“Trauma, abandonment and isolation”:

Experiences of pregnancy and maternity services in Scotland during COVID-19

ENGENDER

Health and Social Care ACADEMY

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Contents

Executive summary

1. Executive summary

This report sets out experiences of accessing pregnancy and maternity services in Scotland at the height of the Covid-19 pandemic between March 2020 and November 2022. The purpose of the research is to inform and influence the Covid-19 Inquiry through a series of recommendations. We also highlight pre-existing systemic issues that were raised by women.

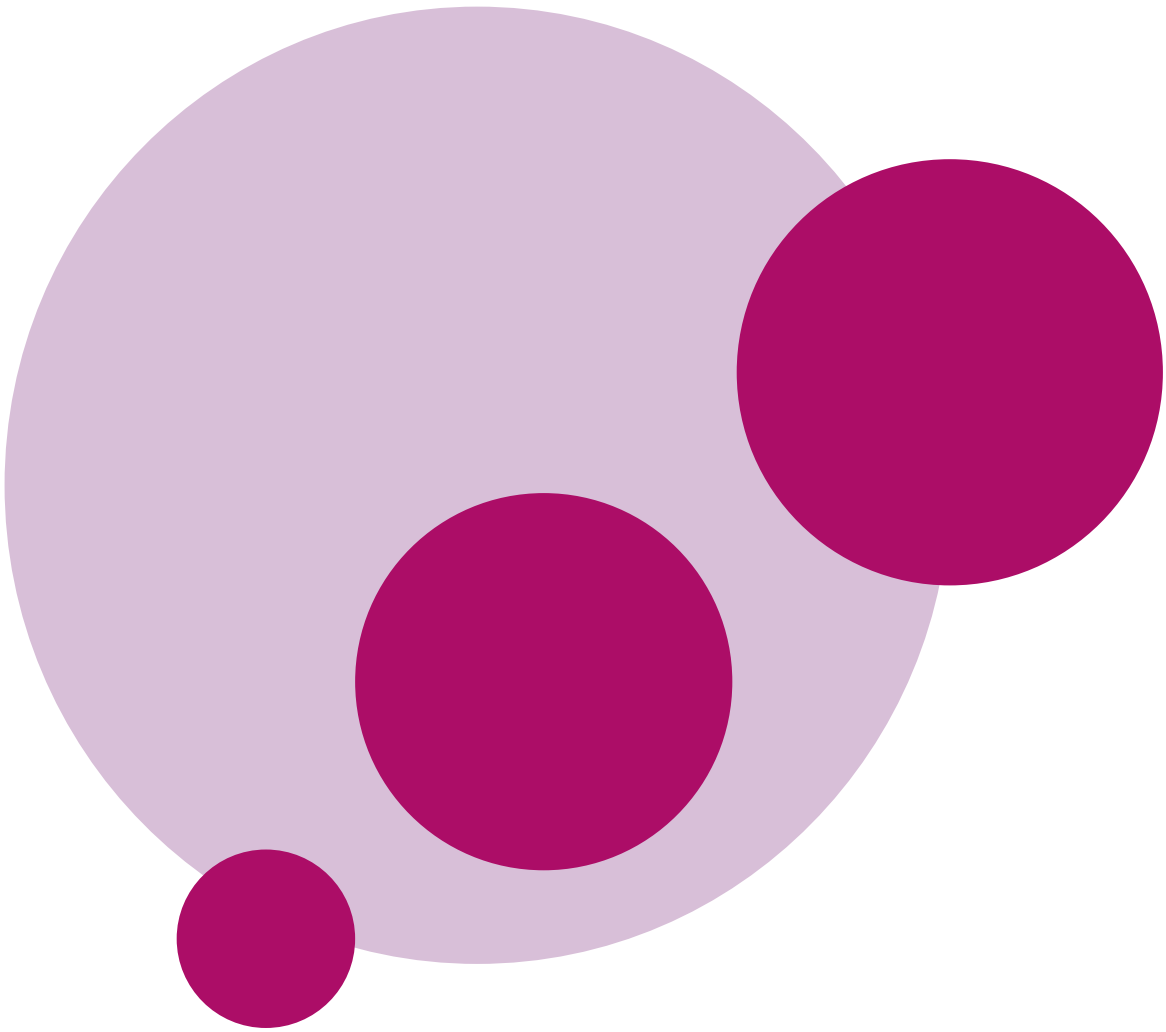
Findings reveal that the standard of care that women received was insufficient, with participants highlighting a lack of in-person support and antenatal provision, poor attitudes and treatment from staff, and the impact of staff capacity on care and treatment. Information on Covid-19 in relation to pregnancy and related services was significantly lacking, including with regard to the vaccine, and this exacerbated anxiety for many.

Isolation was a central theme to emerge from the research, and this impacted all aspects of pregnancy and maternity care. Many participants spoke of their distress at attending appointments alone, for routine scans and care, and in relation to unexpected complications. Women underwent managed miscarriage, fertility procedures, abortion care, labour and post-delivery alone, with many describing this as traumatic. Poor perinatal mental health and wellbeing were described time and time again.

We heard that the inconsistent application of guidance caused distress for those accessing services, with unexplained discrepancies between national guidance and services on the ground, across healthcare settings and in relation to wider related services. The research revealed a lack of flexibility and sensitivity in even the most extreme circumstances, including baby loss. Lack of person-centred care routinely impacted on birthing choices, preferences, and experiences.

The healthcare needs of women were neglected, with restrictions resulting in a narrow focus on labour and delivery rather than a holistic focus on women and their babies. The implications of approaches taken are still emerging, however, our findings indicate long-term consequences for women who were pregnant or gave birth during the pandemic. The research highlights a gap in consistent mental health and wellbeing support for women and a need for accessible support to address the ongoing impacts of trauma.

Finally, the impacts of the Covid-19 pandemic shine a light on pre-existing systemic issues within pregnancy and maternity services and in relation to women's health more broadly. Our recommendations highlight the gendered and intersectional action that Scottish Government and relevant health bodies should take in the face of a future public health crisis or pandemic, and to address underlying structural issues related to women's health inequality.



Summary of recommendations

The following recommendations emerged from women's experiences of pregnancy and maternity services directly in relation to Covid-19.

They are aimed at the Scottish Covid-19 Inquiry and to inform Scottish Government planning for any future public health crisis.

Communication and information

1. Clear, inclusive, accessible and consistent advice regarding pregnancy.
2. Mechanisms to ensure practitioners understand and implement guidelines.

Standard of care

3. A review of perinatal support throughout the pandemic.
4. Co-production of human-rights based services, using learning from Covid-19.
5. Emergency guidance rooted in intersectional gender analysis and existing standards.

Isolation

6. A focus on mitigating perinatal isolation.
7. Mitigations to allow women support during labour, delivery and non-routine care.
8. Intersectional guidelines to ensure that postnatal needs are met for all.

Inconsistent application of guidelines

9. Standardised application and communication of public health guidance.

Flexibility and options

10. Prioritisation of person-centred and trauma-informed care.
11. A holistic approach to labour and delivery, as opposed to a narrow focus on childbirth.

The following recommendations emerged from broader aspects of women's experience of pregnancy and maternity services, many of which were exacerbated by the Covid-19 crisis.

They are aimed at the Scottish Government and public health bodies.

Ongoing implications

12. Consistent access to mental health and bereavement support.

13. Competence building on intersectional, gender-sensitive and trauma informed service provision.

Access to quality services

14. Intersectional and community-based research on access to services.

15. Investment in pregnancy and maternity services and third-sector support organisations.

16. Maternal health policy that is informed by lived experience learning from Covid-19.

17. A broadened duty on perinatal mental health in the Mental Health Act.

Existing commitments

Implementation of existing commitments on women's health:

18. Action on women's right to health in Scotland's second National Human Rights Action Plan.

19. Compassionate miscarriage services, including dedicated facilities.

20. Creation of a Scottish Institute for Women's Health.

Content warning and support services

We encourage you to take care when reading this report as it contains difficult and distressing content related to themes including: miscarriage, stillbirth, complications during childbirth, invasive medical procedures, domestic abuse and sexual assault. Please see the information below for support and advice services.

Amina Muslim Women's Resource Centre

The Amina Helpline on 08088 010301 is a support service for Muslim and BME women in Scotland. All calls are free, non-judgemental, and will not appear on your phone bill. Amina can help women in English, Urdu, Arabic, Bangla and Swahili and, when required, using online interpreting.

Birthrights

Birthrights is the UK charity that champions respectful maternity care by protecting human rights. They provide advice and legal information to women and birthing people, train healthcare professionals to deliver rights-respecting care and campaign to change maternity policy and systems.

Maternal Mental Health Alliance

The Maternal Mental Health Alliance offers a collated collection of support links, including: crisis support, local support organisations, national support online and over the phone, and self-help guides.

Rape Crisis Scotland

The Rape Crisis Scotland helpline offers confidential short-term, crisis and initial support by phone on 08088 010302, email, webchat and text. Their phone, email and webchat support is free and texts will be charged at your normal network rate. Calls do not show on your bill. They also offer local support across Scotland and resources in multiple languages.

Sands

Sands supports anyone who has been affected by the death of a baby before, during or shortly after birth. Services they offer include a free national helpline on 08081 643332 and a bereavement support app; a UK-wide network of support groups; an online forum enabling bereaved families to connect with each other and a wide range of bereavement support resources available online and in print.

