Although women were compelled to wear face masks during their stay in the post-natal units, some of the instances of their mandatory use seemed rather inconsistent when combined with other hospital measures or policies, or lack thereof – such as with the above-mentioned lack of hygiene, or the fact that the staff did not always wear face masks themselves (again, the staff in the post-natal units did not wear face masks all the time in 12 per cent of all 97 reported cases). There was also a case where the entire

post-natal department in one of the hospitals provided only a small corner in a corridor for the women to eat where they, although required to maintain a two-metre distance between each other, were unable to do so due to the very limited size of the corner. One woman also shared the story of having porridge for dinner that women had to put on plates themselves using one common ladle with no protective gloves.

There were women who were highly critical of the seemingly low level of hygiene and anti-epidemic measures in the post-natal units and who put these low standards in stark contrast to the strict requirements imposed on women (for example, the obligation of wearing face masks during labour; the ban on the presence of a companion during labour; and the ban on visitors in the post-natal units).

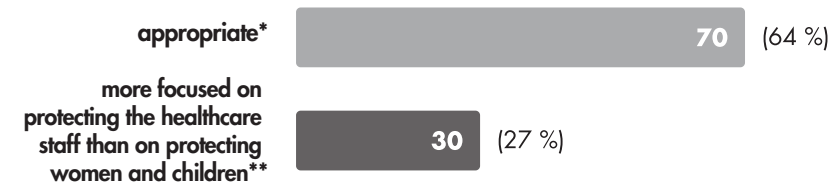
Only about two thirds (64 per cent) of the internet survey respondents who had given birth assessed the protective measures against COVID-19 as appropriate, and more than a quarter (27 per cent) were critical and noted explicitly that the measures were designed more to protect the healthcare staff than to protect women and their babies.

> *"During the birth, everyone insisted on wearing face masks, but after the birth, nobody cared that there were several women with no masks sitting and eating together in a dining room. Also, more disinfection would have been appropriate… They didn't disinfect door handles, a cleaning lady just washed the room floor once a day. The shared showers were filthy, too, and probably cleaned just once a day, in the evening. I would think these missing measures would be in place, especially given the fact that they insisted on wearing a face mask during the birth. They should have focused on health protection after the birth as well."* (respondent DTT)

Graph No. 6 **Measures to protect my health and the health of my child during pregnancy and/or childbirth, as part of the healthcare provided during the COVID-19 pandemic, were, in my opinion, overall:**

Multiple choice question including a semi-open-ended item (sum over 100 %)

*The graph shows a selection of two categories of responses; the category marked with * includes all responses in which the respondents marked measures as 'appropriate', and the category marked with ** includes semantically-related responses within the category '[measures were] more focused on protecting the healthcare staff than on protecting women and children'.*



N = 110

> *"There were eight of us in a room where the newborns had their joints checked and the neonatologist had no problem putting his finger inside the babies' mouth!!!! to quiet them down during an ultrasound exam. Of course, he didn't change the gloves and the mothers were even reproached for not having pacifiers for their babies. It was horrible, my greatest wish was to leave this clinic as soon as possible."* (respondent JOD)

3. Conclusions from the Monitoring and Key Principles for Carrying Out Systemic Changes in the Provision of Childbirth Care in Slovakia

The outbreak of the COVID-19 pandemic in Slovakia brought a very clear confirmation of the fact that the system of providing childbirth care in birthing facilities in Slovakia is not one that would be based on human rights and that would consistently reflect the latest scientific knowledge and the demands of evidence-based medicine. The experience from the initial phase of the pandemic also confirmed that once systems supposed to serve the needs of persons and fulfil their rights are not based on the ambition to meet these needs and fulfil these rights, they are very vulnerable to further malformations and to the further harming of those whom they are supposed to serve, especially if unexpected and unknown circumstances arise and prompt reactions are needed.

During the initial phase of the pandemic, the violations of the human rights of women that had occurred before March 2020 not only persisted, but they were often either of much more massive extent or intensity, or acquired new forms. Examples include violating the right of women to private and family life, and at the same time to health, in additional ways, or with new justifications. This was happening, *inter alia*, through not allowing the women in childbirth to have a companion of their choice present, through denying women and their babies skin-to-skin contact directly after delivery – with the justification that the (banned) companion, who by the condition of Slovak hospitals usually assists with such contact, was not present –, or through the declared (by some of the leading medical authorities) need for separation of mothers from their newborns if the mothers tested positive for COVID-19 or developed symptoms. Another example is the dramatic deterioration of women's access to information (which had been very insufficient even before the pandemic[52]). This happened through cancelling the opportunity for women to visit maternity wards and their prenatal courses that women had used frequently before the pandemic to get acquainted with the maternity wards and with the procedures applied in them, or through not providing sufficient or any information related to giving birth in the new situation of the pandemic on the hospitals' websites. Violations of the right not to be subject to cruel, inhuman and degrading treatment, also in connection with the right to health and healthcare, also acquired new dimensions after the outbreak of the pandemic. An example is the documented denial of pain relief (epidural analgesia) due to the declared need to save on the hospital staff.

52 See, for example, DEBRECÉNIOVÁ, J. (ed.); BABIAKOVÁ, K. – DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – KRIŠKOVÁ, Z. – SEKULOVÁ, M. – ŠUMŠALOVÁ, S.: *Ženy – Matky – Telá: Ľudské práva žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku*. [Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, 2015, pp 127 – 158. Also available at: http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf (last visited on 27 July 2020). An English summary is available at http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf (last visited on 27 July 2020).

When it comes to the provision of childbirth care under the COVID-19 pandemic, the WHO was rather expedite in providing the basic recommendations. These recommendations came in mid-March 2020 and emphasised the right of all women, including those with confirmed or suspected COVID-19 infections, to high quality care before, during and after childbirth. According to the WHO, a safe and positive childbirth experience includes, *inter alia*, having a companion of choice present during delivery, appropriate pain relief strategies, mobility in labour, and birth position of choice. With a specific reference to women with COVID-19 or its symptoms, the WHO also emphasised the importance of a close contact between a mother and her newborn, an early and exclusive breastfeeding, skin-to-skin contact, and of sharing a room with the newborn.[53] As can be seen from these WHO basic guidelines issued soon after the pandemic outbreak, they contained recommendations that had been a part of the internationally accepted medical standards of childbirth care before the pandemic. The Slovak government was also prompt in translating these standards into Slovak and making them widely accessible via governmental websites, albeit without emphasising the need for those providing childbirth care to follow them. This may have been one of the reasons why the maternity wards in Slovakia did indeed not follow them. Instead, they kept using routine and non-evidence-based procedures that are oftentimes demonstrably harmful to health and that violate the rights of women and their children.

To some extent, the outbreak of the pandemic and the subsequent spread of the SARS-CoV-2 virus could have been an opportunity to see in a new light the systemic and highly normalised human rights violations in the provision of childbirth care in Slovak hospitals. In particular, the need to design and carry out effective anti-pandemic measures potentially presented an opportunity to reflect upon the reasons behind the long-term settings in the system of childbirth care and the legitimacy of these settings, and also the possible ways of redesigning them. This approach would not only make the childbirth care system as safe under the new COVID-19 reality as possible, but also women- and other rights holders-friendly on a broader scale. For example, there is no doubt that the fact that women have to share rooms, showers, and toilets with other women while giving birth; that they cannot spend their births in rooms that can be closed with doors; that they are moved between different rooms during their labour and delivery; or the fact that they are assisted by unnecessarily high numbers of hospital staff not only negatively affects the course of the women's labours and the ways these labours are experienced and will be remembered, and the right of the women to privacy, intimacy and dignity, but these factors also increase the chance for the spread of COVID-19.

