

Maternal Health Care in the EU

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Report by *Make Mothers Matter*

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Introduction

The right to health and the right to maternal health are both human rights based on the core principle of dignity. The right to health is built on the fundamental elements of availability, accessibility, acceptability and of high quality of health care.¹

All of the major international legal instruments contain the cornerstone rights underlying the right to health care. These rights are the right to life, the right to privacy, the right to equal treatment and the right to health, which provides that every person should have access to adequate and affordable health care necessary to maintain health and well-being.

The EU in its priorities of the present Commission states that promoting social inclusion and combating poverty are core values of our European way of life.² Under the European Pillar of Social Rights, pillar 16 provides that everyone has the right to timely access affordable, preventive and curative health care of good quality.³

Despite those various international and European legal instruments addressing the right to maternal health care, numerous obstacles remain. Various studies and investigations on Universal Health Coverage in Europe identify certain institutional and organizational barriers in accessing maternal health care, including: *high out-of-pocket payments, language barriers and the absence of clear policies and information, a fear of being deported, the distances to medical facilities, and biases among health care professionals.*

One of the main issues relating to maternal health care, and a core focus of different human right bodies, is the global Maternal Mortality Ratio ("MMR"). Reducing maternal mortality has been a global health priority for some time, and has been reiterated as a core focus point in the Sustainable Development Goals. Although much progress has been made in reducing maternal mortality, significant disparities persist globally, as well as throughout the different regions of the European Union ("EU").

In addition to the core international legal instruments, Member States adopted both legislative and non-legislative measures aimed at enabling access to the health services to pregnant women in accordance with the principle of Universal Health Coverage.

¹ As per the General Comment on the Right to Health enshrined in the ICESCR, the right to health contains 4 elements: availability, accessibility, acceptability and quality, also named AAAQ framework. Acceptability means that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements Quality means that health facilities, goods and services must be scientifically and medically appropriate and of good quality.

² European Union priorities for 2019-2024, see https://europa.eu/european-union/about-eu/priorities_en

³ The European Pillar of Social Rights in 20 principles, see https://ec.europa.eu/info/european-pillar-social-rights/european-pillar-social-rights-20-principles_en



1. International and European legal framework

Human rights are universal and apply to everyone regardless of nationality, ethnicity, race, or any other social, economic or political affiliation. International human rights laws and standards guarantee access to affordable and quality health care for all. This includes access to maternal health care during pregnancy and after childbirth.

1.1. International legal framework

All European Member States are United Nations members, and thus have acceded to its core human rights treaties in which the right to health care and even more precisely sometimes the right to a maternal health care is addressed.

- The Universal Declaration of Human Rights⁴ includes health as part of the right to an adequate standard of living. More particularly, the Alinea 2 of article 25 entitles motherhood to special care and assistance.⁵

- The International Covenant on Economic, Social and Cultural Right guarantees the right of all persons to the highest attainable standard of health with its article 12.⁶

- The EU Member States (MS) are also part of the UN Convention on the Rights of the Child⁷, which provides in its article 24(2)(d) an explicit mention of the right to appropriate pre- and post-natal care for mothers.⁸

- The Convention on the Elimination of all forms of Discrimination Against Women (known as “International bill of rights for women”) does not specifically include the right to health as such but it provides protection to pregnant women and includes provisions addressing the right to access reproductive and maternity care. Specifically, article 12 contains specific provisions requiring governments to grant access to family planning and perinatal care, prohibits discrimination of women in the health care sector and guarantees women “*appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation*”.⁹ Moreover, article 14 focus on rural women, by placing an obligation on governments to provide access to adequate health care facilities, including information, counseling and services in family planning.

- One of the targets of the Sustainable Development Goals adopted by UN Member States in 2015 and that came into force in 2016 is to ensure healthy lives and promote well-being for all at all ages (goal 3).¹⁰ It specifically addresses maternal health care and aims to decrease maternal mortality placing an

⁴ UN General Assembly. Universal Declaration of Human Rights, 10 December 1948 (217 A (III)); Available at: <http://www.refworld.org/docid/3ae6b3712c.html>

⁵ Article 24(2) Universal Declaration of Human Rights: “Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.”

⁶ Article 12 ICESCR

⁷ United Nations. (n.d). Convention on the Rights of the Child. Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with Article 49. Geneva: Office of the High Commissioner for Human Rights. Retrieved 23 October 2019.

⁸ Article 24(2)(d) UN Convention on the Rights of the Child: (2) “States Parties shall pursue full implementation of this rights and, in particular, shall take appropriate measures: (d) to ensure appropriate pre-natal and post-natal health care for mother”

⁹ United Nations General Assembly: Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), GA Res 34/180, 34 UN GOAR Supp. (No.46) at 193, UN Doc. A/34/46, 1979.

¹⁰ Available at https://www.who.int/health-topics/sustainable-development-goals#tab=tab_1



obligation on countries to ensure less than 70 deaths per 100 000 live births across the world by 2030. In addition to that, countries should aim to achieve Universal Health Coverage, which ensures that people can obtain essential health services without incurring financial burdens and hardship. One other aim of the Agenda for Sustainable Development is to put the most marginalized and disempowered at its center and to ensure that no one is left behind.