Saheliya

Saheliya is a specialist mental health and wellbeing organisation for black, minority ethnic, asylum seeker, refugee and migrant women in the Edinburgh and Glasgow area. They offer services including counselling, outreach work, complementary therapies, practical and emotional support, a learning centre, and childcare for under 7's.

Scottish Women's Aid

If you feel scared of or around your partner or if you are worried about someone you know, you can get in touch with Scotland's 24 hour Domestic Abuse and Forced Marriage Helpline on 08000 271 234. Scottish Women's Aid also offer local support across Scotland and resources in multiple languages.

Tommy's

Tommy's offer information and support who has experienced the loss of a aby, whether through miscarriage, stillbirth, neonatal death, or termination for medical reasons. They offer an online baby loss support group and a range of resources and research.

Introduction

2. Introduction

The Covid-19 pandemic has had – and continues to have – a profound impact on the health and social care sector, and on women's lives. Following the declaration of Covid-19 as a public health emergency in January 2020, fast-changing guidance led to numerous mitigations that affected the provision of health and social care across Scotland, including pregnancy and maternity services.

This research is a joint project between the Health and Social Care Alliance Scotland (the ALLIANCE) Academy Programme and Engender. Throughout the pandemic, women's experiences of accessing services, including maternity provision, have been largely neglected. So too has a gendered and intersectional approach to analysing and mitigating the impacts of Covid-19.[1] This report explores the impact of Covid-19 on the experience of accessing pregnancy and maternity services across Scotland. It builds on existing research, including evidence gathered by our organisations that highlights what the pandemic has meant for pregnant women.

> *"Pregnant women were forgotten about and treated like 2nd class citizens with their rights taken away."*[2]

Our findings primarily consist of the voices of those affected by changes to services at the height of the pandemic. We are grateful to all those who completed the survey, shared their experiences and allowed us to print their words here, particularly as this has meant sharing traumatic and distressing experiences for many participants.

Information on related research in Scotland, the UK, and internationally is available at Appendix [2].

2.1 Aims and objectives of the research

The project sought the views of those with experience of pregnancy, trying to become pregnant, or accessing maternity services between March 2020 and November 2022. Our aim has been to gain a better understanding of access to services related to pregnancy, fertility, maternity, abortion, miscarriage, and post-partum care during the Covid-19 pandemic.

We will use this learning to inform our engagement with the Scottish Covid-19 Inquiry, including the Let's Be Heard engagement strand,[3] and stakeholders including Scottish Government, health boards and other public health bodies. It is crucial that women's experiences of the pandemic are recognised, learned from, and used to inform and improve practice as we recover from the disruption caused by Covid-19.

In addition to experiences specific to Covid-19, a range of systemic issues regarding pregnancy and maternity services were also highlighted throughout the survey, many of which were exacerbated by the pandemic. While this report primarily details the experiences and priorities shared with us in relation to Covid-19, the survey data will also be used to inform wider and longer-term work by our organisations to advocate for improved access to reproductive health and wellbeing in Scotland. This is reflected in the recommendations that conclude this report.

2.2 Research design and methodology

A survey was designed to gather data on a range of women's experiences whilst accessing pregnancy and maternity services. These cover midwifery, screening services and wider antenatal support, fertility treatment, abortion care, miscarriage care, labour and delivery, and postnatal support from midwives, health visitors and other health practitioners. The survey included quantitative and open-text questions and was available online from October to November 2022. Participants could access an Easy Read version of the survey. A support page with links to relevant websites and organisations was provided on all versions.

Survey drafts were shared with partners and contributors from the health and social care, women's and equalities sectors to ensure the survey questions

were trauma-informed and sensitive to the breadth of experiences we were seeking to understand. This was particularly important, given the scale of challenges experienced by people throughout the Covid-19 pandemic, as well as potential intersections with systemic issues, including gender-based violence and intersectional gendered health inequalities.

Quantitative descriptive analysis was used to aggregate the statistical data. The open-text survey data was collated and analysed to identify broad themes. A collection of quotes that informed the themes identified in the report are available in Appendix [1]. In some instances, we have included quotes that are unique or in the extreme. While these quotes do not represent the experience of most respondents, it is crucial that minority and minoritised experiences are represented, considered and learned from.

We undertook outreach to ensure that views from different parts of Scotland fed into the research. 202 responses were received in total, including at least three from every health board area. Ultimately, the geographical breakdown of participation was roughly in line with population size across regions, although proportional representation was exceeded in some areas (e.g., 10.1 per cent of responses came from Shetland), whilst others were under-represented in the data (e.g. 4.1 per cent of responses came from Dumfries and Galloway). It is worth noting that over half of the data refers to care received in Greater Glasgow and Clyde (26.6 per cent), Lothian (15.6 per cent) and Tayside (14.5 per cent).

We also conducted outreach to increase participation from groups that experience structural discrimination and other barriers to healthcare. The survey was disseminated through organisations and community groups that work with Black and minority ethnic women, disabled women, neurodivergent women, LGBTI women, young women, refugee and asylum-seeking women, women on low and precarious incomes, single parents, unpaid carers, women with mental health conditions, and women experiencing homelessness.

2.3 Limitations

The findings of the survey are limited by a relative lack of representation from marginalised groups in Scotland. White women were almost homogenously over-represented in the data, with very few participants from Black and minority ethnic communities (2.5 per cent) and a very narrow range of communities represented amongst those that took part.

Young women (aged 18-24) were underrepresented in the data, accounting for only 4.6 per cent of respondents but 16.3 per cent of maternities in Scotland in 2020.[4] Conversely, women aged 35-44 accounted for 46.2 per cent of participants and 23.1 per cent of maternities in the same year.

10 per cent of respondents described their sexual orientation as bisexual, gay, lesbian or other, and 0.5 per cent of respondents identified as trans, meaning that these groups were not underrepresented in reference to best estimates at the population level. However, clear limitations to data gathered on LGBT people's experiences apply given the small sample sizes involved.

Non-disabled women are overrepresented in the data, accounting for 94.2 per cent of respondents, compared with around 86 per cent of women aged 16-44 in Scotland.[5] Similarly, women with long-term health conditions are underrepresented in our survey, with 18.5 per cent describing having a long-term health condition as opposed to 32 per cent of those at the population level.[6] It is also worth noting that women's impairments or health conditions can impact on fertility or likelihood of trying for pregnancy, which may have also impacted on disabled women's representation.[7]

The fact that most marginalised groups for which we collected data are underrepresented in this research is itself a finding. Our survey was, as expected, limited in its reach. In turn, the equalities data we did collect is limited by sample size and by lack of specificity and diversity within groups. For instance, due to scale, we did not ask disabled women to share information about their impairments, and only three Black and minority ethnic groups (from a total of nineteen listed) are represented in the findings. Nor did we collect information on other aspects of discrimination or marginalisation in Scotland, such as income, single parenthood, immigration status, or faith or religion. Again, this was due to the scale of our survey.

One recommendation to emerge from this work is for larger-scale and targeted research to better understand and address barriers for all groups accessing pregnancy and maternity services in Scotland. This should be intersectional in approach, focusing on those who experience structural inequalities, including women of colour, disabled women, LGBTI women, low-income women, women with insecure immigration status, young women, and other groups. Researchers should work with community-based organisations or those with established relationships and follow best practice participation standards.

"It is essential that Scotland learns from people's experiences during the pandemic to improve maternity services and public health messaging. To do otherwise would be to fail, and further compound the trauma, of thousands of parents over the last few years."

2.4 Analysis framework

Our organisations ground our analysis in gender equality and human rights, and the survey data was interpreted through this lens. It is imperative that we understand the intersectional equalities and human rights implications of decision-making during the Covid-19 pandemic and the resulting impact on individuals.

The Scottish Covid-19 Inquiry has committed to taking a human rights-based approach, as outlined in its Terms of Reference.[8] This report, therefore, aims to identify where human rights – particularly the right to health – have been impacted. Scotland's Second National Human Rights Action Plan (SNAP 2) recognises that the right to health is not being fulfilled for some groups of women.[9] It is, therefore, crucial to understand the implications that Covid-19 has had on women's access to healthcare.

2.4.1 Human Rights

The UK and Scottish Governments have legal obligations to respect, protect and fulfil the rights contained under the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), as well as other international treaties that relate to health and gender equality. Of particular relevance to the experiences of people accessing pregnancy and maternity services during Covid-19 are Article 12 of ICESCR, which sets out the right to the highest attainable standard of physical and mental health,[10] and Article 12 of CEDAW, which sets out women's equal right to healthcare including access to perinatal care.[11]

As established in General Comment 14 of the Committee on Economic, Social and Cultural Rights, the right to health is measured and evaluated through consideration of specific human rights standards, known as the AAAQ framework:[12]

- **Availability:** functioning public health and health care facilities, goods and services, and a sufficient quantity of programmes.
- **Accessibility:** health facilities, goods and services are accessible to everyone, without discrimination, are affordable, can be accessed physically and via easily understood information.
- **Acceptability:** all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender differences.
- **Quality:** health facilities, goods and services must be scientifically and medically appropriate, and of good quality.

The realisation of the right to health should also be underpinned by the concepts of 'progressive realisation', 'maximum available resources', and the non-use of 'retrogressive measures'.[13] This means that UK and Scottish Governments must move forward continuously in their work to fulfil the right to health, must provide appropriate funding, and must not take action that leads to poorer health outcomes.