Nevertheless, the long-existing spatial arrangements and the personal discontinuity in the provision of childbirth care do not seem, for now, to be questioned by the healthcare providers and other accountable stakeholders as systemic factors representing a direct

53 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

and serious epidemiological risk, at the least. Our monitoring has shown that not only did the above-mentioned violations of the right to privacy and the protection of intimacy persist during the initial phase of the pandemic, but they were sometimes also presented as reasons justifying and legitimising further human rights violations (e.g., the ban on birth companions) in the name of the protection against COVID-19 spread. It would therefore be reasonable to keep in mind that many of the human rights standards that have been firmly established over years are not only rights per se (which is already a sufficient and binding reason for their observance), but their observance can also act as prevention from COVID-19 spread, or as a guarantee of keeping the potential negative impacts of the disease to the minimum.

Probably also due to the homogenous nature and the exclusive position of those who determine the nature of the childbirth care system in Slovakia (male obstetricians), and due to the strongly hierarchical and gendered relations within the system, the official expert discourse presented in the media during the first wave of the pandemic was rather homogeneous, too. In most of the cases, this discourse did not reflect upon, question, or contest the rightness of the measures adopted and the procedures undertaken in connection with the childbirth care provided in the hospitals, or their human rights dimensions. There were few exceptions.[54]

There were several other factors that may have contributed to this state of affairs and to the systemic nature of the violations of the rights of women in childbirth during the initial phase of the COVID-19 pandemic, including the following:

– The Public Health Authority of the Slovak Republic, the Ministry of Health of the Slovak Republic, and other state bodies did not pay any particular attention to the legal framework for limiting human rights under emergency situations in general. Neither did they reflect upon the human rights dimensions and the legality, the necessity, and the proportionality of the measures undertaken with implications for the field of childbirth care during the pandemic.
– The measures adopted in the field of childbirth care by the Slovak public authorities during the initial phase of the pandemic were unclear, ambiguous and confusing. It was also difficult to get a sense of orientation in them, as the adopted decisions were not published in the official Collection of Laws, but only on governmental websites with unclear structures and poor research opportunities. The leeway left to the hospital managements and maternity wards in terms of the application of the

54 See, for example, interview with MUDr. Peter Kaščák, PhD., the head of the Gynaecology and Obstetrics Clinic at the Trenčín hospital, published in the magazine *.týždeň* on 29 March 2020, available at: https://www.tyzden.sk/temy/63588/manzelov-zporodnice-nevyhaname (last visited on 27 July 2020); interview with MUDr. Peter Kaščák, PhD., the head of the Gynaecology and Obstetrics Clinic at the Trenčín hospital, published in the daily *Denník N* on 27 March 2020, available at: https://dennikn.sk/1824482/porodnik-kascak-stretavame-sa-s-odmietanim-interrupcii-ak-to-nie-je-akutny-zakrok-tak-co-uz-je (last visited on 27 July 2020); interview with MUDr. Peter Kaščák, PhD., the head of the Gynaecology and Obstetrics Clinic at the Trenčín hospital, published in the magazine *Mama a ja* [Mama and Me] on 29 March 2020, available at: https://mamaaja.sk/clanky/tehotenstvo/gynekolog-peter-kascak (last visited on 27 July 2020).

measures enabled them to act in arbitrary manners with regard to the ways and conditions under which childbirth care was provided.

– Attempts to gain meaningful, systemic and systematically structured feedback from those primarily affected, i.e., pregnant and birthing women and women who have recently given birth, were missing. Also missing was a discussion with these women, as well as with representatives of other stakeholders in the field of childbirth care (e.g., women's initiatives and organisations, organisations of midwives and nurses) that would have been initiated by the hospitals and the public bodies responsible for adopting policies and carrying out supervision over the provision of childbirth care during the COVID-19 pandemic.
– The Ministry of Health of the Slovak Republic and other public bodies responsible for the provision of childbirth care services and for the observance of human rights in childbirth care did not undertake any visible initiative during the initial phase of the COVID-19 pandemic to supervise the observance of human rights in this field, and to sanction and remedy the possible violations. The only public body that was vocal in calling upon the government and the hospitals to observe human rights and international medical standards in the field of childbirth care was the Slovak Public Defender of Rights, who has, however, no direct powers in the field of childbirth care.

This report has tried to shed light on some of the violations of the human rights and the international medical standards of childbirth care that occurred in Slovakia after the outbreak of the COVID-19 pandemic. It has also covered some of the broader systemic aspects of these violations that have, however, much deeper systemic causes entrenched in the ways childbirth care in Slovakia is designed and has been operating for many years.[55] The report thus also provides feedback to all the stakeholders with responsibilities in the field of childbirth care, including in the times of the current COVID-19 pandemic or any other potential emergency situations – in particular to the individual providers, their managements and the healthcare staff; the government, the Ministry of Health of the Slovak Republic and other public bodies, mainly the higher regional units, the Healthcare Surveillance Authority of the Slovak Republic and the Public Health Authority of the Slovak Republic; and the health insurance companies. We believe that this report will be taken seriously and will be perceived as a contribution to the important systemic changes that need to be done – not only because of the pandemic and as a prevention from potential future harms caused by this or other pandemics, or by other challenges

55 For more details on the systemic aspects, see DEBRECÉNIOVÁ, J. (ed.); DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – HREŠANOVÁ, E. – KRIŠKOVÁ, Z. – LAFFÉRSOVÁ, Z. – SEKULOVÁ, M.: *Ženy – Matky – Telá II: Systémové aspekty porušovania ľudských práv žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku.* [Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, Ženské kruhy, 2016. Also available at: http://odz.sk/wp-content/uploads/ZMT2_systemove_apekty_v6_w.pdf (last visited on 27 July 2020). An English summary is available at http://odz.sk/en/wp-content/uploads/ZMT2_SUMMARY_EN_final.pdf (last visited on 27 July 2020).

to the healthcare system, but also because the way childbirth care has been provided in Slovakia for years is not legitimate and sustainable as such.

We therefore believe that in the process of designing the changes, where all the above-mentioned stakeholders should closely cooperate, these principles and recommendations will be followed:

- Childbirth is a life-changing experience, and the persons affected the most are pregnant and birthing women and their newborns. Therefore, they must be placed into the absolute centre of childbirth care. Women must also be a part of all the processes through which changes will be designed and carried out, and their frank and detailed feedback must be actively sought and welcomed.
- Every woman has the right to a safe and positive childbirth experience, and all pregnant women and their newborns have the right to high quality care before, during and after childbirth, including to mental health care. This also applies to persons with confirmed or suspected COVID-19 infections, as well as to extraordinary times such as the COVID-19 pandemic. Childbirth has lifelong implications for both women and children, and childbirth care is essential and emergency healthcare. For these and other reasons, human rights in childbirth cannot be denied at any time, including in times of emergencies.
- The observance of human rights is not a superstructure to healthcare (which is a right in itself), but an essential and integral part of it, and a legal obligation vested not only with the State and its bodies as the primary responsibility-bearers, but also with all healthcare providers, be it institutions or individuals. Many human rights principles are contained in internationally accepted medical standards on childbirth care, and many of these medical standards are at the same time human rights. Human rights and internationally accepted medical standards on childbirth care are thus firmly intertwined and cannot be separated from each other.
- The duty to provide childbirth care (and healthcare in general) on the basis of high-quality scientific data (evidence-based medicine) is an expression of the quality component of the right to health and to healthcare, and of the right to enjoy the benefits of scientific progress and its application. In order to fulfil these rights, it is essential for all stakeholders with responsibilities in the field of the provision of childbirth care to continually follow scientific research in the field, and to provide for continuous and adequate training to healthcare providers on the latest scientific knowledge and standards in the field. It is especially important for cases of emergency or otherwise extraordinary situations when prompt reactions are needed. It is equally important that the State summarises this knowledge on a continuous basis and thus knows what the evidence-based standards of care are, makes them accessible to healthcare providers, and ensures their application and enforcement.
- Women are autonomous and free beings, and hospitals are not places where personal rights and freedoms can be violated. This does not only mean that every

single intervention that is intended by the healthcare staff can only be performed with an informed consent of the woman concerned, but that the hospital staff must restrain themselves from all actions that negatively affect personal autonomy, integrity, and freedom, including through (physical or psychological) violence, coercion, manipulation, or withholding information. The right of women not to be separated from their newborns and their right to take all decisions regarding their children, with the best interests of the child being the primary consideration, are also expressions of this freedom and of the right to private and family life.