All these international legal instruments contain four cornerstone rights, which guarantee the right to health care and the right to maternal health care. These rights are:

- *The right to life.* The most cardinal right attached to every human being, on which all other rights depend. All governments must not only refrain from taking life, but must also actively promote the conditions required for survival.
- *The right to privacy,* which protects every person's ability to make personal decisions related to their decisions related to their sexuality, reproductive health and their family planning, without government interference.
- *The right to equal treatment,* provides that every human being is entitled to exercise the full range of human rights without facing different treatment on the basis of personal characteristics. Infringement of this right persists to this day, especially with regards to vulnerable women and women from marginalized groups.
- *The right to health* which provides that every person (despite their race, ethnicity, religion, gender, etc...) should have access to adequate and affordable health care necessary to maintain health and well-being.

The right to health imposes three obligations on States:¹¹

To respect: obligation "to refrain from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and irregular immigrants to preventative, curative and palliative health services; to abstain from enforcing discriminatory practices as State policy; and to abstain from imposing discriminatory practices relating to people's health status and needs."

To protect: includes "the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties. States should also ensure that third parties do not limit peoples access to health-related information and services"

To fulfill: "give sufficient recognition to the right to health in national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. This obligation also requires the state to implement positive measures, including allocation of budgets and financial resources that enable and assist individuals and communities to enjoy the right to health. To ensure availability of and access to quality services without discrimination, a human rights-based approach also requires that the means to these ends should be participatory, inclusive, transparent and responsive"

¹¹ Leading the realization of human rights to health and through health: report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.



1.2. Laws and principles at a European level

The Charter of Fundamental Rights of the European Union¹², recognizes the right to access to preventative health care and right to benefit from medical treatment under the conditions established by national laws and policies. Thus, the right to health is not specifically included but it is guaranteed indirectly through diverse articles, notably the prohibition of inhumane and degrading treatment (article 3), the right to respect for private and family life (article 8) and prohibition against discrimination (article 14, Protocol 12. Article 1).

The 20 principles of the European Pillar of Social Rights dedicated an entire Chapter III to social protection and inclusion, having notably included the principle 16 guaranteeing for everyone a right to timely access to affordable, preventive and curative health care of good quality.¹³ This means that every person should have access to adequate and affordable health care as necessary to maintain health and well-being.

The communication of the European Commission of November 2020 proposes the first building blocks for a European Health Union, which “implements the obligation to ensure high level of human health protection as defined in the Charter of Fundamental Rights of the European Union” and describes the role of the EU actions in supporting the Member States to improve the resilience, accessibility and effectiveness of their health systems”.¹⁴

Otherwise, in order for Member States to provide equal access to health care, they must strive to achieve and provide Universal Health Coverage to all, as defined by WHO¹⁵, including equal access to quality health care that improves the health of patients and where seeking such care does not cause financial harm to those receiving it. European Universal Health Coverage would be paid for by society as a whole, with the goal to minimize the overall expense of acquiring health care. It also aims at spreading the costs and risks to ensure that those living in poverty can still access and get the medical care they require which they might not otherwise be able to afford.

However, studies show the existence of barriers in accessing maternal health care, undermining Universal Health Coverage across the EU, these *include high out-of-pocket payments, language barriers and the absence of clear policies and information, a fear of being deported, the distances to medical facilities, and biases among health care professionals*. The various types of national health systems- insurance based or universal coverage- within the MS, accompanied by major differences in laws and policies between MS place vulnerable groups such as undocumented migrant women, Roman women and other minority groups at risk of not receiving adequate medical care when needed.

Member States have adopted both legislative and non-legislative measures aimed at enabling access to the health services to pregnant women in accordance with the principle of Universal Health Coverage.

2. Current challenges

¹² Charter of Fundamental Rights of the European Union, 18 December 2000, Official Journal of the European Communities (2000/C 364/01; Available at: http://www.europarl.europa.eu/charter/pdf/text_en.pdf

¹³ Principle 16 on Health Care, Chapter III on Social protection and inclusion “*Everyone has the right to timely access to affordable, preventive and curative health care of good quality*”, see https://ec.europa.eu/info/strategy/priorities-2019-2024/economy-works-people/jobs-growth-and-investment/european-pillar-social-rights/european-pillar-social-rights-20-principles_en

¹⁴ Building a European Health Union: Reinforcing the EU’s resilience for cross-border health threats, 11.11.20, see <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52020DC0724>

¹⁵ WHO – Universal Health Coverage, see https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

2.1. Maternal Mortality Ratio

One of the main issues relating to maternal health care, and a core focus of different human right bodies, is the global Maternal Mortality Ratio (MMR), which is defined by WHO as deaths due to complications from pregnancy and childbirth. Significant disparities persist globally, as well as throughout the different regions of the European Union. There is especially a stark contrast between Western and Eastern European Member States.¹⁶ Some Eastern European Members States including Hungary, Latvia and Romania the MMR rate is 2-4 higher than the EU average (estimated to be 10 deaths per 100,000 live births).¹⁷

The 2007 Confidential Enquiry into Maternal and Child Deaths¹⁸ reported that maternal deaths were seven times more likely to occur to women living in the poorest circumstances. These women mostly represent migrants, asylum seekers or minority groups. Indeed, throughout the European region, perinatal mortality rates vary by social and ethnic group, with migrants tending to be the most disadvantaged group. MMR for immigrant women is much higher in countries such as the Netherlands, Germany, Finland and Denmark.¹⁹

The disparities among the Member States can be attributed to various factors, the main factors being unequal access to maternal health care, discriminatory attitudes by health care professionals and unreliability of reported data. Most maternal deaths are preventable if births are attended by skilled health care professionals who are properly educated, with access to proper equipment; if there is adequate investment in health care centers including midwifery care or if pregnant women are granted regular access to maternal health care, including universal access to midwifery care.²⁰ To reduce MMR, sound investment in and universal access to midwifery care is essential.