The 'PANEL principles' set out five key underlying principles that are essential to applying a human rights-based approach in practice.[14] These include the following:

- **Participation:** People should be involved in decisions that affect their rights.
- **Accountability:** There should be monitoring of how people's rights are being affected, as well as remedies when things go wrong.
- **Non-discrimination and equality:** All forms of discrimination must be prohibited, prevented and eliminated; People who face the biggest barriers to realising their rights should be prioritised.
- **Empowerment:** Everyone should understand their rights and be fully supported to take part in developing policy and practices which affect their lives.
- **Legality:** Approaches should be grounded in the legal rights that are set out in domestic and international laws.

The Scottish Human Rights Commission highlights that some retrogression of rights may occur during times of crisis "subject to stringent tests being met", including human rights standards and principles. However, any retrogression of rights must be temporary and time-limited, necessary and proportionate, non-discriminatory and mitigate inequalities, ensure the protection of a minimum core content of rights, and consider all other options.[15]

It is beyond the scope of this research to fully assess the extent to which crisis management and initial recovery responses to the pandemic by the Scottish Government and health bodies met these human rights obligations and fulfilled a human-rights based approach in the delivery of pregnancy and maternity services. This should be explored in greater depth by the independent inquiry.

2.4.2 Gender equality and intersectionality

The Scottish Government, NHS health boards and other public health bodies are also subject to a range of legal duties under the Equality Act 2010. Listed authorities are obliged to eliminate discrimination and advance equality for people with protected characteristics across all of their work, including policy development and delivery of services. This means that pregnancy and maternity services must be equally accessible to all women and pregnant people, and the standards of care received must not result in health inequalities on account of age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, or sexual orientation,[16] and maternal health policy must seek to address structural gender inequality.

The Scottish Government is also committed to reducing gender inequality and improving health outcomes for women across a range of strategy and policy frameworks. These include the Women's Health Plan,[17] the mental health transition and recovery plan,[18] the Five-Year Forward Plan for Maternity and Neonatal Care,[19] responses to the First Minister's National Advisory Council on Women and Girls reports,[20] Equally Safe,[21] and the Fair Work Action Plan.[22]

Perinatal care that ensures good physical and mental health for women cuts across all of these agendas in a cyclical way. Intersectional gender inequalities act as barriers to good health and wellbeing, including by limiting access to services. Women have less access to well-paid and secure work than men. Pregnancy and maternity discrimination is commonplace. Women are more reliant on inadequate and shrinking social security entitlements and do not have equal access to resources within households. Most lone parents, primary caregivers for children and unpaid carers for disabled and older people are women. Men's violence against women is endemic. More women live with

long-term health conditions and poor mental health and wellbeing than men, and women's health needs are often dismissed, minimised or misunderstood within medicine and healthcare.

These structural inequalities are often experienced more acutely or in particular ways for women faced with intersecting marginalisation, including women of colour, disabled women, LGBTI women, low-income women, women with insecure immigration status, young women and other groups.

Lesser access to resources, the experience of violence, the demands of caring roles, pregnancy and maternity discrimination, poor health and wellbeing, and intersecting discrimination prevent women from accessing quality pregnancy and maternity care. In turn, this drives and sustains structural gender inequality. For instance, poor perinatal care can impact on women's labour market opportunities and, therefore, unpaid caring roles, long-term physical and mental health, or vulnerability to gender-based violence.

This report is not intended as a comprehensive gender analysis of pregnancy and maternity services at the height of the pandemic in Scotland. Largely, the voices of participants in this project speak for themselves. However, some commentary on structural gender inequality and intersectionality is integrated throughout the findings.

2.4.3 Health and social care standards

In line with this human rights and equalities approach, our analysis also draws upon the Scottish Government's Health and Social Care Standards,[23] that set out what people should expect when accessing health and social care services in Scotland and seek to ensure that the basic human rights to which we are all entitled are upheld.

These standards, published in 2017 and updated in 2022, set out a collective standard of care which focuses on the experience of people using services and ensuring the five key outcomes outlined below. It is important to consider these outcomes when looking at the key challenges and experiences faced by women across Scotland accessing pregnancy and maternity services.

The headline outcomes are:

1: I experience high quality care and support that is right for me.

2: I am fully involved in all decisions about my care and support.

3: I have confidence in the people who support and care for me.

4: I have confidence in the organisation providing my care and support.

5: I experience a high quality environment if the organisation provides the premises.

We endorse the SNAP 2 recommendation for a human rights review of 'My support, my life', to assess how these standards are used by public bodies, scrutiny bodies, private and third sectors, and their impact on people who access care and unpaid carers.[24]

A gendered and intersectional approach

Throughout this report, we refer to the need for a gendered approach to the development and delivery of services. This means embedding gender equality concerns from the outset of policy and programme design and ensuring that structural gender inequalities are taken into account and mitigated as a core aim of the work.

Not all women have equal access to services. Marginalised groups are not well served by blanket approaches that do not address other forms of inequality and discrimination. For instance racism, ableism, homophobia, transphobia and ageism all intersect with structural sexism, creating additional barriers to good health and wellbeing for different groups of women. An intersectional approach fundamentally works to ensure equality of access for all.

Findings: Covid-19 Specific Experiences

3. Findings: Covid-19 Specific Experiences

3.1 Communication and information

This section of our report explores experiences of communication and information provision when accessing pregnancy and maternity services during Covid-19.

The Scottish Health and Social Care Standards recognise that effective communication and information provision is essential for delivering high-quality health and social care services which respect the rights and preferences of those accessing care and support.[25] In particular, the standards outline the importance of involving people in shared decision-making about their care and the provision of accessible and inclusive information to enable informed choices.

The survey findings highlight some significant issues with communication and information faced by women across Scotland in accessing pregnancy and maternity services. These are explored under the following headings:

- Covid-19 guidance regarding pregnancy and maternity services
- Lack of communication
- Information about vaccination
- Accessible information
- Tailored information provision

3.1.1 Covid-19 guidance regarding pregnancy and maternity services

We asked participants to respond to the statement, "Covid-19 restrictions and how they related to maternity and pregnancy services were clearly communicated to me." 52.5 per cent either strongly agreed or agreed, while

31.8 per cent disagreed or strongly disagreed. A further 15.6 per cent neither agreed nor disagreed.

Some respondents described positive and person-centred communication with healthcare professionals during pregnancy.

"My midwife and I discussed how best to minimise the likelihood of catching Covid-19. Communication about Covid-19 was good. All letters clearly explained you should not attend appointments if you were experiencing symptoms. I would receive a call or text message 24 hours before an appointment asking if I was well and had not experienced any Covid-19 symptoms. The procedure for attending appointments was clearly explained - on my own, wear a mask, temperature check etc. The advice at the time was that pregnant people were not to receive the vaccine."

"Restrictions relating to having Covid and the effect on my birth plan were clearly communicated."

However, the fast-changing guidance led to widespread confusion regarding restrictions and inconsistent messaging. This led to women feeling overwhelmed and uncertain, with potentially negative impacts on mental health and wellbeing.

"Constantly changing, inconsistent message or decisions that it felt like a roulette."

"Although information available to midwives was communicated clearly to me there was often confusion over which rules/restrictions applied when and where and what had changed etc."

"Rules changed often with tiers etc. in place, it was overwhelming keeping up with these and trying to stay hopeful about things changing."

Other respondents described limited or absent information provision, meaning that women had to proactively seek out the information they needed.

"I got almost all information via social media and community forums. Official information was very much lacking. It was very stressful."

"Information not voluntarily given at community midwife appointments, I had to specifically ask."

Some survey respondents also described contradictions between official guidance and how this was communicated to people who were accessing services, and to healthcare professionals. There was a perception that official guidance was not translated at ground level or took too long to be reflected in practice.

"Communication was extremely limited, poorly conveyed, and frequently appeared to be poorly understood by healthcare staff. I do not say that to blame the individuals in question, but to highlight inconsistencies with information sharing and staff support."

"There was a massive delay (weeks, maybe months) between the Royal College of Obstetrics releasing guidance that pregnant women should get the vaccine (June 2021 I think) and for that advice to be trickled through to pregnant women."

"Information on health board website about partner being allowed into appointments/labour ward/visit etc., differed from what I was actually told in person."

3.1.2 Lack of communication

Women raised that inadequate or a lack of communication across different pregnancy and maternity services had adverse impacts on their care. The model of remote communications had particular implications that were not always well understood by practitioners. Wider impacts of the move away from in-person care are covered in Section 3.2 on 'Standard of care'.

"It was so, so rubbish. I cried with frustration and disappointment after every appointment. Also, they didn't fully appreciate how telephone appointments changed things - the booking appointment midwife told me I'd get my dental fee exemption certificate at my 16 week appointment, and I had to point out that that appointment would be over the phone. I was told I could get it at my 20 week appt instead then. I'm entitled to it from the start!"

A number of women raised issues with communication in relation to miscarriage in the context of Covid-19.

"I discovered I was pregnant within the first month of lockdown, notified GP but got zero appointments. I then miscarried, again notified GP but again got zero appointments or follow ups."

"I didn't see anyone face to face. I struggled to get hold of my GP and when I spoke to her in a telephone consultation she said I was having a miscarriage."

"It wasn't a positive experience unfortunately I got told over the phone that I had experienced a loss and that my periods would be back within 4-6 weeks and if not to take a pregnancy test to check that the baby had passed completely and if I needed support to speak to the doctor. This isn't ok. I then got follow up phone calls about appointments that I was trying to cancel via the automated system then a phone call asking why I had cancelled the appointments to tell them that I had experienced a loss!"