– Health and human rights during childbirth cannot be separated from health and human rights issues that immediately precede or follow childbirth, and from reproductive health and rights of women in general. Nor can health and human rights of women in childbirth be separated from health and human rights of their newborns. Therefore, approaches to reforms must be complex and holistic and must also focus on the elimination of the fragmentation in care which is at the moment typical for childbirth and postnatal care (nowadays, a woman who comes to the hospital to give birth, and her baby later on, are taken care of by at least three different hospital departments – the maternity ward, the postnatal unit, and the newborns' unit). This means, *inter alia*, that emphasis needs to be put on how to maintain care that is continuous on the personal provider level, but also on the organisational, administrative, and accountability levels.
– The State and its bodies as well as hospital managements must create adequate and safe working conditions for all staff involved in providing childbirth care. This involves practical guarantees of the general labour standards such as adequate work time, proportionate workload, adequate remuneration, including for overtime work, adequate and sufficient premises and equipment, adequate training, and adequate protection of the occupational health and safety. In the times of the COVID-19 pandemic, and in times of emergencies in general, the fulfilment of these standards is even more pressing and has very practical and also material connotations (such as the need for sufficient and reliable sanitation, protective equipment, COVID-19 testing tools, etc.). The State and hospital managements must, however, make many other adjustments to make sure that the healthcare staff are able to primarily focus on providing healthcare to their clients. This includes practical assurances that the staff providing care do not have to primarily or excessively focus on carrying out administrative or technical tasks.
– Changing the system of childbirth care will require changes in approaches and attitudes, as well as changes in the hospital cultures and the cultures of their working environments. Adequate processes leading to the desired transition and training in communication and in other soft skills cannot thus be underestimated.
– Collecting sufficient amounts of good quality data and evaluating them, all on a continuous basis, is an essential component of a childbirth care system that is based on human rights, on the latest scientific knowledge, and that is at the same time responsive to client needs.

– The State, public bodies, and hospital managements must make sure that allegations of violations of rights are adequately addressed, not only in terms of proper investigations and of providing timely, efficient, and fair remedies, but also in terms of preventing cases of repetition, and in terms of the ability to infer lessons learned that will enable improvements. The listed entities should also monitor the observance of human rights in childbirth and investigate and remedy the potential violations out of their own initiative and without waiting for signals from those directly affected. In any cases of violations of rights or allegations of them, victim-blaming or other ways of negatively affecting women for invoking their rights are unacceptable.
– Taking into account the latest scientific knowledge, the newly-emerged challenges and demands connected to the COVID-19 pandemic as well as the broad concept of personal freedoms, including the freedom of choice, makes the need for the discussion on the legitimacy, safety, cost-efficiency, and the environmental sustainability of the monopoly of the facility-based obstetric model of providing childbirth care, and the possible alternatives to it, mainly with regard to low-risk pregnancies, even more legitimate and pressing. We believe that the discussion will be based on relevant and complex data, will depart from women's needs and rights, and that the representatives of the current childbirth care system will also be willing to look at the ways in which the outcomes of the discussion can be turned into practice.

4. Summary of Main Findings from the Monitoring and Recommendations for the Provision of Childbirth Care in Slovakia in Compliance with Relevant Human Rights and Medical Standards, with Special Focus on the COVID-19 Pandemic Period

Based on the findings presented in this report as well as on other existing evidence on violations of the human rights of women in connection with childbirth care in healthcare facilities in Slovakia, we urge that solutions be sought and implemented as a response to the problems that co-design the current state of affairs in this field and that are being aggravated by the pandemic. With this goal in mind and having regard to the findings from the monitoring, we have selected and summarised a set of problematic areas and, for each of these areas (that are by no means exhaustive and that do not represent all the kinds of violations present in the provision of childbirth care), we present our recommendations. The measures we propose, with a special focus on the COVID-19 pandemic, and their implementation are, in our view, a necessary precondition for a functioning childbirth care system that fulfils human rights.

The following recommendations are intended for the State and its bodies, since it is the State that is primarily responsible for the provision of health care. This responsibility also includes the State's obligation to ensure that the rights of persons receiving the care are respected, protected and fulfilled. Even though the State, in practice, transfers the said responsibility onto healthcare providers, individual healthcare professionals, as well as onto other entities, it cannot divest itself of that responsibility in any case. Hence, the Slovak Republic bears the overall responsibility for the quality of childbirth care provided and for the observation of human rights in healthcare facilities.

The recommendations are further intended for all entities that provide health care to women before, during and after childbirth, as well as for those providing neonatal care. In particular, they include all healthcare facilities such as hospitals and outpatient doctor's offices, their managements, doctors, midwives and other medical and non-medical personnel.

The following recommendations should lay the groundwork for the fulfilment of rights and needs of all women with no exception, taking into account the varied needs and demands women may have with respect to their reproductive health and to the provision of healthcare during pregnancy, childbirth and the postnatal period. Besides other factors, these needs vary according to women's personal history, their health conditions or disability, the social background, nationality or ethnicity, the level and kind of education, their religion or belief, sexual orientation, marital status or age. These needs are also shaped by women's access to digital technologies and/or the availability of infrastructure. For each woman who needs reproductive health services, we must therefore take into account not only the universal human rights principles and medical

standards for the provision of childbirth care, but also the diversity of individual needs that may require different approaches to their fulfilment in practice.

Regardless of their life stories and individual circumstances, all women have the right to equality, respectful treatment and dignity. All stakeholders involved in the provision of childbirth care must act in compliance with the principle of equal treatment and must not contribute to the deepening of inequality of women, whose rights, including the right to sexual and reproductive health, are at special risk during the pandemic. Also for this reason, the discriminatory and socially unfair conditioning of the fulfilment of women's rights by monetary payments in the provision of childbirth care (e.g., for the presence of a birth companion, for giving birth in a separate room or for accommodation in a single room, for companions' testing for COVID-19, or for the application of epidural analgesia) is particularly unacceptable during the pandemic.

All the recommendations that we are presenting in this section are based on human rights and medical standards for the provision of healthcare during pregnancy, childbirth and the postnatal period. They promote the desired changes in the provision of reproductive healthcare services to women in Slovakia also at the system level. We believe that observing the human rights of women and newborns, including in the time of pandemic, is a way for Slovakia to ensure both the protection of public health as well as the fulfilment of rights of every person receiving healthcare at the same time.