2.2. Unequal access

Various studies and investigations on Universal Health Coverage in Europe have identified institutional and organisational barriers in accessing maternal health care in Europe. People who have the most difficulties accessing health care in at least half of Member States, are mainly the rural population, the elderly, the less mobile and the vulnerable women including pregnant women but also migrants and refugees, who avoid seeking care because of the many barriers in accessing maternal health care.

2.2.1. Affordability of maternal care

According to the Centre for Reproductive Rights Report of 2018, the single most important factor behind not accessing maternal medical services in the EU countries is the affordability of maternal care due to high out of pocket payments.²¹ Moreover, there are problems related to the existence of "informal"²²

¹⁶ Miteniece, E., Pavlova, M., Rechel, B., Groot, W, *Barriers to accessing adequate maternal care in Central and Eastern European countries: A systematic literature review*, *Social Science & Medicine* (2017), doi: 10.1016/j.socscimed.2017.01.049.

¹⁷ Ibid.

¹⁸ WHO – Maternal Mortality, see <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>

¹⁹ Rechel B. et al, Mladovsky P., Deville W., Rijks B., Pterova-Benedict R., McKee M, *European Observatory on Health Systems and Policies Series: Migration and health in the European Union* (2011).

²⁰ "What are the most effective interventions during pregnancy for preventing stillbirth?", Cochrane org., available at: <https://www.cochrane.org/news/what-are-most-effective-interventions-during-pregnancy-preventing-stillbirth>

²¹ Center for Reproductive Rights, *Perilous Pregnancies: Barriers in access to affordable Maternal Health Care for Undocumented Migrant Women in the European Union* (2018), available at: https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/CRO/INT_CCPR_CSS_CRO_37141_E.pdf

²² Mishtal, J. (2010). Neoliberal reforms and privatisation of reproductive health services in post-socialist Poland. *Reprod Health Matters*, Mishtal, J. (2010). 18(36), 56-66. doi: 10.1016/s0968-8080(10)36524-4.



payments to health care professionals in Central and Eastern Europe, that pregnant women are asked to make. These informal payments seem to be more common in the maternal sector due to the planned nature of care and the prolonged contact with health care professionals²³.

The lack of financial means equally affects native-born as well as migrant mothers.²⁴

Poor financial planning on the part of governments causes another type of limitation of maternal care. One example is Romania where even though there is a constitutional right for every woman, irrespective of whether she is a taxpayer or not, to have access to basic maternal healthcare services, the government sets a monthly budget limit for hospitals for such services preventing many mothers, who do not make that limit, from getting essential monitoring and blood tests, month after month²⁵.

In numerous Member States, however, such issues have already been tackled through both legislative and non-legislative measures aimed at enabling access to health services for pregnant women in accordance with the principle of Universal Health Coverage.

2.2.2. Lack of information and linguistic barriers

Language barriers and the absence of clear policies and information available in various languages create a problem on the access, which leaves migrant women uninformed about the procedure to follow.²⁶ The lack of adequate interpreters often leads to interruption of treatment or to other dangerous situations in which consent to medical interventions is granted without properly understanding them.

2.2.3. Fear of deportation

Because of fear of being reported to authorities, many women, notably migrant women, avoid seeking any antenatal care. This in spite that in some countries such as Portugal, Spain, France, Italy, The Netherlands, the Czech Republic, Denmark and Norway, it is prohibited for health care professionals to report the immigration status of their patients. In other countries such as Sweden, Slovenia, UK, Croatia and Germany, health professionals are required to report the immigration status of their patients. The guarantee of a privacy of information about the migration status of pregnant women would be an important measure to introduce, to focus more on maternal health care rather than migration status.

2.2.4. Geographical distance

Geographical distances to medical facilities may be an issue to access adequate and timely maternal health care. Some Central and Eastern European countries still struggle with ensuring geographical accessibility of services because of lack of maternal wards in rural areas and because no public transport exist between these areas.²⁷

Romania²⁸, for example, reports a staggering number of women who have their first contact with a medical professional when already in labor: in almost a quarter of all yearly births, women report not

²³ Parkhurst, J. O., Penn-Kekana, L., Blaauw, D., Balabanova, D., Danishevski, K., Rahman, S. A., Ssengooba, F. (2005). Health systems factors influencing maternal health services: a four-country comparison. *Health Policy*, 73(2), pp. 127-138.

²⁴ Expert Panel on effective ways of investing in Health (EXPH), Preliminary Report on Access to Health Services in the European Union.

²⁵ According to our member Mame Pentru Mame, see <https://mamepentrumame.ro> EN site and see <https://mamepentrumame.ro/mothers-for-mothers-association/>

²⁶ Policy Department for Citizens' Rights and Constitutional Affairs Directorate General for Internal Policies of the Union PE 608.874, Access to maternal health and midwifery for vulnerable groups in the EU, Woman's rights and gender equality, April 2019.

²⁷ Miteniece, E., and al. (2017)

²⁸ World Vision report on the barriers mothers meet in seeking medical services (2016), available at: <https://blog.worldvision.ro/wp-content/uploads/2016/09/Raport-sintetic-studiu-calitativ-Bariere-accesare-servicii-medicale-prenatale-si-de-PF-edited.pdf>



having had access to any prenatal checkup. The main reason for this is the geographical distance to the nearest medical facility. The closing down of small community hospitals and clinics for lack of funding and medical personnel has caused a narrowing of access to essential healthcare services for women. Transport fares to the nearest medical facility are indeed a barrier for many poor rural women to attend regular medical checkups during pregnancy.