3.1.3 Information about vaccination

We asked survey respondents whether public health information about Covid-19 vaccines and infection in relation to maternity and pregnancy was easy to understand. A large minority of respondents (42 per cent) either disagreed or strongly disagreed.

We also asked survey respondents whether they felt they were given all of the information that they needed about Covid-19 vaccines and infection in pregnancy and maternity. 48 per cent of respondents either disagreed or strongly disagreed. Within this, information on vaccination was broadly described as confusing, contradictory, limited, and – in some cases – obsolete.

"When I was pregnant and then breastfeeding there was no clear information/guidance for the public or health professionals available regarding the vaccine."

"I felt like one day pregnant women were advised against the vaccine then the next it was strongly advised and it made me question if getting the vaccine was the right thing for my child."

"Neither my midwives or vaccinator were able to give me any information as to whether it was safe to get vaccinated."

Many respondents reported undertaking their own research or relying on personal contacts and professional networks to make an informed decision regarding the Covid-19 vaccine. This has clear equality implications, including in terms of intersectional access to such contacts and scientific research.

"I had to research myself as no information was provided."

"The recommendations on vaccines were very vague. I relied on my own research and trusted academic journals and scientists. Nurses/ midwives didn't seem to know the answers and were loathed to offer advice or information. Getting the Covid-19 vaccination was a complete farce and I had to go through a friend who is a civil servant to get info and an appointment. It was very stressful."

Confusing, conflicting, and fast-changing guidance resulted in hesitancy to access the vaccine. Guidance from the Royal College of Obstetricians and Gynaecologists (RCOG), which was introduced in April 2021, states that whilst women are strongly recommended to access the vaccine, this is a personal choice, and they should discuss options with a medical professional such as their doctor or midwife.[26] However, as our survey highlighted, in practice, it was felt that staff weren't sufficiently forthcoming or informed to provide women with the necessary support and advice.

Lack of information about the vaccine for pregnant women occurred within exceptional circumstances. However, the confusion and lack of prioritisation that women reported to us reflect wider issues regarding knowledge around pregnancy and breastfeeding within medicine. For instance, women have previously told Engender that confusion regarding anaesthetics that are safe during pregnancy or breastfeeding has affected their care.[27]

This is largely because women's health is chronically underfunded and under-researched.[28] Whilst Covid-19 vaccines were produced and approved at speed, it is no surprise that pregnant women were left in the dark about what to expect. Women are not central to medical research or health-based innovation, in which white men have historically been and continue to be the default subject to the exclusion of women and minoritised groups.[29] Meanwhile, research focused on women's health is largely modelled on white women[30] despite clear evidence regarding the significance of race and ethnicity on health outcomes.

3.1.4 Accessible information

We asked survey respondents whether information about Covid-19 and maternity services was provided in an accessible format. Around 20 per cent indicated that this was not the case. The provision of accessible information is of key importance for many disabled women, including learning disabled women and women with sensory loss, neurodivergent women, and those whose first language is not English.

The pandemic highlighted the need for tailored, person-centred approaches to information provision throughout health and social care interactions to accommodate people's different lived experiences.[31] Accessible information, using a range of formats, alongside guidance and support from healthcare professionals, helps empower individuals to make informed choices about the support and services they receive.[32]

3.1.5 Tailored information provision

In addition to issues relating to confusing, contradictory, and limited communication, some respondents highlighted a lack of information specific to their individual health needs. This had implications for women's decisions around self-isolating, with potentially severe impacts on health and wellbeing.

"I didn't receive any information specific to my individual health needs as a patient of a long-term health condition, nor how it related to my pregnancy."

"There was confusion amongst all of the team around how my asthma (meant I was already shielding) and pregnancy would relate to my Covid-19 risk."

"I was pregnant at the very beginning of the pandemic and no one really knew anything about how it impacted pregnancy. I am also asthmatic so with the limited information available I all but isolated from March – June/July 2022."

Summary and recommendations

Our research indicates that information about Covid-19 was a significant issue for those accessing pregnancy and maternity services. Many respondents highlighted confusion regarding fast-changing guidance, describing a gap between policy and practice, with guidance taking too long to filter through to implementation on the ground. Similarly, many found available information to be limited or lacking altogether. A significant proportion of respondents also found information about Covid-19 vaccines to be lacking, confusing and contradictory, with many people relying on their own research or personal contacts to try to make an informed decision about whether to receive it. A lack of accessible formats was highlighted, and respondents also reported that they received limited information specific to their individual health needs.

These findings highlight the need for improved communication and accessible information for people accessing pregnancy and maternity services during times of crisis.

Recommendations

Scottish Government and relevant health bodies should:

- Ensure that tailored information and advice for pregnant women is clear, timely, inclusive and accessible, and is communicated consistently across health boards and health settings.
- Create mechanisms to ensure that practitioners understand guidelines for pregnant women, including regarding vaccination, and that these are consistently implemented across health board areas.

3.2 Standard of care

This section looks at participants' experience of standard of care whilst accessing pregnancy and maternity services during the pandemic. Key issues are set out here, but this is an overarching theme that also emerges in other areas of the report.

Gender inequality often undermines the standard of care that women receive. Women routinely describe experiences of not being listened to, taken seriously or actively involved in treatment planning or prescription choices. Women wait longer for pain medication than men, wait longer to be diagnosed, are more likely to have physical symptoms ascribed to mental health issues, and are more likely to suffer illnesses that are ignored, minimised or denied by medical professionals.[33] This can be even more pronounced for Black and minority ethnic women, who routinely experience structural racism and racial bias whilst accessing healthcare. Black women are more than four times likely to die during or up to six weeks after pregnancy in the UK than white women.[34] Research shows that Black women's pain is even more disbelieved and disregarded within the health system.[35] Whilst these themes were not reflected in our survey responses, they provide important context when considering the impacts of the pandemic on women's healthcare and the future development of pregnancy and maternity services.

Against this backdrop, many women indicated that the standard of care that they received was not what they had expected or hoped for. The following quote from one participant, a parent of a pregnant woman, highlights the extent to which the Covid-19 pandemic undermined good care for some women accessing pregnancy and maternity services:

> *"I feel strongly that the outcomes from the lack of care through our daughter's pregnancy have had profound and life changing consequences and whilst the parents are managing with the care of their baby with family support, we are very concerned that they have been significantly let down by the NHS care they ought to have received."*

The following issues relating to the standard of care emerged in our survey:

- Lack of in-person care
- Poor access to antenatal and postnatal care
- Attitudes and treatment from staff
- Staffing and capacity issues

3.2.1 Lack of in-person care

Almost three-quarters of survey participants, 73 per cent, responded that they had experienced unexpected changes to their in-person care at one or more stages during their pregnancy. This refers to appointments that were conducted on the telephone or via video call as part of public health measures introduced at an early stage of the pandemic. The shift from in-person appointments to video or phone calls was identified as a barrier to quality communication and care. A high proportion of women told us that this led to anxiety or difficulties interacting with health professionals.

Telemedical care has accessibility implications for disabled women, including learning disabled women and those with visual or hearing impairments. Other complex or specific needs may not have been met with the shift away from in-person care, including for women experiencing coercive control, young women accessing abortion, and women with previous experience of miscarriage or baby loss.

"I only had video consultations with the consultant. I found it really difficult to get my thoughts across in this setting - face to face would have been much easier. I was never offered a face to face appointment with the consultant."

"Several appointments were conducted over the telephone or video call. I found these much less personal and worried that something may have been missed."

Remote appointments also signified fewer routine physical checks, as well as reassurance regarding more complex cases. Support with breastfeeding was severely impacted by the lack of in-person care.

"Some midwife appointments were over the phone which meant blood pressure and urine samples were not monitored."

"I tried to access breast feeding support over the phone which was really ineffective. It causes more stress and strain not having someone there in person to explain and support. I was unable to access any classes until my baby was 6 months old due to restrictions."

3.2.2 Poor access to antenatal and postnatal care

Numerous participants highlighted that antenatal services were unavailable in their local health boards. Classes were substituted with leaflets which often did not meet women's support needs.

"There were no antenatal classes offered during my pregnancy. There was no online alternative either. I was given a leaflet with some websites to read, however I feel I missed out on valuable support from both health professionals and other expectant parents by these classes not being held."

"No online antenatal classes were offered in health board for first six months of [the] pandemic, nor even any Q&A Zoom sessions etc. Very poor."

When antenatal support was reintroduced, it came in the form of online training. For many, this was insufficient to meet their needs, including the chance to ask questions and develop support networks with other parents. Some took the decision to pay for private classes to have the benefit of in-person support, raising clear issues with equality of access to care.

"All NHS antenatal classes were replaced with an online training session (not with real people) that was not helpful in preparing me for labour or post-partum."

Several participants highlighted a lack of postnatal care, with mothers of newborns having to proactively seek support for themselves.

"We had my son in Aberdeen. We are from Shetland but when I came home with him after having three weeks in neonatal, I had expected to hear from my health visitor straight away. But heard nothing so after a week I contacted my health centre which did not know who my health visitor should be. I did find out for myself and contacted her. She said she had not been told about us. I was very disappointed as this was my 1st baby who was premature so had hope the service would have been there for me to start with."

"The health visitor missed that we were discharged from the maternity services and [I] had to contact the maternity unit for help."