4.1. Woman-Centred Childbirth Care and the Right to a Positive Childbirth Experience

Childbirth is a life-changing experience with profound implications on the life of women and their children, and on their physical and mental health. It affects the entire families, too. Childbirth care represents emergency healthcare and its proper provision in compliance with medical and human rights standards must be ensured even in the times of the pandemic. In its COVID-19 related recommendations, the WHO has emphasised that high quality care provided during childbirth also includes the right to a safe and positive childbirth experience, including mental health care.[56]

Woman-centred childbirth care is extremely important for a positive childbirth experience. Woman-centred care requires that the healthcare staff take a proactive approach to identifying and fulfilling women's individual needs and communicate in a professional manner that enables trust. The right to a positive childbirth experience applies to women with confirmed or suspected COVID-19, too.

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56 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

The monitoring undertaken jointly by CDA and Women's Circles showed that in many cases, women did not perceive childbirth as a positive experience. They often complained about the prevailing feelings of loneliness, pain, and healthcare personnel's indifference towards their needs. Women described situations when they wanted to consult their childbirth-related ideas or questions with the healthcare staff but there was no room for such consultations. In a number of cases, the healthcare staff showed no interest in the needs, expectations and preferences of individual women at birth. Due to the prohibition of a birth companion, women had to face their fears or pains alone, feeling lonely and abandoned in the most difficult moments. Many of them did not have enough information about the progress of their labour and delivery and could not make informed decisions. The decisions were in fact made by the healthcare staff, in some cases even without giving prior information to the woman concerned.

Hospitals have to provide real and sufficient opportunities for women to discuss their questions or childbirth-related scenarios with the healthcare staff, to express how they imagine and wish to give birth, and/or consult their birth plans with the staff. In the provision of healthcare services, healthcare staff must respect women's will and endeavour to meet their needs and expectations, providing them with unbiased and true information. They must do so without stigmatising, manipulating, intimidating or otherwise penalising women for having autonomously expressed their ideas on what their childbirth should look like. These rights also apply to women with confirmed or suspected COVID-19.

4.2. Providing Healthcare Solely on the Basis of Informed Consent

Pregnancy- and childbirth-related healthcare must be provided solely on the basis of informed consent. Informed consent does not only require that women's autonomy in decision-making be respected and encouraged, but also that their physical and mental integrity be respected and protected. The requirement that childbirth care is provided solely on the basis of informed consent applies during the COVID-19 pandemic, too, including with respect to women with confirmed or suspected COVID-19 infections.

Before a woman gives her informed consent with any intervention during her childbirth, a process of good quality communication between the healthcare provider(s) and the woman concerned must have taken place. In this process, the healthcare personnel must provide the woman with all relevant and necessary information, making sure that everything they do or plan to do is in line with an autonomous and informed decision of the woman. If the aforementioned parameters are not met, an 'informed consent' form alone, despite its title and albeit bearing a signature of the woman concerned, does not prove the existence of her informed decision. A woman's signature on a hospital form may be seen as the final step in the process of informed and autonomous decision-making, but it cannot serve as a substitution for it.

The joint CDA's and Women's Circles' monitoring showed that a properly obtained informed consent had often been replaced by solely obtaining women's signatures on forms entitled 'informed consent'. However, the signature alone did not meet the purpose and the legal requirements for informed consent. In many cases, women were not informed in advance about the purpose and the nature of the interventions and procedures the healthcare staff were carrying out in connection with childbirth. Women learnt of some of the interventions that had been carried out on them ex-post only, from their medical records. In some cases, interventions were even performed despite women's explicit refusal.

We urge healthcare providers and every healthcare worker to engage in clear communication with a woman concerned before they perform any intervention or procedure that concerns her. Any intervention that the healthcare staff proposes to perform can only be carried out after the woman has been properly informed and has given her free and informed consent. At the same time, every woman must be advised in advance that she does not have to give her consent to the proposed intervention as well as that she is entitled to withdraw her consent anytime during childbirth.

The aforementioned legal requirements for pregnancy- and childbirth-related informed consent do not only apply to the provision of healthcare to pregnant and birthing women but, by analogy, to the provision of neonatal healthcare as well. The persons eligible to receive all information and make all legal acts related to informed consent (its provision, refusal, withdrawal) on behalf of hospitalised newborns are their mothers and fathers as their legally designated representatives.

4.3. Fulfilling the Right to Healthcare During Pregnancy: Medical Check-Ups of Pregnant Women, Pregnancy Counselling Sessions

Healthcare during pregnancy and childbirth is necessary and unpostponable, and therefore essential healthcare that must be provided also during the pandemic. Regular antenatal counselling for pregnant women and their medical examinations are a standard part of pregnancy-related healthcare to which women are entitled and which is covered by health insurance. This care constitutes a significant component of women's sexual and reproductive health. Therefore, it must be available, accessible (both formally and in practice), of high quality, and acceptable – to all women concerned.

CDA's and Women's Circles' monitoring showed that some healthcare providers reduced the volume of the standard antenatal care during the pandemic, postponing or even completely cancelling medical check-ups. The affected pregnant women, with their unmet need for specialised healthcare, thus experienced increased concerns about their health and healthy progress of their pregnancies.

Healthcare providers must not arbitrarily cancel or reduce counselling sessions or medical examinations of pregnant women. If the conditions for the provision of healthcare

services have changed due to the pandemic, it is necessary to adjust the provision of these essential healthcare services so that they can be provided without restrictions.

4.4. Providing Information About Childbirth, Childbirth Care, and About the Conditions of its Provision During the Pandemic

Women have the right to healthcare-related information before, during and after childbirth. This covers not only the right to information about pregnancy, childbirth and the postnatal period as such, but also the information about the conditions under which healthcare is provided during this time. Such information, which the healthcare facilities and other providers have an obligation to provide, must be given in a sufficient amount and quality, must be accessible to all women and/or other persons who need it, and must be provided in a manner that is comprehensible for the recipients. Since pregnant and birthing women do not use such information only to make decisions about individual aspects of pregnancy- and childbirth-related care, but also to choose the provider of such care, it is necessary that individual healthcare facilities and/or other healthcare providers make the information available well in advance so that women can make informed decisions without stress and time duress. This also involves the obligation for all entities that provide healthcare to regularly inform about any changes in such care. These principles must especially be observed in the time of the COVID-19 pandemic when healthcare providers operate under constrained and tightened regimes, under constantly changing conditions, and when the possibilities for personal contacts are very limited.

The outcomes of the CDA's and Women's Circles' monitoring indicate that many outpatient doctor's offices and hospitals modified the provision of health care and the conditions for its provision, but have hardly always provided timely and sufficient information about such modifications. This has considerably limited women's, as well as other persons', access to information. The women struggled with an acute lack of information as to whether and how childbirth care was provided in particular healthcare facilities – for example, with respect to antenatal counselling, birth companions, administration of epidural analgesia or to the possibilities of staying in the hospital with a partner after childbirth. Because women had no opportunity to consult their childbirth-related preferences (see further in the text) with individual healthcare facilities in order to compare them, they could not make informed choices on the hospitals in which they would wish to give birth. Such a confusing situation put them under stress and was raising their uncertainty. The instances of antenatal care not being delivered according to an originally agreed schedule only made those feelings worse.

The monitoring has further shown that hospitals were cancelling the pre-birth visits to maternity wards, as well as their antenatal classes. Even before the outbreak of the pandemic these had often been the sole option for women to get into direct contact with maternity ward staff, to familiarise themselves with the ward's premises and procedures,

with the course of childbirth, or to have their specific questions answered. The hospitals, however, failed to provide any alternatives to make up for this loss, depriving many women of a highly relevant source of information.