2.3. Maternal mental health

MMM is a partner of the Cost Action research funded project, Riseup PPD (Peripartum Depression), which aims at filling gaps in Peripartum Depression Disorder research, practice, and social awareness by reviewing cutting-edge research on standardized diagnostic criteria, screening tools, and efficacy and cost-effectiveness of prevention and treatment programs.²⁹

Research of the Cost Action Riseup PPD reveals that pregnancy and the first year postpartum – referred to as the peripartum period – constitute a period of tremendous physiological, psychological, and social changes in women's lives. It is now well-established that the transition to motherhood is increasing women's vulnerability to the development of mental disorders.³⁰ The most prevalent peripartum mental health problems globally are depression and anxiety³¹. Research of the Cost Action Riseup PPD shows that 1 in 5 women will develop a mental illness in the perinatal period.³² It adversely affects the mother and her overall health, the infant's health and development, disrupting mother-infant dyad and family relationships. Furthermore, it puts a strong burden on society as a whole.³³ Additionally, the lack of knowledge surrounding mental illnesses are significant barriers to accessing healthcare, leading mothers to suffer in silence.

Deprioritising mental health prevention and screening programs comes with a heavy cost: new-mothers affected by severe postnatal depression are at a high risk of suicide and infanticide. Maintaining unrealistic standards and popular beliefs about how women should feel nothing but joy and serenity when becoming mothers while dismissing or even condemning perfectly legitimate manifestations of exhaustion, dissatisfaction and unhappiness discourages mothers to ask for help when in a dire mental state and even prevents immediate family to do so.

A specific task-force on 'Perinatal Mental Health and the COVID-19 Pandemic' within the EU funded project Cost Action Riseup PPD has been set up to understand the impact of COVID-19 pandemic on the psychological well-being of pregnant women and new mothers.³⁴ The scarce evidence indicates negative effects on pregnant and postpartum women's (PPW) mental health. The presence of a social and health crisis poses tremendous psychological demands in women already experiencing a very vulnerable and critical period, as is the case of pregnancy and postpartum.

²⁹ Rise up PPD, *Research Innovation and Sustainable Pan-European Network in Peripartum Depression*, see <https://www.riseupppd18138.com>

³⁰ Riseup-PPD COST ACTION (CA18138), *World Maternal Mental Health Day 2021*, see https://www.riseupppd18138.com/uploads/2/6/9/7/26978228/wmmhd_21statement.pdf

³¹ Fawcett E. J., Fairbrother N., Cox M. L., White I. R. & Fawcett J. M. (2019). *The prevalence of anxiety disorders during pregnancy and the postpartum period*. *Journal of Clinical Psychiatry*, available at: <https://doi.org/10.4088/JCP.18r12527>

³² Rise up PPD, *Research Innovation and Sustainable Pan-European Network in Peripartum Depression*, see <https://www.riseupppd18138.com>
Another research paper of the Cost Action Riseup PPD: *Emerging issues and questions on peripartum depression prevention, diagnosis and treatment: A consensus report from the COST Action RISEUP-PPD*, May 2020, *Journal of Affective Disorders*, available at: https://www.sciencedirect.com/science/article/abs/pii/S0165032720302196?dgcid=rss_sd_allhttps://www.sciencedirect.com/science/article/abs/pii/S0165032720302196?dgcid=rss_sd_all

³³ Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems*. London: Center for Mental Health and London School of Economics.

³⁴ Rise up PPD -Covid-19, *Investigation of impact of Covid-19 pandemic in perinatal mental health*, see <https://momsduringcovid.org/fr/> and <https://www.riseupppd18138.com/covid-19-taskforce.html>



The task force aims to review the best practices that are mitigating the negative impact of COVID-19 on women's perinatal mental health and to support research activities aimed at evaluating and promoting the wellbeing of mothers and their families. An international study is underway on pregnant and postpartum women in 13 different countries. Some more up to date information will be published in the coming months.

The cost action Riseup-PPD has also become a global partner of the World Maternal Mental Health Day (WMMH Day) campaign to raise awareness and enforce changes in peripartum mental health. The key message of the campaign is that maternal mental health matters, and that women, as well as their family and friends, need to recognize the signs of maternal mental problems and that they are not alone.

2.4. Impact of COVID-19

2.4.1. Lockdown measures and transport disruptions

Maternal health care has also been impacted by the recent corona virus ("COVID-19") pandemic. The COVID-19 pandemic poses considerable challenges for countries to provide quality essential health care, including maternal and newborn health services. Pregnant women face challenges and barriers in accessing safe maternal health care due to lockdown measures and transport disruptions. Additionally, they experience anxieties over the possibility of being exposed to the corona virus.³⁵

Measures implemented in response to the outburst of the COVID-19 pandemic made it difficult for many pregnant women to reach health care facilities.³⁶ The COVID-19 pandemic has pushed many health systems to the brink, resulting in non-urgent care being deprioritised due to thousands of COVID-19 patients being admitted and most hospitals being suddenly transformed into COVID-19 care centres. As a result of overcrowded hospitals, some pregnant women have been forced to travel to distant hospitals for check-ups and perinatal examinations, such as screening tests, or have had to replace in-person check-ups with online consultations.

Additionally, even those women who managed to reach health facilities have reported not receiving timely care. Some facilities experienced a shortage of health care professionals, as many were treating COVID-19 patients. In other centres, maternal health services were cut back despite being classified as essential services. As a result, a considerable rise in maternal mortality globally is expected over the next six months.