In addition to these themes, digital exclusion is a gendered issue that may have prevented women from accessing perinatal advice and support. Women are the majority of non-internet users, and it is likely that disabled women and BME women are particularly affected by digital inequality.[36] The reliance on written material means that linguistic or English literacy barriers are also likely to have affected women's access to antenatal health.

3.2.3 Attitudes and treatment from staff

Negative experiences

Some respondents highlighted poor attitudes and treatment from staff and the impact this had on their care. People described feeling overlooked and neglected and, in some instances, received "little empathy" from staff. In some circumstances, women's pain was ignored and dismissed (see Section 3.6 on 'Narrow focus on delivery and urgent postnatal care' and Section 5 on 'Wider issues with pregnancy and maternity services' for further information on this). Although many of these experiences occurred in extraordinary circumstances, this tracks with existing evidence that women's pain is often underestimated and dismissed in comparison to men's.[37]

"There were definitely staff shortages in the hospital (the midwife team was at half the capacity) and I was left for long periods of time without pain relief."

"I had a rogue midwife who did a lot of things she wasn't meant to and then retired before I could put in a complaint. My antenatal, birth, and postnatal care were horrible and I'm very haunted by it. My 6-week check with the GP was appalling - he didn't even ask how I'm doing. I had an answer prepared as I was struggling in some ways, but never got to use it as I was never asked."

In some instances, people felt that their experience would have an impact on future decisions around pregnancy.

> *"I received very little empathy from overworked hospital midwives and my experience has put me off ever getting pregnant again, I can't even visit the hospital as it would be intensely traumatic."*

These experiences do not align with Scotland's Health and Social Care Standards, which state that 'I experience warmth, kindness and compassion in how I am supported and cared for, including physical comfort when appropriate for me and the person supporting and caring for me.'

Positive experiences

Several respondents highlighted positive experiences of care from staff and services. There was a recognition that staff were operating in particularly challenging and uncertain circumstances due to changing restrictions but still managed to uphold high standards of care. See Section 4.2 on 'Mental health and wellbeing' for further information on supportive experiences.

> *"I received amazing and incredibly compassionate care during my pregnancy by all NHS staff. I understood that a lot of the uncertainty and restrictions were due to Covid and not a reflection on the staff or board."*

> *"Couldn't fault. Especially my own midwife and health visitor. And the wonderful midwives in the prenatal ward and delivery suite. They deserve so much recognition for the outstanding care they deliver!!"*

3.2.4 Staffing and capacity issues

Respondents highlighted challenges with delays, staffing and capacity issues within all settings and at all points across the system. This understaffing was particularly apparent within hospital and emergency settings, which may have resulted in poor levels of care and attention. Although our report covers the Covid-19 pandemic, it is important to keep in mind that existing pressures on the NHS were exacerbated by the pandemic and are not a new phenomenon.

"The hospital staff seemed busy and short staffed, and I found support from them was lacking."

"Lack of staff on maternity ward at Aberdeen maternity hospital was detrimental after my c-section."

Respondents also highlighted challenges with midwife services, including staffing levels and continuity of care. For example, many described seeing multiple midwives and the impact this had on developing trusting relationships.

"It's been quite difficult getting support from midwives outside of their regular prescriptive routine of what to check for at each meeting etc. (including timely blood test results). They say it's the labs that are overworked."

"I had to have all scans on my own and did not have one midwife for appointments and saw someone different every time."

Summary and recommendations

Findings from the survey indicate that Covid-19 disrupted and impacted the standard of care that women received. Women felt that health outcomes were impacted by the lack of in-person care, including the lack of antenatal support or provision. Replacement classes were introduced online, and this was insufficient for many who made the decision to access private support, impacting on equality gaps between different groups of women. Postnatal support was also lacking. Treatment and attitudes from staff were highlighted, including both positive and negative experiences. It was suggested that pressures on staffing and capacity impacted levels of care.

Recommendations

Scottish Government and relevant health bodies should:

- Review perinatal support throughout the pandemic and explore alternative support models that could be applied during any future period of restrictions.
- Embed human rights-based practice across services, learning from Covid-19 through co-design and co-production with service users and practitioners.
- Use intersectional gender analysis, Scotland's Health and Social Care Standards, and principles of the maternal and neonatal care plan[38] to underpin development of any future guidance regarding pregnancy and maternity.

3.3 Isolation

Many women told us that isolation stemming from Covid-19 restrictions had a negative impact on their experiences of pregnancy, accessing fertility and perinatal services, giving birth, and life with a newborn baby. We did not use words related to isolation (e.g., isolated or isolating) in any of our questions, but these terms were used 33 times in open-text box responses to a wide range of questions and in relation to all aspects of pregnancy and maternity care.

Pregnancy and motherhood of young children can be isolating at the best of times due in part to highly gendered inequalities that relate to parental leave, single parenting, poverty, gender-based violence, childcare, poor perinatal mental health, and cultural expectations around caring roles. Issues linked to isolation also intersect with immigration status, race, care experience, age, faith, sexual orientation, gender identity and other identity-based discrimination.

Within this broader context, respondents described feeling isolated whilst accessing pregnancy and maternity services in healthcare settings, both as outpatients and inpatients, and as a result of altered or unavailable perinatal support. This heightened the broader isolation from support networks that many people experienced due to lockdown restrictions. Those carrying first or unwanted pregnancies, women experiencing miscarriage, survivors of abuse and trauma, and mothers of older children experienced acute and/or particular forms of isolation. These issues are explored under the following headings:

- Attending appointments alone
- Restrictions in hospital around birth
- Perinatal isolation

3.3.1 Attending appointments alone

Women had to attend appointments, scans and procedures alone, meaning that extremely difficult news was received without support, and experiences that were expected to be joyful were instead fraught. For many disabled women and those with long-term health conditions, BME women, migrant, refugee or asylum-seeking women, and younger women, attending appointments alone may also have presented practical, linguistic, and cultural barriers.

Unexpected complications

The worry about and reality of miscarriage or complications was a strong theme to emerge in the data.

"I was not allowed anyone in my scans with me. This affected me very badly as I had previously had a pregnancy that ended in miscarriage at 16 weeks. To go through a scan alone was horrible."

"Not having my partner there during my early scans due to bleeding was incredibly traumatic. I was at one point in [A&E] alone being given an internal examination on my own and told I was having a miscarriage. I was later phoned to come for a scan on my own. Thankfully, the baby was safe and well but to go through this alone was inhumane."

"I couldn't tell you what the sonographer told me or offered me in terms of support. After she gave the news that I had miscarried, I went blank. Having someone else there with me would have been so helpful to listen and take on board what the sonographer was saying, and also physical support - a hug, to let me cry."

Lack of trauma-sensitivity

Rules that women could not be accompanied to appointments were applied in a blanket way. Lack of discretion or flexibility regarding non-routine appointments or previous trauma caused women distress. Participants explained that knowing in advance that they would be alone during scans to address complications was extremely difficult.

"I need additional care due to a previous neonatal death and to have to attend appts myself was not easy."

"I also had to go to an additional growth scan alone towards the end of my pregnancy, this made me feel really anxious and overwhelmed. Staff here were also great, but I was left alone in the room whilst someone sought a colleague for a second opinion, and again this just felt like a really scary and overwhelming situation to be in alone."

Inadequate support

Respondents had to attend managed miscarriage, fertility treatment, or abortion care services by themselves. Going into these demanding situations alone, which often require practical as well as emotional support, added an additional layer of strain for those accessing services.

"I wasn't told that for most of my medically managed missed miscarriage I would be alone."

"Not allowing my partner to attend appointments was really isolating and made the process much harder. Especially when we had an unsuccessful implantation and then a miscarriage. It was very upsetting to go into the aftercare appointments alone."

"Lack of support [accessing abortion]".

Several respondents described frustration at an inconsistent approach to accompaniment, where partners were allowed at routine scans but not at additional ones or partners being able to attend appointments but not alternative support.

"No, not [alone] for planned scans but I did have to go in for a low movement check alone."

"Although partners were allowed to attend at times my husband worked away which made it difficult as I had to attend on my own where in previous pregnancy I took my mum when my husband was away."

"Partner wasn't allowed in any of the scans outwith 12 and 20 weeks."

Lack of flexibility regarding the reality of women's lives also caused practical and gendered difficulties. For instance, women were unable to take their children to appointments leading to the need for costly childcare. This may have prevented women from accessing needed healthcare.

"Scans alone. Appointments alone. Had to pay for extra childcare for my other children in order to attend appointments due to husband being on shift and no allowance for a child to come to the unit with me."

3.3.2 Restrictions in hospital around birth

A high proportion of women highlighted the impacts of being isolated in hospital prior to, during, and after giving birth. This had particular implications for women with long-term health conditions, as highlighted in respective sections of this report. While many respondents were clear that they understood the rationale for the restrictions in place, they also felt enduring distress and disappointment at having missed out on irreplaceable experiences.

> *"I was unable to have any family come and visit me and my first son, something special I will never get back or have again which makes me sad because it's a special moment."*

Limited visitation

Many women were specifically affected by their partner having to leave immediately after the birth and having extremely limited visiting access.