During the pandemic, which requires that personal contacts be limited as much as possible, it is advisable to provide information and communicate with clients online. Hospitals and outpatient doctor's offices may provide women who use digital technologies with up-to-date, real-time and interactive information, with the possibility for a desired feedback on both sides. In addition to the more common forms of online communication, such as information published on websites, in social media profiles or delivered via email, they may also use digital technologies to provide online counselling, web-based chat services, online courses, or video calls.

However, offline forms of communication, that may include notices and posters displayed on notice boards in healthcare facilities or leaflets available in outpatient doctor's offices, as well as in other public spaces, are equally important. Offline communication is particularly important for women who do not use, or have access to, digital technologies, either because they live in areas without internet coverage or because of their social exclusion or other forms of vulnerability.

At the same time, all women should also be able to contact any healthcare facility directly – by phone – and receive all healthcare-related information they need. The more information healthcare facilities actively provide through generally accessible communication channels (such as websites, leaflets), the lesser the need there is for individual women to seek additional information. In any case, healthcare facilities should allocate sufficient capacity for the provision of case-specific individualised information to women, and to answer their questions.

In addition, regardless of how they provide information, healthcare facilities should make sure that the information they provide is comprehensible, clear, accurate and non-misleading, disclosed in a user-friendly format, and that the ways in which it is provided accommodate the diverse needs and capacities of women, including their language, education or any sensory and/or intellectual disability. In this regard, cooperation with professions and organisations that provide support to disadvantaged women and groups of population is particularly important; for example, with social (field)workers or with organisations providing assistance and support to women or to particular disadvantaged groups (such as people with disabilities).

When providing any information about childbirth and childbirth care, healthcare facilities and individual health professionals must keep in mind that such care, and hence care-related information, too, has to be provided in accordance with the latest scientific knowledge and with the national and international human rights standards.

At the system level, it is also necessary to create real room for the possibilities to extend the health care services provided to women before, during and after childbirth to involve

so-called community midwives (i.e., midwives providing their services directly in the communities and home settings, and on an individual basis). The provision of services by community midwives would not only be beneficial in terms of the provision of information and care as such, but it could also have epidemiological benefits.

4.5. Reasonable Conditions for Having a Companion of Choice Present Throughout Labour and Delivery

Every woman has the right to the presence of (a) companion(s) of her choice throughout the entirety of her childbirth. The presence of a birth companion increases the chances for physiological childbirth without the need for medical interventions, enhances women's satisfaction with childbirth and generally contributes towards a positive childbirth experience. The importance of a birth companion of a woman's choice, including in the time of the COVID-19 pandemic, has also been emphasised by the WHO.[57]

Our monitoring revealed that a number of hospitals completely banned, or considerably constrained the possibility for women to have a companion of their choice present during childbirth in the period under review. Even where birth companions were allowed, the hospitals specified that it could only be a woman's partner or the father of the child. This way they ruled out in advance any possibility for women to choose another close person to accompany them during their childbirth. This kind of restriction is discriminatory against women who wish to have a different person as their birth companion, who do not have a partner, live in a violent relationship, whose partner does not want to, or cannot be present at childbirth, or those living in same-sex relationships. Besides, some hospitals introduced conditions that were hard or outright impossible to meet – for example, a requirement for birth companions to present with a negative PCR test not older than a few days which they should have procured at their own costs. Given the fact that a physiological childbirth cannot be precisely scheduled and that complying with these conditions would have required repeated and, on top of that, costly testing in many cases, these requirements made the possibility to have a companion of choice present unrealistic for many women.

Hospitals must enable women to have a companion of their choice present at childbirth even during the pandemic. Hospitals are not entitled to determine whom the women should have as their birth companion. Hospitals must define such conditions that give women a real possibility to choose and have a birth companion of choice present at childbirth. When designing anti-epidemic measures which birth companions are required to meet, it is necessary to consider their proportionality so that they do not build insurmountable barriers that prevent the possibility of birth companions' presence. Where hospitals

57 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

require negative tests for COVID-19 from birth companions, arrangements should be put in place for their free-of-charge testing at hospitals' costs.

4.6. Undisturbed Labour and Delivery with the Feeling of Safety

Childbirth is no exception to women having the right to privacy, intimacy and dignity. Creating a peaceful and safe environment for childbirth is also fundamental to a natural course of labour and delivery and to a positive childbirth experience. All entities providing childbirth care have an obligation to make such spatial, personnel and other arrangements that create conditions for women to have an undisturbed and smooth labour and delivery with a constant feeling of safety. These are essential components of childbirth care also from the perspective of internationally recognised medical standards. For example, according to the WHO, respecting the women's right to privacy at childbirth is a good practice that should also be encouraged at the system level.[58]

Labour and delivery should take place in the same single room for their entire duration, in a peaceful atmosphere and privacy and with a minimum number of healthcare staff attending. Yet fulfilling these conditions is not common practice under the existing childbirth care system in Slovakia. Our monitoring carried out during the pandemic showed that women giving birth in a hospital setting were moved between different rooms, often with several women sharing one room. Cases when the women had to use shared sanitation facilities were not rare either. The number of medical personnel present at childbirths was usually higher than necessary. Such circumstances not only have negative implications on the course of the labour and delivery as such but also represent an epidemiological risk for both women and healthcare staff in the time of pandemic.

Based on the findings from our survey among women, we recommend that the following measures be implemented to the greatest extent possible:

- Throughout childbirth, the woman and her companion(s) should be placed in a single room that can be closed by door, ideally with a private bathroom.
- It is unacceptable that that a woman give birth in a room shared with other birthing women.
- The woman should not be transferred during childbirth or, alternatively, she should only be transferred when absolutely necessary.
- Throughout childbirth, the woman should be in contact with a single midwife, from the onset of labour through to skin-to-skin contact immediately after childbirth.

58 WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva : World Health Organization, 2018, p 19 – 22, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020).

– The number of healthcare personnel assisting the woman in childbirth needs to be limited to the absolutely necessary minimum at all times.
– The woman's right to intimacy also needs to be ensured by other means – for example, by keeping the door closed; knocking on the door; refraining from entering the room in which a woman is giving birth, unless necessary; by furniture arrangements, etc.

4.7. Appropriate Pain Relief Strategies

One of the tasks of childbirth care is to provide birthing women with a full spectrum of appropriate pain relief options. They include non-medication, such as freedom of mobility, hot water, warm compresses, massage or a possibility to change birth positions, as well as medication forms, such as epidural analgesia. A failure to provide women with appropriate pain relief by all available means at all stages of childbirth and postpartum care is in direct conflict with one of the medicine's fundamental functions and violates the women's right not to be subject to torture or other cruel, inhuman and degrading treatment. The WHO includes appropriate pain relief strategies among those childbirth care standards that cannot be circumvented, not even in the time of the COVID-19 pandemic.[59]

Pain connected to childbirth was the most prevalent feeling described by the women who participated in our survey. Their answers to open-ended questions showed that they were not offered all available pain relief options, such as the possibility to change birth positions or the adoption of mobility during their labour and delivery. Pain relief during the suturing of birth injuries or after a caesarean section was also described as inadequate, or even non-existent. In addition, statements by the hospitals collected during monitoring showed that some of the hospitals stopped providing epidural analgesia altogether, justifying it as a precautionary measure aimed at protecting their anaesthesiology staff members.

Hospitals must ensure that their healthcare personnel are trained to deliver the entire spectrum of appropriate pain relief strategies during childbirth, during suturing of birth injuries, and after childbirth. It is also necessary that the personnel inform women about non-pharmacological pain relief options and encourage them to move freely, change positions or use warm water or massage. At the same time, the COVID-19 pandemic cannot be used as a pretext for downgrading the standards in the provision of pharmacological means of pain relief, such as epidural analgesia, allegedly for preventive reasons.