A tragic case to serve as warning of how unprepared for a health crisis some member states were comes once again from Romania where an outbreak of Coronavirus among medical staff was so severe it made to closed down all the maternity-hospitals in one of the biggest cities in the north-eastern part of the country leaving pregnant women in panic. Desperate and without guidance some considered unassisted homebirth (homebirth is not regulated in Romania, medical professionals do not have license to assist

³⁵ UNICEF, *Maternal and newborn health and COVID-19*, May 2020, available at: <https://data.unicef.org/topic/maternal-health/covid-19/>

³⁶ Smriti P., Saugat K., Madhusudan S., Ejms K. A., Access to Maternal Health Services during COVID-19, July 2020, *Europasian Journal of Medical Sciences* 2(2):48-52, available at: https://www.researchgate.net/publication/344451173_Access_to_Maternal_Health_Services_during_COVID-19



homebirths) while others were left with no other option but to drive 100 km to the nearest maternity in neighboring cities.³⁷

2.4.2. *Effects of COVID19 on physical and mental health*

Early 2021, The Lancet published a study³⁸ in which a worldwide systematic review and meta-analysis of 40 studies in 17 countries on the effects of the pandemic on maternal, fetal, and neonatal outcomes was performed. Some European countries participated: Denmark, Ireland, Italy, The Netherlands and UK. Its findings are twofold.

First, it found worldwide an increase in maternal mortality and stillbirth, maternal stress, and ruptured ectopic pregnancies during the pandemic compared with before the pandemic. This echoes a new study from the Oxford University found out that Women with COVID-19 during pregnancy were over 50% more likely to experience pregnancy complications compared to pregnant women unaffected by COVID-19. They are at higher risk of complications such as premature birth, high blood pressure with organ failure risk, need for intensive care and possible death.³⁹

Second, The Lancet study observes a significant harm to maternal mental health. Of the 10 studies included in the analysis that reported on maternal mental health, six found an increase in postnatal depression, maternal anxiety, or both. In the same line, UNICEF also highlights the abnormally high anxiety as well as isolation suffered by women during the pandemic.⁴⁰

The study gives as proposed explanation for the increase in adverse pregnancy outcomes the reduced access to care. Although maternal anxiety was consistently shown to be increased during the pandemic, health-care providers around the world have reported reduced attendance for routine and unscheduled pregnancy care. This reduction could be driven by concern about the risk of acquiring COVID-19 in health-care settings, governmental advice to stay at home, or reduced public transport and childcare access during lockdowns. In HICs, much of routine care was rapidly restructured and delivered remotely using diverse models, including telephone or video-based appointments. Although technology can provide a COVID-19-secure path to continuity of antenatal care, there remains inequality of access for people without regular access to high-speed internet or privacy in their living space.

Wider societal changes are also echoed in observed changes in maternal health. Intimate-partner violence, already a leading cause of maternal death, has increased during the pandemic and has already been highlighted as a contributor to increased maternal mortality. Women have been disproportionately more likely to both become unemployed and take on more childcare because of nursery and school closures. The resultant financial and time constraints are likely to have far-reaching consequences for mothers' physical, emotional, and financial health during pregnancy and in the future.

MMM agrees with The Lancet study when it states that "women's health-care is often adversely affected in humanitarian disasters and the authors recall the need to plan and provide for robust maternity

³⁷ DIGI24 Ro, 25 March 2020, available at: <https://www.digi24.ro/stiri/actualitate/sanatate/suceava-devine-cel-mai-mare-focar-de-coronavirus-din-romania-nelu-tataru-pesto-170-de-medici-si-pacienti-sunt-infectati-1280841>

³⁸ *Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis, March 2021, The Lancet*, available at: <https://www.thelancet.com/action/showPdf?pii=S2214-109X%2821%2900079-6>

³⁹ *Research uncovers high risk to pregnant women from COVID-19*, April 2021, *Oxford University*, available at: <https://www.ox.ac.uk/news/2021-04-23-research-uncovers-high-risk-pregnant-women-covid-19>

⁴⁰ UNICEF, *Maternal and newborn health and COVID-19*, May 2020, available at: <https://data.unicef.org/topic/maternal-health/covid-19/>



services in any emergency response".⁴¹ Indeed, in the interests of safety, new practices are being adopted by perinatal health care services that seem to contrast with respectful and supported birth and postpartum period, negatively impacting new mothers' mental health and consequently their newborn. Emerging evidence shows that perinatal mental disorders have increased since the COVID-19 outbreak, suggesting that COVID-19 may place an additional burden on perinatal women, with potential adverse outcomes on their mental health.⁴²

Health-care providers planning for service delivery in the ongoing pandemic must consider how to establish robust antenatal and postnatal care pathways that explicitly reach out to vulnerable individuals and communities.

2.5. Discriminatory attitudes

2.5.1. *Biases among health care professionals*

Disparities in accessing health care services are also influenced by cultural and religious diversity. For example, studies show that Islamophobia often influences the way Muslim patients are depicted and how maternity care policies tend to be "faith-blind".

There is also a constant discrimination of Roma women seeking maternal care in the Balkan countries, who are often denied services and forced to give birth on their own and are also regularly verbally abused and disrespected by medical professionals. For example, in Bulgaria, it is reported that Roma women are required to bring their own consumables while other women are not⁴³.

2.5.2. *Disrespectful practices*

Disrespectful practices at health care facilities are reported on a daily basis. This includes discriminatory practices, physical abuse and abandonment. These practices violate women's rights to respectful maternal care,⁴⁴ as well as their rights to life, bodily integrity and freedom from discrimination.