> *"I found it very difficult that my partner was only allowed in the room while I gave birth then he had to leave, and was only allowed in the hospital 1 hour each day while I was there."*

> *"I am still dealing with the consequences of my partner only being allowed to be with me for 1 hour per day while me and my daughter were in hospital - and I kept being told that I was lucky that I could have this hour!"*

> *"I spent 14 hours on a ward alone with no support at all, my partner was kicked out within an hour of my baby being born. It was hellish."*

Labour and delivery

Others spent long periods of time alone, waiting for induction or surgery, or in the early stages of labour. Participants described how difficult and frightening this was, with significant impacts on their experience of giving birth.

"I had an elective c-section, spent a long morning on an empty ward completely alone, waiting to be taken for surgery. It was scary and isolating."

"I was admitted at 37 weeks for induction. I was unable to have my partner attend with me on admission, however he was able to visit for an hour in the evening. I was in a side room, and felt very isolated. There was no discussion with me on admission regarding my birthing plan, or how the induction process might make me feel. I had a bad reaction to the medication which resulted in me significantly vomiting for most of my first night in hospital. I felt forgotten and that I was a burden to the staff when I had to buzz numerous times. The following day I again felt isolated in the side room."

"I was induced and had a long and difficult labour, most of which was spent alone in a small cubicle and in severe pain due to a reaction to the medication. By the time I was moved to the labour ward I was exhausted and upset - it made the rest of the experience even more difficult to cope with."

Postnatal support

Restrictions also had implications for access to vital and routine postnatal support from practitioners for women and for their babies.

"In hospital post birth I was in isolation, making it harder to access specialist breastfeeding support and basic checks like my baby's hearing check were missed."

3.3.3 Perinatal isolation

The lack of antenatal and coordinated postnatal support that is detailed in Section 3.2 on 'Standard of care' had an isolating impact on women. Participants told us they had missed out on important opportunities to meet other new parents in their areas, undermining prospects of developing wider peer support networks.

Mental health and wellbeing

High numbers of respondents described isolation from friend and family networks during restrictions and how this affected their mental health and wellbeing, with some experiencing ongoing trauma and other long-term impacts.

"I isolated as much as possible in the 6 weeks before my due date, which covered Christmas. That was a lonely time but I couldn't risk my husband catching Covid-19 and not being allowed to be with me while in labour. It was also very hard to only have him visit for 2 hours a day on the postnatal ward. I'd had a traumatic birth and needed his support, and he missed out on those first days with his son."

"When I look back on my maternity leave, it is a time of trauma, abandonment and isolation."

"As I said after the baby was born I felt very let down by the midwives and I felt I was on my own. I was so glad this was not my first baby."

"Most of our family and friends were unable to meet my baby until he was about 6 months old. It was incredibly difficult and my mental health suffered hugely. I tried to do classes online (including one provided by NHS) but it was difficult and I also feel I missed out on building a support network of other mums at baby classes etc."

Care for older children

Several participants highlighted the additional pressures of existing caring roles for older children and the impact of isolation from grandparents and other support. This is a gendered issue, with women continuing to undertake the majority of childcare and domestic labour in Scotland. This imbalance intensified during the pandemic.[39] Single parents, 92 per cent of whom are women, were particularly affected by isolation and lack of support for older children.

"I had limited support from family and friends, community groups were difficult to access as most had been stopped. I felt fairly isolated and wished family and friends had been able to visit and support in the form of childcare for older sibling, cooking meals, housework etc. I felt my mental and physical wellbeing was greatly impacted and I look back on this period as traumatic. The January 2021 lockdown is one of the lowest points of my life with a new baby and toddler and very little support."

"I was very isolated. I was not able to utilise grandparents for support which would have been a big help considering I already had an older child. Not being able to attend baby groups has left me isolated from peers with babies the same age."

"It was a very worrying time, both the risk of becoming unwell and the judgement from members of the community for 'rule breaking' (allowing my child to stay with grandparents whilst I was in hospital)."

A number of profoundly gendered issues that intersect with this widespread experience of isolation were not explicitly raised in our survey, but should also be taken into account. Safety was further undermined for women experiencing domestic abuse or at risk of domestic abuse during Covid-19 restrictions.[40] The Royal College of Midwives and Royal College of Obstetricians and Gynaecologists describe domestic abuse as a maternal health issue, stating that "not only is domestic abuse more likely to begin or escalate during pregnancy, but it has significant health implications for pregnant women and their babies".[41] Unwanted pregnancies can also place women at risk of harm from coercive partners, and disabled women experience especially high levels and particular forms of violence against women.

Single mothers faced especially stark challenges juggling childcare and employment in pregnancy and postnatally, as well as managing care of older children and newborn babies. Women who are unpaid carers for disabled and older people, a group for whom isolation was a predominant pre-existing issue, have also been specifically and particularly impacted by Covid-19. Many unpaid carers, including pregnant women and women with young children, continued to take additional precautions when restrictions were eased. Many have had to shield for years, and some continue to do so.

Summary and recommendations

Isolation negatively impacted on all aspects of women's pregnancy and maternity care at the height of the pandemic, as well as their broader perinatal experiences. Having to attend appointments alone, whether for routine scans or in relation to unexpected complications, was a key theme to emerge and had a lasting impact on many participants. Women described undergoing managed miscarriage, fertility procedures, and abortion care alone as traumatic. Similarly, many were forced to spend much of pre-labour, labour and the immediate postnatal period in isolation. This had a wide range of impacts, including for disabled women and those with pre-existing health conditions. Lack of antenatal and postnatal support in the community, both formal and informal, contributed to poor mental health and wellbeing for many women. Those with existing caring roles were impacted in particular ways by restrictions mandating isolation.

Recommendations

Scottish Government and relevant health bodies should:

- Explore how perinatal isolation, and therefore poor health outcomes, can be mitigated within any emergency public health guidance and more broadly.
- Apply mitigations to allow women attending non-routine appointments, giving birth, or experiencing miscarriage or baby loss to be accompanied in any future public health crisis.
- Produce intersectional guidelines to ensure that postnatal support needs are met, including for disabled women and those with health conditions, and with regards to c-sections, arising complications, and perinatal mental health.

3.4 Inconsistency across health boards, healthcare services and healthcare settings

Inconsistent delivery of services across and within health boards was a key theme to emerge from the survey. A sense of injustice regarding the inconsistent interpretation and application of guidelines came through clearly in women's responses to a range of questions regarding access to pregnancy and maternity services. This caused anxiety, frustration and concern.

These responses stand in stark contrast to several of Scotland's Health and Social Care Standards, and in particular number 4: "I have confidence in the organisation providing my care and support."

Issues relating to inconsistent delivery of pregnancy and maternity services during Covid-19 are explored under the following headings:

- Discrepancies between national guidelines and service delivery
- Discrepancies between different health boards or healthcare settings
- Comparison with other aspects of restrictions and guidelines

3.4.1 Discrepancies between national guidelines and service delivery

Numerous participants raised that it was difficult to ascertain what to expect when accessing services as restrictions 'on the ground' were often not in line with national guidelines.

"Information available from Government websites differed from restrictions on ward access etc. on the ground."

"Midwives themselves were very distressed at local health board policy which contradicted guidance provided both nationally and by the RCM [Royal College of Midwives] etc. at times."

"Government level advice was frequently not followed in different healthcare settings. Policies and information within individual settings often differed between in person visits and information given online by that setting."

3.4.2 Discrepancies between health boards or healthcare settings

Other respondents expressed frustration at the inconsistent application of guidelines across hospitals or health boards, meaning that it was hard to know what to expect. We understand that this may be partly explained by the 'footprint' of different health settings, in terms of available space and required social distancing. However, there was a systemic failure to communicate this to those accessing services. This was highly stressful for pregnant women, leading to unsatisfactory experiences and potential negative impacts on health outcomes.

"My partner wasn't allowed to attend my 12 weeks scan when it was allowed in the rest of Scotland as Raigmore hospital didn't allow it until the following week."

"Dad allowed into ultrasound due to hospital policy which was counter to / against the ever-changing national policy."

"My partner was not allowed to various appointments or scans. My friend in another hospital was allowed her partner into every appointment. This was distressing as there were times I was told baby had stopped growing or I had gestational diabetes and had no support with me to help take in all the information."

"I feel really lucky, and a little guilty, telling friends about my experience. My partner attended all appointments and was allowed in the hospital between 8am and 8pm while I was being induced, and after I'd given birth. A friend who was seen in Leith (I was seen by the Tollcross team) wasn't allowed her partner at appointments. I now live in Glasgow and all my friends here had a very different experience - they didn't have the same midwife at all appointments and their partners were very restricted in the amount of time they were allowed to be in the hospital during and after the birth. One friend's husband wasn't allowed in the hospital until she was in third stage labour. These sorts of stories are terrifying."

"I gave birth at a maternity unit then transferred to hospital due to repairs needed. Both settings had different expectations of mask wearing, Covid testing etc."

There were also inconsistencies across healthcare settings regarding informal practices that emerged, such as recording scans for partners that were not permitted to attend.

"Initially NHS Tayside would not allow the scans to be photographed or videos either so my partner missed out. I could not be accompanied at the appointment (and onward referral (following baby being [more] quiet than usual)."

"Not allowed to hear heartbeat nor record it for partner waiting outside in car. I'd previously been told I could do this."

3.4.3 Comparison with broader guidelines

Some participants voiced frustration with broader elements of the restrictions and what was permitted in other aspects of healthcare or public life at times when women were still not allowed to be accompanied at maternity wards in hospitals.