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59 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020). More generally, see also WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience.* Geneva : World Health Organization, 2018, p 4, 5, 83 – 114 and 125 – 132, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020).

Appropriate pain relief options must also be available for the treatment of birth injuries. Before the treatment, healthcare personnel must always make sure that the applied pain relief agents are effective. Effective pain relief must also be available in postnatal wards for women who had a vaginal birth with complications, and after caesarean sections.

4.8. Supporting Skin-to-Skin Contact Immediately After Childbirth

Skin-to-skin contact is a basic and essential element in providing support to a child's and mother's health and to breastfeeding. Immediately after delivery, a mother and her child form an inseparable whole – they share a unique relationship, their physical and mental health and needs being closely intertwined. Skin-to-skin contact immediately after childbirth is a practice recommended by international professional organisations, including for the period of the COVID-19 pandemic. It is also recommended for women diagnosed with COVID-19.[60]

Our monitoring revealed that not all women were supported in having skin-to-skin contact immediately after delivery. In some cases, the lack of skin-to-skin contact was justified by the absence of a birth companion (whose presence was prohibited). There were many cases when skin-to-skin contact was limited to a few minutes after delivery, or a baby was cleaned and dressed first. Several women said that skin-to-skin contact was not guaranteed automatically; some of them had to put a lot of effort into achieving it. There was hardly any skin-to-skin contact after caesarean sections. Moreover, the monitoring of hospitals' statements revealed that some of them even adopted procedures for routine separation of newborns from their mothers who would test positive for COVID-19.

Hospitals must create conditions for the provision of postpartum care that is free of separating women from their newborns, that respects their physical and mental health and needs, and encourages breastfeeding. Healthcare personnel have an obligation to inform women about the importance of skin-to-skin contact and, after childbirth, should support and assist them in practicing it safely, without disruptions and difficulties. We urge that healthcare personnel pay special attention to encouraging skin-to-skin contact after caesarean sections. Skin-to-skin contact must not be routinely denied to newborns and women with confirmed or suspected COVID-19 infections.

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60 See, for example, WORLD HEALTH ORGANIZATION: *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva : World Health Organization, 2018, p 6 and 163 and sources included there, available at: https://www.who.int/publications/i/item/9789241550215 (last visited on 27 July 2020). See also WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

4.9. Anti-epidemic Measures in the Provision of Childbirth Care Complying with Human Rights and Medical Standards

In connection with the COVID-19 pandemic and based on the regulations issued by the Public Health Authority of the Slovak Republic, healthcare providers adopt specific anti-epidemic measures to protect all persons involved in the provision of childbirth care. When designing and implementing any measures in this area, they must take into account all the requirements for quality of childbirth care and for fulfilling the rights of women during childbirth, including their right to a positive childbirth experience. This means that the measures adopted must not downgrade the medical and human rights standards for the provision of childbirth care and harm physical or mental health of women and their children.

The monitoring revealed that the necessary anti-epidemic measures in hospitals and outpatient doctor's offices were not always adopted, or that they had been insufficient (for example, bad time management of clients' admissions at outpatient antenatal care departments; women were not provided with face masks, or their face masks were not exchanged regularly during childbirth and hospitalisation in postnatal wards; a failure to provide women with protective face shields during childbirth; high numbers of personnel present at childbirth; insufficient disinfection of instruments, items or equipment shared by several women). Some anti-epidemic measures were not sufficiently complied with by the personnel (for example, no/improperly fitted face masks; not wearing/not exchanging protective gloves, etc.), which raises questions about their effectiveness in preventing COVID-19 transmissions. The approach adopted by the hospitals which, on the one hand, insufficiently eliminated the epidemic risk and, on the other hand, violated the women's human rights more than before the pandemic (e.g., the prohibition of birth companions, non-provision of epidural analgesia) represent further systemic drawbacks on the part of the hospitals. These drawbacks were also impacting on the ways women were experiencing their childbirths. Including due to these drawbacks, women did not feel to be autonomous and equal human beings, did not feel safe and did not feel treated with respect and support during their childbirth and hospital stay.

For the sake of the protection of the health of women and children, as well as of public health, appropriate anti-epidemic measures need to be adopted and implemented in the field of the provision of healthcare before, during and after childbirth during the COVID-19 pandemic. These measures must be in compliance with all relevant medical and human rights standards and, subsequently, strictly followed by healthcare and other staff in hospitals and across all inpatient and outpatient departments that provide care to women and their children.

Based on the findings from our survey conducted among women, we particularly recommend implementing the following measures:

- Hospitals should provide a possibility for pregnant women and women in labour to enter the hospital through a special entrance in order to minimise their contacts with other persons and the time they spend waiting before entering the hospital under the special pandemic regime, often in labour pains.
- Time, spatial and personnel arrangements must be made to minimise women's and their newborns' contacts with other persons during medical check-ups.
- Healthcare personnel must be strictly protected against potential COVID-19 infection at work. Protective equipment for healthcare staff must meet the required quality specifications and must be available in sufficient amounts. Medical personnel must be trained to use it properly.
- When in contact with women and children, healthcare staff must always wear face and nose protection, properly fitted, and unused protective gloves.
- Healthcare facilities must apply more stringent disinfection and sanitation measures for their premises, equipment and instruments. Examination tables and instruments used for the provision of care to women and children must be disinfected after every use.
- Requiring women to have their mouth and nose covered by a face mask during labour and delivery should take into account their current needs stemming from their actual physical and psychological condition, and an option to use a protective shield should be provided as an alternative, at least in cases of an urgent need.
- Hospitals should provide women with protective face masks or shields and ensure their regular replacement.
- Appropriate sanitation means (liquid soap and paper towels) should be available at every washbasin in a hospital. Antiviral hand gels or sprays must be available at each entrance to interior premises.

We consider it necessary to monitor the implementation of the anti-epidemic measures, assess their effectiveness, and to continuously remove any shortcomings that may appear on the part of healthcare providers, so as not to put pregnant and birthing women, women after childbirth and their newborns at risk of COVID-19 infection and so as to prevent them from bearing an unreasonable burden.

4.10. Protection of Privacy, Family Life and Health, Including While Staying in Postnatal Ward

A serene and safe environment for women and their children staying in a postnatal ward is in the interest of the protection of their privacy, family life and health. Standard health care should involve placing every woman after childbirth in a separate room along with her baby where she can stay for her entire hospitalisation at the postnatal ward and where she and her baby will ideally receive all the healthcare needed including the needed support and assistance with breastfeeding. At times of occurrence of communicable

diseases, the health support potential of this kind of setting is strengthened also by its anti-epidemic nature. Whenever the epidemic situation so permits, even to the slightest possible extent as imagined by public authorities and/or hospital managements, mothers and their babies should be allowed to spend the time of their hospitalisation after childbirth with close person(s) of their choice.

The monitoring showed that during their stay in the postnatal wards, women had to share rooms with other women and their newborns, used shared sanitary facilities, ate in shared dining rooms and underwent medical examinations of their children in postnatal wards *en masse*. Only some women and their babies were accommodated in separate rooms with private bathrooms after childbirth, with an extra fee charged for this service in a majority of cases.