As analyzed by Ms Simonovic, Dubravka, Special Rapporteur on Violence against Women, these disrespectful acts include discriminatory practices, physical abuse (such as unnecessary episiotomy, caesarean procedures, use of force, such as abdominal compression, e.g.) and abandonment (long delay in receiving care).⁴⁵ Make Mothers Matters had the opportunity to contribute to the report of Ms Dubravka in May 2019. Our report, gathered the voices of its members and partners, on mistreatment and violence against women during reproductive health care with a focus on childbirth.

There are reported cases of physical abuse when it comes to maternal health care, concerning the most vulnerable groups, who are in the majority of cases, minors, unmarried women and migrants, and other

⁴¹ *Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis, March 2021, The Lancet*, p.13.

⁴² Motrico, E., Mateus, V., Bina, R., Felice, E., Bramante, A., Kalcev, G., Mauri, M., Martins, S., & Mesquita, A. (2020). *Good Practices in Perinatal Mental Health during the COVID-19 Pandemic: A Report from Task-Force RISEUP-PPD COVID-19*. *Clínica y Salud*, 31(3), 155–160, available at: <https://doi.org/10.5093/clysa2020a26>

⁴³ Colombini, M., Rechel, B., & Mayhew, S. H. (2012). *Access of Roma to sexual and reproductive health services: qualitative findings from Albania, Bulgaria and Macedonia*. *Glob Public Health*, 7(5), 522-534, available at: <https://pubmed.ncbi.nlm.nih.gov/22175646/>

⁴⁴ WHO, *Policy Brief on preconception care*, see

https://www.who.int/maternal_child_adolescent/documents/preconception_care_policy_brief.pdf

⁴⁵ Report of the UN Special Rapporteur on violence against women of 2019, see <https://digitallibrary.un.org/record/3823698>



minority groups, as reported in 2014 by WHO.⁴⁶ This abuse could be manifested in many different ways, such as obstetric or gynecological violence against women, negligent, reckless, discriminatory, and disrespectful acts by health professionals and legitimized by the symbolic relations of power that naturalize and trivialize their occurrence. To cite some: episiotomies without consent, the use of unnecessary force such as abdominal compression, the lack of information on the procedures, an excessive or inappropriate vaginal touching during birth or when anaesthetized.⁴⁷

Some countries worldwide have taken measures to ban these practices. In Europe, Luxembourg has called for an integration of obstetric and gynecological practices into health education, while Poland has introduced a regulation on perinatal care provided by gynecological and obstetric hospitals. However, those legal documents do not define instruments for monitoring the degree of compliance with these principles.⁴⁸

Finally, an important problem is the neglect and the abandonment during labor.⁴⁹ Women suffer from long waiting times which makes them perceive themselves as a nuisance, and feel ignored during deliver. This is sometimes due to a poor rapport with health care professionals. Many women experience insufficient communication with health professionals, including inadequate clarification or explanations regarding the ordinary procedures.

2.6. Threatening safe access to maternal health

Despite commendable efforts to improve women's right to health, various countries have implemented policies violating the very principles and laws guaranteeing access to maternal health care.

In Croatia⁵⁰ and the Czech Republic,⁵¹ for example there is a recent ban on the assistance of a midwife during home birth, making homebirth almost impossible in practice and increasing the risks for mothers. In the Czech Republic, the Grand Chamber has recently decided that a law prohibiting the assistance of a midwife during home births did not violate the right to respect for private and family life under article 8 of European Court of Human Rights (ECHR). A similar case from Romania was taken to the European Court of Human Rights (ECHR), without a positive outcome for the mother (the ECHR held that the mother in case had not exhausted all the legal procedures at national level).⁵²

Under Croatian law, health professionals, including midwives, are prohibited from assisting with home births. Croatian law puts pregnant women wishing to deliver at home at risk.⁵³ This is even more important in this period of Covid-19, when there are more deliveries at home.

⁴⁶ WHO, *Health 2020 – A European policy framework and strategy for the 21st century*, see https://www.euro.who.int/data/assets/pdf_file/0011/199532/Health2020-Long.pdf?ua=1

⁴⁷ DW, *Women around the world face widespread abuse during childbirth*, 25 Nov 2019, available at: <https://www.dw.com/en/women-around-the-world-face-widespread-abuse-during-childbirth/a-51393868>

⁴⁸ Rozporządzenie Ministra Zdrowia z dnia 16 sierpnia 2018 r. w sprawie standardu organizacyjnego opieki okołoporodowej, see <http://isap.sejm.gov.pl/isap.nsf/download.xsp/WDU20180001756/O/D20181756.pdf>. See further: <http://prawo.sejm.gov.pl/isap.nsf/download.xsp/WDU20180001756/O/D20181756.pdf>.

⁴⁹ Bohren M.A., *Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*, *PLoS Med.* 2015 Jun; 12(6), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4488322/>.

⁵⁰ Application no. 18568/12, lodged on 9 February 2012.

⁵¹ Application nos. 28859/11 and 28473/12, lodged on 11 December 2014. See https://www.echr.coe.int/documents/fs_reproductive_eng.pdf

⁵² The full decision can be consulted at [https://hudoc.echr.coe.int/eng#{\"fulltext\":\[\"42594/14\"\],\"languageisocode\":\[\"ENG\"\],\"documentcollectionid2\":\[\"JUDGMENTS\",\"DECISIONS\",\"COMMUNICATEDCASES\"\],\"itemid\":\[\"001-194387\"\]](https://hudoc.echr.coe.int/eng#{\)

⁵³ Case of POJATINA v. CROATIA – European Court of Human Rights, First Section. Judgement Strasbourg: 4 October 2018, Final Judgement 04/02/2019



3. Good practices and positive legislative action

In the field of maternal health care, many good practices have been adopted by Member States, aiming at help all mothers and also more specific minority groups.