"Knowing that people could go to the pub, have small gatherings and weddings and go on dates all while I was alone in hospital felt like a betrayal. The guidelines felt cruel and empty, they never once tested me or my partner. They had us crammed into wards at 150 per cent capacity."

"I was only allowed 1 birthing partner even though there was hardly any restrictions anywhere anymore. There was visiting allowed in the rest of the hospital but I was only allowed 2 visitors, so basically having to choose between me and my husband's parents."

Summary and recommendations

Participants voiced their frustration at the inconsistent interpretation and application of guidelines, which caused considerable uncertainty and anxiety for those accessing services. Women were unsure of what to expect and described a sense of unfairness and loss due to a perceived postcode lottery regarding the implementation of restrictions. This pertained to discrepancies between national guidelines and delivery of services on the ground, discrepancies in application across health board areas and between healthcare settings, and in relation to other aspects of the guidance, such as hospitality settings.

Recommendation

Scottish Government and relevant health bodies should:

- Develop an approach to standardise and communicate the application of emergency public health guidelines across health boards and between health settings, and to implement corrective action if needed.

3.5 Flexibility and options

This section explores experiences of flexibility and choice when accessing pregnancy and maternity services during Covid-19. The Scottish Health and Social Care Standards promote flexibility and choice in how people are cared for and supported, to enable people to be in control of their own care and support, and to ensure that care and support is adaptable to individual needs, choices and decisions.[42] Once again, this is a highly gendered issue which links to health inequalities for women. As described in Section 3.2 on 'Standard of care', women are less actively involved in planning their own treatment than men. This is reflected in research into women's experiences of Self-directed Support, which found that women were more likely than men to have had decisions about their support made by a social work professional.[43] Disabled women, and learning disabled women in particular, continue to experience inappropriate and paternalistic interference in their reproductive decision-making.[44]

The survey data highlights that widespread disruption to pregnancy and maternity services during Covid-19 impacted upon flexibility, choice and control for a high proportion of women. These issues are explored under the following headings:

- Centralisation of services
- Lack of flexibility in application of Covid-19 mitigation measures
- Vaccination
- Treatment options

3.5.1 Centralisation of services

Several respondents reported a centralisation of pregnancy and maternity services, with appointments and scans being moved away from local units. As a result, respondents had to travel longer distances to access care, and several respondents reported the impact this had on continuity of care. For women experiencing their first pregnancy, this lack of continuity was often particularly difficult, causing additional stress and anxiety.

> *"Having to go all the way to the main hospital 40 minutes away for scans."*

"All appointments moved away from my local centre to a more central location. I never saw the same midwife twice."

"I did not have one midwife for appointments and saw someone different every time."

3.5.2 Lack of flexibility in application of Covid-19 mitigation measures

Across the survey findings, respondents expressed a general understanding of the measures taken by healthcare services and professionals to mitigate Covid-19 infection, and some felt that it was necessary and reasonable for such risks to be balanced against personal preferences in the context of the pandemic.

"The approach taken on the labour ward where I and my birth partner could remove masks when we were in the labour suite I found very positive [...] I had to take a Covid test before admission but again this felt reasonable. I felt my labour experience was as normal as possible given Covid restrictions at the time."

"My partner had to socially distance during scans and stand outside until our appointment. Felt like he was unwelcome in the process. Obv the healthcare [professionals] needed protecting so we never minded but it did make the whole process rather an unhappy one."

In this context, it is worth noting gendered patterns regarding public complaint. Women and girls are socially conditioned to be 'nice' and often avoid confrontation when navigating public spaces, including services.[45] This squarely relates to women's security and safety, as well as cultural expectations regarding femininity. We highlight this here as data compiled by the Scottish Covid-19 Inquiry will relate to clearly gendered issues, and those interpreting evidence should be mindful of these cultural inequalities regarding expected behaviours.

Midwifery and screening services

Respondents also described a lack of flexibility in restrictions that meant having to attend appointments (including scans and midwife appointments) alone. This had a significant emotional impact for many women, particularly for those who had experience of fertility treatment, miscarriage, or baby loss. The findings indicate a complete lack of flexibility and sensitivity for personal circumstances in many cases, including the trauma that many women were experiencing. Further information on this is set out in Section 3.3 on 'Isolation'.

"Husband was not allowed into scans or midwife appointments. When we were sent to hospital following a routine midwife appointment where she struggled to find heart beat I was told I HAD to come into hospital alone at 40 weeks to be told on my own that our baby had died. I will never forgive the NHS for this."

"I had late scans, and one which was concerning my health and baby's health and complication. I attended these appointments alone. The screening still took place as normal but difficult to be alone during."

"I believed I was suffering an early miscarriage (having previously had one). I had to attend alone. My partner was not allowed to attend any scans or appointments until v. late in pregnancy and then only ones with a consultant and no scans. It was his first and only baby. We were both very distressed."

Labour and delivery

Respondents explained that inflexible application of mitigations failed to take account of individual needs. In turn, this led to traumatic and difficult care experiences. Several respondents shared how a lack of flexibility in restrictions meant that they experienced labour and delivery alone in extreme or very difficult circumstances.

"Towards the end of my pregnancy I started to have high blood pressure and suspected pre-eclampsia. I attended maternity triage on a number of occasions and could not have my husband with me (he waited outside in the car). The decision was made that I would be induced. I was in hospital alone for a number of hours before he could come in. Once he arrived at the hospital he was told he was not allowed to leave and if he did (even to get some fresh air) he was not allowed to return."

"Partner being asked to leave and couldn't come back in the morning after birth, a haemorrhage and other complications made this very hard."

Similarly, women raised a range of issues highlighting the lack of flexibility or discretion with restrictions relating to maternity care in hospital. The lack of support women received following caesarean section, a major surgery, was documented by several participants.

"I was moved to a ward 4 hours after my daughter's birth and did not see my husband for a day and a half. He was not allowed to be on the ward with me at any time. My daughter was readmitted 2 days after her birth as she had lost weight and had jaundice. Again I attended all these appointments alone. My daughter was admitted and I was allowed to stay with her, despite having a private room I was not allowed to have my husband there at any point."

"After having a c-section my husband was only allowed to stay for 2 hours and then sent home so I was left in a room with no husband and no visitors with a newborn"

Masks

We asked respondents whether they were required to wear a mask during labour. 84.1 per cent were not required to do so and chose not to wear a mask. 26.8 per cent were required to wear a mask, but not during active labour, and 6.1 per cent were required to wear a mask at all times.

"During the c -section I was asked to wear a mask which was understandable but difficult."

"I was made to wear a mask at times during labour and most of my birth choices were not respected, with Covid given as rationale. It was horrific at times."

Respondents also shared specific experiences and challenges of mandatory mask-wearing during pregnancy.

"Having to wait with masks on in hot waiting rooms for scans. I suffered from hyperemesis so being alone was difficult. Carrying a bag, wearing a mask, speaking to people were all difficult. I had less checks than in my first pregnancy despite both being considered high risk... I know why we wear/wore masks but it was incredibly difficult for someone with hyperemesis. It made me not want to leave the house and I became quite isolated."

"I just wish they would do away with masks at all for pregnant women as it's horrific being out of breath or feeling like you can't breathe with a mask on."

3.5.3 Vaccination

Several respondents reported a lack of procedural flexibility that impacted on people's ability to access the vaccine.

"I was unable to book one via the online system and my midwife was not able to book it for me. I've still not had my booster for Covid and baby is now born. I am due a booster due to other conditions too."

Prescriptive eligibility criteria meant that several pregnant women were unable to receive the vaccine on account of their age. Young women felt unnecessarily exposed to potential infection in healthcare settings, and that pregnant people should have been prioritised in vaccination programmes.

"I was too young to be offered the vaccine while I was pregnant. I woke up in hospital on the second day of my induction to my tea, my toast, and my text inviting me for my vaccine. I found it frustrating that I wasn't prioritised as a pregnant person, because when I was in hospital to give birth (June 2021) the transmission of Covid-19 was primarily taking place in health care settings. As a pregnant person I was almost guaranteed to go to hospital, and I felt that I should therefore have been offered the vaccine as a priority. Even if I wasn't necessarily going to suffer because I was low risk in other ways, I was going to be in the place where Covid was transmitted and it could have helped with lowering transmission."

3.5.4 Treatment options

The survey findings highlighted a lack of flexibility regarding treatment options across all aspects of pregnancy and maternity services.

Several respondents reported distressing experiences of miscarriage and abortion during Covid-19, with limited treatment options, support and follow-up care.

"I was offered no support or follow up care, and only given a leaflet to choose a treatment option. When I telephoned with my choice I was told that was not an option 'due to Covid'."

"I was seen in a room for five minutes and sent home with [abortifacient] pills. No offer of help or support."

Survey respondents described how Covid-19 impacted their birthing options and experiences. 43 per cent felt their options for delivery changed before labour, for example, whether they had less choice in birth setting or a choice of caesarean delivery.

"Because of Covid restrictions I chose to have my birth at home so that my partner could be present. I wasn't allowed anyone else present. I had thought that these restrictions would have changed by the time I gave birth so planned to have my mum there too but that wasn't able to happen."

"I wanted water birth. Was told not possible as these rooms were used for Covid patients."

"I made choices based on pandemic rules and not just about my own birthing preferences in order to not be left alone and partner sent home amid active labour. I think the situation also contributed to a high blood pressure in labour."

The flexibility afforded by the introduction of telemedical abortion was highlighted as a positive change, enabling women to take abortion medication at home.