Based on the findings from our survey conducted among women, we particularly recommend implementing the following measures:

– In hospitals, it is advisable, especially in the time of pandemic, to place each woman and her baby in a separate room after childbirth, ideally with a private bathroom. Where it is not feasible due to the layout of hospital premises or bed occupancy, the number of women and their babies sharing a single room needs to be reduced as much as possible.
– If hospital rooms for women with children differ in their layout, accommodation capacity and quality, the 'first come, first served' rule must be followed. It means that accommodating a woman and her child in a separate room, or one with a private bathroom, must not be conditional upon her having funds to pay for the service of this kind. The proposed solution is not only socially fair and non-discriminatory but it also prevents the spread of COVID-19 in the time of pandemic.
– Healthcare provided to women and their children after childbirth in hospitals, including the needed interventions as well as the support and assistance with breastfeeding, need to be provided, to the maximum possible extent, directly in the room where the woman and her child are staying.
– It is equally important to create conditions for in-room dining for women.

4.11. Preventing the Separation of Parents and Their Newborns Including Preterm Infants and Other Hospitalised Children in Need of Specialised Care

Preterm infants or newborns with specific health issues often require long-term hospitalisation and specialised care. Contact with a mother (parents), the support of breastfeeding and kangaroo care are essential to the health and welfare of prematurely born children. The absence of maternal/parental care impairs the health of preterm

infants, prolongs their hospitalisation time, and increases their mortality.[61] Close contacts of parents with their children, a possibility to provide the children with care and establish a relationship with them do not only fulfil the right to health but they are also an expression of the right of parents and their children to privacy and family life. By contrast, apart from violating their right to health and privacy, separating mothers from their newborns represents a form of cruel and inhuman treatment as well.

During the period of our monitoring, we encountered cases when preterm infants were completely separated from their parents as part of anti-epidemic measures implemented in hospitals. Mothers of preterm infants were discharged from hospitals after childbirth on grounds that the hospitals needed to preventively set aside beds for patients with COVID-19 who, however, were not present in hospitals at the time. The children remained in hospitals (at ICUs, usually) without any chance of contact with their parents throughout their entire hospitalisation. The absence of child-parent contact demonstrably harmed the best interest, health and rights of children, as well as of their parents.

The Ministry of Health of the Slovak Republic and hospitals must ensure that hospitalised preterm infants and/or newborns with specific health issues have contact with parents. Anti-epidemic measures must not be a barrier to parents' direct contact with their hospitalised children, to breastfeeding and maternal care. Hospital managements and staff in neonatology and paediatric wards need to be advised that any action through which they arbitrarily prevent parents from being in direct contact with their hospitalised children is violating their rights, including in the time of pandemic. Hospitals and the relevant wards have an obligation to create conditions under which mothers of preterm infants can stay in hospitals together with their children in one room and provide them with kangaroo care throughout the entire time of hospitalisation.

4.12. Care for Women with Confirmed or Suspected COVID-19

Pregnant women with confirmed or suspected COVID-19 require increased attention in the time of the pandemic. The WHO has emphasised that women with COVID-19 also have the right to a positive childbirth experience.[62]

COVID-19 should not be seen as an indication for caesarean section or instrumental delivery. Even mothers with suspected or confirmed COVID-19 should be encouraged

61 See, for example, BOUNDY, E. – DASTJERDI, R. – SPIEGELMAN, D. – FAWZI, W. – MISSMER, S. – LIEBERMAN, E. – KAJEEPETA, S. – WALL, S. – CHAN, G.: Kangaroo Mother Care and Neonatal Outcomes (A meta-analysis). In: *Pediatrics*, Volume 137, No 1, January 2016. See also WORLD HEALTH ORGANIZATION: *Kangaroo mother care: a practical guide*. Geneva : World Health Organization, 2003, p 2, 5 – 8, available at: https://www.who.int/maternal_child_adolescent/documents/9241590351/en (last visited on 27 July 2020).

62 See WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth (last visited on 27 July 2020).

to practice skin-to-skin contact immediately after childbirth, to breastfeed, and to share a room with their infants for 24 hours a day throughout their hospitalisation. Confirmed or suspected COVID-19 infection must not serve as a reason to preventively separate mothers from their babies and to not breastfeed them. According to the WHO, health risks associated with separation and lack of breastfeeding outweigh the health risks for newborns to be infected with COVID-19: newborns and young children appear to be at low risk of COVID-19, and among the cases of confirmed COVID-19 in this group, most have experienced only mild or asymptomatic illness.[63] Moreover, such a precaution cannot protect newborns from being infected by the healthcare personnel, or from other bacterial or viral infections to which newborns are exposed in hospitals and against which breastfeeding provides protection. Exposing newborns to the risks associated with separation and lack of breastfeeding only to prevent them from being infected with COVID-19 by their mothers is therefore disproportionate, carrying inherent specific risks that cannot be ignored.

Our monitoring revealed that the recommended procedures of some hospitals applicable to birthing women with confirmed or suspected COVID-19 that hospitals published during the period under review were in stark contrast to the WHO's standards and guidelines for the time of the COVID-19 pandemic. They also violated the basic human rights of women and children. The problematic hospitals procedures involved mainly: preventive instrumental deliveries; immediate separation of mothers from their newborns following the delivery, supposed to last for 14 days; no support of skin-to-skin contact after childbirth; contraindicated breastfeeding. These procedures also give rise to very serious concerns about potential large-scale violations of women's and children's human rights and harms to their health if the epidemic situation is to deteriorate further.

Based on the aforementioned findings and on the standards on the provision of childbirth and postnatal care in general, and during the COVID-19 pandemic in particular, we recommend that the entities providing such care as well as other entities which are responsible for its provision in accordance with human rights and medical standards implement mainly the following measures:

– Women with confirmed or suspected COVID-19 should be enabled to have an undisturbed physiological childbirth free of routine augmentation and/or routine surgical interventions. Caesarean section and/or other forms of instrumental delivery must be medically indicated and may only be performed with a prior informed consent of the woman concerned.
– Healthcare personnel that provide care to such women and their newborns must have a sufficient supply of appropriate protective equipment at their disposal and must be trained in its proper use. All measures designed to minimise the risk of healthcare staff being infected must be implemented with regard to maintaining the

63 See WORLD HEALTH ORGANIZATION: *Breastfeeding and COVID-19* of 23 June 2020, available at: https://www.who.int/news-room/commentaries/detail/breastfeeding-and-covid-19 (last visited on 27 July 2020).

highest level of professional standards and quality of provided care, the right of all women to a positive childbirth experience, and to women's and their children's human rights guaranteed by the Constitution and international treaties.

– Women with confirmed or suspected COVID-19 should be encouraged to practice skin-to-skin contact immediately after childbirth, to breastfeed, and to share a room with their infants for 24 hours a day throughout their hospitalisation. At the same time, women should be given sufficient information about the increased need for good respiratory hygiene and the proper use of protective equipment when in contact with their newborns. Regular disinfection of surfaces in the premises where the mother and her baby are staying is equally important.

The Ministry of Health of the Slovak Republic, the Public Health Authority of the Slovak Republic, and other bodies and institutions with supervisory tasks and responsibilities over the quality of healthcare provided in healthcare facilities across Slovakia should constantly follow and collect the most recent evidence-based childbirth-related knowledge, including in connection with the COVID-19 pandemic. Such knowledge should be regularly updated, and healthcare personnel must be familiarised with the correct procedures. Supervisory authorities have an obligation to require strict compliance with those procedures in practice.