3.1. Best practices on maternal health care

Norway is one of the most inclusive countries for pregnant women. All pregnant women have the right to access prenatal care, care during childbirth as well as post-natal care. In this way, they have implemented an equal right to access, including for immigrants and asylum seekers. Prenatal care and all care related to the pregnancy and delivery of the child is free for all.

In the Netherlands, the healthcare system is known for being very accessible to all people offering an evenly distributed geographical coverage. Maternal care is regulated under the Health Care Insurance Act. A general practitioner or midwife can generally be reached within a few minutes.

Prenatal care in Germany is regulated by law and supported by directives and standard procedures in the Maternity Guidelines (*Mutterschafts-Richtlinien*). The Prenatal care is based on a nationwide program of care and every pregnant woman in Germany has a statutory right to medical care.⁵⁴

In Romania health coverage is not "*universal*" and great socio-economic inequalities persist. There is some progress with the introduction of a plan granting pregnant women and postpartum mothers special rights within the social health insurance systems. Women who qualify for the plan (usually because they have no income) are insured without having to pay the insurance premium or the co-payments. They are also entitled to free ambulatory treatment and transport to the hospital for delivery and emergencies.⁵⁵ Romania has also introduced the National Anti-Poverty and Social Inclusion Plan addressing the inequalities of the health care system and provide for better access to the health care system. This includes maternal care for deprived groups: people living in rural areas, the unemployed, and marginalized Roma communities. Despite these measures, Romanian rural women still face many health disadvantages, as detailed in section 2.2.1 and 2.2.4.

3.2. Legislative practices related to vulnerable groups

Member States across the EU have taken different approaches to regulating access to maternal health care for certain groups of women but, in particular, undocumented migrant women. Two approaches have been identified.

The first consists of a group of Member States (Belgium, Estonia, France, Germany, Greece, Italy, Ireland, the Netherlands, Portugal, Romania Spain and Sweden) that have implemented laws and policies providing undocumented migrant women with full access to maternal health care either free of charge or at a subsidized rate.

- The Netherlands provides health care coverage for undocumented migrants living in the Netherlands, which includes emergency services and care, and access to primary and

⁵⁴ Vetter K, Groeckenjan M., Prenatal care in Germany, Dec 2013, PubMed, available at: <https://pubmed.ncbi.nlm.nih.gov/24337130/>

⁵⁵ Vlădescu C, Scîntee G, Olsavszky V, Allin S and Mladovsky P, *Romania: Health system review*, *Health Systems in Transition*, 2008; 10(3): 1-172.



secondary care as well.

- Germany has adopted the Refugee Benefits Act for asylum seekers, for persons granted discretionary leave to remain, and for other foreigners with only temporary permission to remain in Germany. It stipulates that the "costs of medical and nursing assistance as well as support, midwifery care, medications, dressings and medical aids for expecting mothers and during the postnatal period are covered by the state, as long as they meet the required criteria"⁵⁶. Despite this coverage, however, undocumented migrant women do not have insured access to maternal health care as they are not allowed to be insured by the Health Insurances. An alternative is to pay for the services out-of-pocket, which is often not an option for women who typically do not have a source of income.
- According to our member Irish Maternity Support Network⁵⁷, under the Irish legislation⁵⁸, public maternity care is provided free of charge to all resident in Ireland. Private options are also available within public facilities for those who wish to avail of it. Poor infrastructure and lack of investment limit access to certain options (such as homebirth and scans) rather than laws. However, in certain cases, notably hyperemesis gravidarum and gestational diabetes medication is not provided and women must cover the costs of some of these medications themselves.
- Under Spanish local laws, all migrants are entitled to the same health care coverage as nationals with one condition: migrants have to register in the "local civil registry" in order to obtain their individual health card. This condition does not apply to pregnant women. However, there have been situations where migrants could not comply with this condition, as they had no habitual residence. Thus, they have no access to health care. Some regions have developed more welcoming systems, granting undocumented migrants health cards without requiring prior registration in the civil registry.⁵⁹

The second group of Member States (Austria, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Finland, Hungary, Latvia, Lithuania, Luxembourg, Malta, Poland, Slovakia, Slovenia and the UK) have laws and policies that prevent easy and quick access to affordable maternal health care, and require women to cover some or all of the costs themselves.

3.3. Non legislative practices on maternal health

Many non-legislative actions have been put forward by Member States as an efficient way to raise awareness about the importance of maternal health care. This includes lobbying, setting up information points, and making information accessible to a wider public, including various age, ethnic and religious groups.