About the Authors

Janka Debrecéniová holds a law degree from Matej Bel University in Banská Bystrica, Slovakia, a Magister Juris in European and Comparative Law degree from the University of Oxford, and a PhD from Trnava University in Trnava, Slovakia. Since 2000, she has been working for Citizen, Democracy and Accountability where she participates in the organisation's advocacy, litigation, publication, educational, and research projects, mainly in the fields of non-discrimination and equal treatment, the human rights of women, and gender equality. From 2009 to 2016, she was a member of the European Network of Legal Experts in the Non-Discrimination Field. In the last few years, she has provided various consultations in the field of reproductive rights to several bodies and institutions operating on both international and national levels, including to the Council of Europe Commissioner for Human Rights, the UN Special Rapporteur on violence against women, its causes and consequences, and the WHO. Among other publications, she is the editor and co-author of two reports on violations of the human rights of women in childbirth in healthcare facilities in Slovakia, in particular *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia* (Citizen, Democracy and Accountability, 2015), and *Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia* (Citizen, Democracy and Accountability, Women's Circles, 2016).

Miroslava Kotríková Rašmanová studied philosophy at the University of Ss. Cyril and Methodius in Trnava and at Charles University in Prague. Since 2011, she has been a member of the NGO Women's Circles. She is an activist, a lecturer, and an author of various texts and publications. She focuses on topics such as the international expert guidelines for maternity care and breastfeeding support, the ethical aspects of healthcare, and the reproductive rights of women. She co-authored the report *Analysis of Breastfeeding Support in Maternity Hospitals in Slovakia* (MAMILA and Women's Circles, 2015). She is also a co-author of the publication *Bonding – Born into a Mother's Arms* (Women's Circles, 2015). Currently she is a PhD student at the Olomouc University Social Health Institute.

Lýdia Marošiová is a sociologist who graduated with an M. A. from Comenius University in Bratislava. As a young scholar, she completed a two-semester fellowship of the Pew Charitable Trusts at the New School for Social Research in New York City (1995). Her professional journey has been strongly tied to two non-governmental think tanks: the Minority Rights Group – Slovakia (nowadays Citizen, Democracy and Accountability), and the Institute for Public Affairs, where she has developed her drive and sociological expertise in the political-cultural struggle in Slovakia related to making the voices of women, minorities, migrants and other groups heard. As a freelancer and a managing director of the research agency Krajinka, she conducted many projects with the problem-driven research approach used in civic advocacy and in (public) policies, but also in (political) marketing. Out of the publications and client reports that she (co-) authored, she considers successful those which thoroughly depict the experience perspective of people from vulnerable groups or other people who are not privileged and represented in various social contexts.

Občan, demokracia a zodpovednosť

www.odz.sk
www.diskriminacia.sk

Občan, demokracia a zodpovednosť (Citizen, Democracy and Accountability (CDA)) is a human-rights non-governmental organisation based in Slovakia with almost 30 years of experience. One of its main aims is to promote the rights to human dignity and the protection against discrimination, and especially the assertion of the human rights of women, including reproductive rights. In accordance with its mission, the organisation is focused on advocacy and litigation as well as educational activities and monitoring. In its work, CDA strives for positive changes in society with the aim of contributing to the fulfilment of the principle of the rule of law and the accountability of public authorities at all levels. Therefore, in the areas of its activity, the organisation is also involved in public policy-making and setting policy processes as well as monitoring implementation and compliance with human rights obligations.

Ženské kruhy

www.zenskekruhy.sk

Ženské kruhy (Women's Circles) is a human-rights non-governmental organisation founded in 2011 in Slovakia as a women's civic initiative with the goal of changing the state of healthcare for women with regard to pregnancy, birth, and puerperium. Within its mission, the organisation performs community, education, advocacy, and research activities. Activities are focused mainly on disseminating information concerning respectful maternity care and women's rights in childbirth.

In previous years, the organisations jointly issued these two publications on the violations of the human rights of women in the provision of childbirth care in Slovakia:

DEBRECÉNIOVÁ, J. (ed.); BABIAKOVÁ, K. – DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – KRIŠKOVÁ, Z. – SEKULOVÁ, M. – ŠUMŠALOVÁ, S.: *Ženy – Matky – Telá: Ľudské práva žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku*. [Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, 2015.

A full text of the publication is also available at http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf.

An English summary is available at
http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf.

DEBRECÉNIOVÁ, J. (ed.); DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – HREŠANOVÁ, E. – KRIŠKOVÁ, Z. – LAFFÉRSOVÁ, Z. – SEKULOVÁ, M.: *Ženy – Matky – Telá II: Systémové aspekty porušovania ľudských práv žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku*. [Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, Ženské kruhy, 2016.

A full text of the publication is also available at http://odz.sk/wp-content/uploads/ZMT2_systemove_apekty_v6_w.pdf.

An English summary is available at http://odz.sk/en/wp-content/uploads/ZMT2_SUMMARY_EN_final.pdf.

The publication you are now holding in your hands is yet another outcome of the several years of cooperation between two Slovakia-based non-governmental organisations, Citizen, Democracy and Accountability (*Občan, demokracia a zodpovednosť*) and Women's Circles (*Ženské kruhy*), towards promoting respect for the human rights of women in the provision of childbirth care. In their previous publications, *Women – Mothers – Bodies I* and *II*, these organisations documented and analysed a number of serious and systemic violations of women's human rights related to childbirth care provided in healthcare facilities in Slovakia.

This publication presents the results of monitoring designed, among other things, to identify and describe violations of the human rights of women in the provision of antenatal and childbirth care in healthcare facilities in Slovakia in the period from March to June 2020, a period often referred to as the first wave of the COVID-19 pandemic. The monitoring was carried out using several methods, the primary source of information being an internet survey of women about their experience with the provision of healthcare before, during and after childbirth during the said period.

The findings from the monitoring showed that the pregnancy- and childbirth-related violations of human rights and internationally recognised medical standards that had been documented prior to the present monitoring not only persisted during the first wave of the pandemic, but such violations were often either of much greater extent or intensity, or acquired new forms. Examples included denying the women in childbirth the right to have a companion of their choice present; not allowing them to practice skin-to-skin contact with their newborns directly after delivery with the justification that the (banned) birth companion was absent; or separating mothers from their newborns if the mothers tested positive for COVID-19 or developed symptoms. Yet another example was the dramatic deterioration in access to information for pregnant women. Hospitals' websites provided insufficient or no information at all on how childbirth care would be provided in the new, pandemic setting. However, there have also been many other violations, such as refusing to provide appropriate pain relief during childbirth due to the declared need to save on the hospital staff.

In the wake of the pandemic, Slovakia's institutionalised childbirth care system has once again proved not to be founded on human rights, the latest evidence-based scientific knowledge, and on the recommendations of internationally recognised professional organisations. The experience from the first wave of the pandemic confirms that the existing system has no real ambitions to satisfy the needs and rights of those whom it should serve in the first place. Quite the opposite, in situations where pregnant and birthing women and their newborns need special support and protection, the system is highly prone to harm them even more than before the pandemic.

This publication calls for solutions to problems that have been among the causes leading to violations of human rights in the provision of childbirth care in Slovakia over a long period of time and that have become even more pressing during the pandemic. At the same time, it presents specific recommendations for the State and its authorities to follow, and not only for the duration of the pandemic. These are proposals for measures based on human rights and medical standards whose implementation is a prerequisite for a functioning, women- and children-centred childbirth care system that respects and fulfils human rights. The necessity of re-thinking the long-term design of the childbirth care system in Slovakia in the context of the need for implementation of effective anti-epidemic measures is an opportunity to look at the systemic and highly normalised violations of human rights in the provision of childbirth care in a new light, and the findings contained in this study are a confirmation that the pandemic times are a suitable moment to launch systemic changes.

Občan, demokracia a zodpovednosť

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Ženské kruhy