Some of the good practices implemented in various Member States are:

- Raising awareness through government-backed projects
A very effective way to encourage women to know their rights and to seek help or

⁵⁶ *Asylbewerberleistungsgesetz in der Fassung der Bekanntmachung vom 5. August 1997 (BGBl. I S. 2022), das zuletzt durch Artikel 18 des Gesetzes vom 12. Juni 2020 geändert worden ist*, available at: <https://www.gesetze-im-internet.de/asylblg/BJNR107410993.html>

⁵⁸ The Maternity and Infant scheme is legislation implemented in 1954 under the Health Act 1953, subject to subsequent amendments and is contained in sections 62 and 63 of the Health Act 1970, available at: [Health Act, 1970 \(irishstatutebook.ie\)](https://www.irishstatutebook.ie/eli/1970/act-1/section-62)

⁵⁹ Rechel B. et al, European Observatory on Health Systems and Policies Series (2011).



assistance is via nation-wide campaigns. The UK, for example, organized an *awareness week* in May 2020 with a special focus on maternal mental health during difficult times.⁶⁰ Another example is the global *campaign "World Maternal Mental Health Day"*,⁶¹ held on 5 May 2021. The cost action Riseup-PPD, became a global partner of this campaign to raise awareness and enforce changes in peripartum mental health, drawing the attention to the fact that worldwide 20% of women experience some type of perinatal mood and anxiety disorder (PMAD). Although statistics vary by country, this is a global concern. The key message of the campaign is that maternal mental health matters, and that women, as well as their family and friends, need to recognize the signs of maternal mental problems and that they are not alone.

- Training programs and protocols
In order to reduce the MMR, health care professionals should be adequately trained. The trainings should focus on the skills of the health care professionals and on effective communication strategies and leadership. Further, it is essential that practitioners are properly trained on how to use available technology and equipment.
- Actions directed at closing barriers to maternal health for migrants
Studies and research have shown that migrant mothers are in a particularly vulnerable position with regard to pre- and post-natal health care. Some Member States have already adopted various measures in this sense. These include, training and communication programs in order to improve the intercultural competence of hospital staff. Austria and Portugal have training and communication programs in order to improve this.⁶² Similarly, in Finland, the PALOMA program is serving as an online training program disseminating information about refugees and ways to support their well-being.⁶³

Other countries have focused on the availability of information. In Germany, various leaflets and telephone services are available in migrants' languages. Similarly, in Italy, a special health program called CARE has been created to assist migrant mothers increase their health literacy. Malta, Greece, Croatia and Slovenia have launched similar programs, and available material is translated into languages such as Arabic, Farsi, Tigrinya. It is distributed to migrants, refugee centers and health access points.⁶⁴

Another rather unique measure is the introduction of anonymized health insurance vouchers, used by the Federal State of Berlin, Germany, entitling undocumented migrants to assistance, which they can use without being reported.⁶⁵

- Civil society solidarity programs
The program *SAMAS for better and for worse* from a Romanian NGO, devised a national free lactation counseling service to help COVID19-positive new mothers maintain their

⁶⁰ Available at: <https://ihv.org.uk/news-and-views/news/uk-maternal-mental-health-awareness-week-4-10-may-2020/> (Last accessed on 30 November 2020).

⁶¹ Riseup-PPD COST ACTION (CA18138), World Maternal Mental Health Day 2021, https://www.riseupppd18138.com/uploads/2/6/9/7/26978228/wmmhd_21statement.pdf

⁶² Policy Department for Citizens' Rights and Constitutional Affairs, Directorate General for Internal Policies of the Union PE 608.874 – April 2021, *Access to Maternal health and midwifery for vulnerable groups in the EU. Women's Rights and Gender equality*.

⁶³ Available at: <https://thl.fi/en/web/immigrants-and-multiculturalism> (Last accessed on 1 December 2020).

⁶⁴ Available at: <https://www.inmp.it/eng/content/view/full/15369> (Last accessed on 1 December 2020).

⁶⁵ Flegar V, Dallí M, Toebes B, *Access to Preventive Health Care for Undocumented Migrants: a comparative study of Germany, the Netherlands and Spain from a Human Rights Perspective*, in *Laws 5* (2016), 9, available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2749197



lactation active until they are reunited with their babies. Providing, also free of charge, professional psychological counseling to help mothers cope with the anxiety of separation from their newborns. The program, without funds from public sources, has helped hundreds of women and has demonstrated how much civil society can assist during a crisis.⁶⁶

⁶⁶ The program Samas by the NGO Mame Pentru Mame is featured at page 25 on <https://en.calameo.com/read/00640963797a5c2db66a3>.



Conclusion

Although Europe is considered one of the safest regions in the world to give birth, disparities regarding safe access to health care persist between the various Member States.

It has been reported that the main barriers in accessing maternal health care in Europe are *high out-of-pocket payments, language barriers and the absence of clear policies and information, a fear of being deported, the distances to medical facilities, and biases among health care professionals*. Additionally, pregnant women face other challenges, namely challenges related to disrespectful practices in health care facilities, such as physical abuse, abandonment and neglect during labor. Maternal death is more likely to occur to women living in the poorest circumstances.

On top of that, the current COVID-19 pandemic reinforces the anxieties amongst pregnant women and hinders timely access to health care services.

In order to overcome the biggest obstacles preventing women from safe access to maternal health care, all Member States have not only acceded to the core UN human rights treaties but also committed themselves to achieve the goals set out in the UN 2030 Agenda for Sustainable Development.

Member States have adopted both legislative and non-legislative measures aimed at enabling access to health services for pregnant women in accordance with the principle of Universal Health Coverage. As outlined in this report, an exemplary country is Norway, where all women have the right to access: (i) perinatal care, (ii) care during childbirth, and (iii) post-natal care. Another country is Germany, where prenatal care is regulated by law and supported by directives and standard procedures.

Alongside the legislative proposals put forward by certain Member States, another efficient way in raising awareness on the importance of maternal health care is by adopting non-legislative methods, such as lobbying, setting up information points and making information accessible to a wider public. This is notably what Make Mothers Matters and its members pursue and will continue to advocate for.