"I previously never wanted to have an abortion but with the cost of living we knew we couldn't afford to have another one and wanted to prioritise the quality of life our 2 children have. I thought it was great that I could have it at home. I had to pick up the medication from our local hospital. The instructions were very clear and the doctor went through all the information on the phone very clearly. It was awful to experience but being able to do it in my home made it better."

Summary and recommendations

The research indicates that while many respondents understood the need for measures to mitigate Covid-19 infection in healthcare settings, others experienced restrictions as illogical, inconsistent and inflexible. The data highlights a lack of flexibility and sensitivity in the application of Covid-19 mitigation measures, particularly in distressing circumstances such as miscarriage and baby loss. Covid-19 restrictions also had a direct impact on birthing options, preferences and experiences, with respondents describing a lack of person-centred care and choice. Additionally, the centralisation of services led to lengthy travel times for some respondents and lacking continuity of care. The findings also highlight specific challenges faced by some individuals in accessing the Covid-19 vaccine due to inflexible processes and criteria.

Recommendation

Scottish Government and relevant health bodies should:

- Retain a clear focus on person-centred and trauma-informed care within any future emergency response, including prioritisation of birth plans and support preferences wherever possible.

3.6 Narrow focus on delivery and urgent postnatal care

A final Covid-19 specific theme to emerge was a narrow focus on delivery and urgent postnatal care. Many women described an experience of maternity services that seemed overly focused on the birth itself, to the detriment of other aspects of health for both themselves and their babies. We have included this theme within the section on 'Covid-specific experiences', but many of the issues raised cross over significantly with Section 5 on 'Wider issues with pregnancy and maternity services'.

We are aware that a narrow focus on birth within hospital settings is a pre-existing issue that was perceived by some women prior to the pandemic. However, the survey data highlights that this was amplified by disruption to maternity services during Covid-19, with wider health and support needs being overlooked for many who took part in our survey whilst in labour and post-delivery.

These issues are briefly explored under the following headings:

- Breastfeeding
- Caesarean section
- Complications
- Long-term health conditions
- Mental health
- Pain
- Separating mother and baby
- Sexual assault

3.6.1 Breastfeeding

Many women choose to attempt breastfeeding, with well-established potential positive impacts on health outcomes and bonding between mothers and

babies.[46] Various respondents to our survey described disappointment and frustration at the lack of support with breastfeeding during the pandemic.

"I had no lactation support despite wanting desperately to breastfeed."

"Lack of in person support meant I was unable to breastfeed due to latch issues."

"Generally OK but very poor regarding breastfeeding. I was threatened with readmission to hospital as I was grossly ill-informed regarding breastfeeding. I struggled with breastfeeding until I was put in touch with breast buddies."

3.6.2 Caesarean section

Caesarean section is a surgical procedure that carries possible complications and significant recovery time. This is often overlooked by social networks and society more broadly within the context of the joys and demands of a newborn baby. Given the pressures in hospitals during the height of the pandemic, women undergoing c-sections also felt inadequately supported by the healthcare system.

"I had a c-section and only had my partner there during the operation and then spent a week alone with no visitors trying to recover with a newborn after heavy blood loss."

"I had a long and difficult labour ending in an emergency c-section and I was home less than 24 hours after the surgery with next to no information on how to care for myself or my baby. I was anxious and in a lot of pain and experienced some complications healing and don't feel the aftercare was great."

3.6.3 Complications

Similarly, complications that arose during pregnancy or birth were not picked up on or addressed in a timely manner. This led to a prolonged period of intervention and a second hospitalisation for one woman who took part in our survey.

"Had HG [hyperemesis gravidarum]. Not properly discussed or treated as I was hardly ever seen in person."

"Immediately after birth, my symptoms of infection were dismissed as standard postnatal issues by the health visitor, community midwife and hospital staff. After my second stay and surgery, my health visitor in particular recognised that I needed proper support - she really stepped in to support my daughter, partner and I to recover from our horrible start."

"It was my first time being pregnant and my partner and I needed guidance on what was "normal" and to be expected. We trusted the professionals who told us the sickness I had was bad luck and prolonged morning sickness. Nobody asked to see me in person to run tests even though I had persistent symptoms and issues. My baby was delivered 14 weeks early due to undetected type 1 diabetes. I had symptoms of this condition before I was even 12 weeks pregnant and cannot help but feel that if tests were done earlier on and I had more contact and support with midwives and doctors, things could have been different."

3.6.4 Long-term health conditions

The reality of women's long-term health conditions as they related to restrictions was not always taken into account during labour. Participants described a lack of flexibility and degree of care that is inconsistent with Scotland's Health and Social Care standards.

"As an asthmatic person in a huge amount of pain and distressed, I was reminded to wear my mask whilst crawling to and from the toilet on my own. After a traumatic birth and a lack of mobility due to my SPD [symphysis pubis dysfunction, or pelvic girdle pain], I was told my partner could only visit 1 hour a day. I could not walk or breathe. I went 3 days not eating, only occasional toast they could bring to the bed."

"Not having anyone with me during labour after admission was very difficult. It was difficult emotionally, but also practically - I am very short sighted (close to threshold for legally blind) and after I removed my glasses at one point a midwife moved the table they were on. Without them I could not find or operate the call button for help, and so was left on my own with no access to food, water, light, or any supplies."

3.6.5 Mental health

The impacts of Covid-19 restrictions and wider aspects of the pandemic on perinatal mental health and wellbeing are documented throughout this report, and in particular in Section 4.2 on 'Mental health and wellbeing'. Within this, women's mental health was negatively impacted by their birthing experiences, resulting in part from a lack of holistic support and a narrow focus on delivery.

"I wanted a debrief with consultant about some things that had happened during my labour and this ended up taking 8 months after delivery to get that appointment because of Covid-19 related delays and workloads and poor communication. Having that appointment sooner would have helped me massively and I think because I wasn't severely depressed my feelings of anxiousness, which were unusual for me and debilitating, were brushed off as 'baby blues' and I was left to it."

3.6.6 Pain

Staffing and bed shortages meant that pain management was lacking for some women. Clearly, this had adverse impacts on their experience of labour and delivery. Pain is a highly gendered issue, with women's pain more poorly understood, diagnosed and treated than men's across primary and acute healthcare settings.[47]

"It was horrendous, I lay in the corridor in huge amounts of pain before anyone let me in the building. And my husband was told to leave 10 minutes after my baby was born via emergency c section and not allowed to return till he picked me up from the car park 2 days later. I had 0 help on the ward and was in huge amounts of pain with no support."

"Left with no painkillers for 24+ hours despite requesting. And no additional support to care for newborn."

We also touch on women's pain in Section 3.2 on 'Attitudes and treatment from staff' and Section 5 on 'Wider issues with pregnancy and maternity services'.

3.6.7 Separating mother and baby

The application of restrictions also meant that some women experienced separation from their babies in the neonatal period. This had grave implications for their wellbeing, as well as for breastfeeding and other practical concerns.

"I went into hospital 10 days after birth as I had a haemorrhage and experienced a huge amount of pain and blood loss. I was told that my baby could not come with me in the ambulance because of Covid restrictions (not allowing visitors) and so I left my 10 day old, breastfeeding baby with my partner from 2am in the morning (when the ambulance came) till 2pm the next day when I was moved to a ward that allowed visitors.

This was incredibly traumatic for both me and my partner (possibly our baby too). I was in the ambulance for 4 hours before being admitted to hospital. As I was breastfeeding, once I was in a hospital gown, my gown was immediately drenched from breastmilk so I was cold and wet and there was no one around to help me with a change of clothes or blanket. I wasn't offered any food or drink the whole time I was in A&E (till 9am the next morning) which given the breastfeeding was really hard.

In the meantime my partner who had been left with our 10 year old, had to walk 30 minutes away to a 24 hour asda with our baby to buy formula milk at 2 in the morning. I later found out I should not have been separated from my baby and this was incorrect information given to me by the ambulance team. After this event I became very protective over my baby, suspicious of people trying to provide support and would not be separated for even short amounts of time, fearing the intentions of anyone who suggested I was."

"I was transferred by plane to RAH at 6 am Glasgow. [This] was very difficult for me. I was so scared. Looking back my mental health had been suffering for some time and I was separated from my husband and newborn baby [...] I was then transferred to the postnatal 4 bedded ward. After several hours of waiting my son was able to reunited with me at visiting time at 6pm. My husband and mother were able to see me briefly and I was left alone with my baby until I asked to be discharged at 4pm the next day."

3.6.8 Sexual assault

Survivors of sexual assault need access to gender sensitive, trauma-informed care and support. This is particularly important when they are isolated and unable to access existing support networks, as was the case in hospitals during Covid-19 restrictions. Experiences such as those described below are likely to compound existing trauma and undermine recovery from sexual violence and post-traumatic stress disorder (PTSD).

"I cannot put into words the trauma even now. I was left unsupported by my partner in an overrun hospital. [...]The hospitals were well over capacity and I had to labour in a ward full of women who had already had their babies. I was alone, no partner, no midwife until "active" labour. I was told they had to check me to know if I was dilated enough to have my partner with me. My birth plan was clear I did not want any more vaginal checks than absolutely necessary. I felt I had no choice but to submit to check after check to convince them I could have a partner."

Summary and recommendations

Women told us that their health and support needs were neglected when giving birth at the height of the pandemic. Restrictions and pressures relating to capacity meant that a narrow focus on delivery and essential postnatal care undermined quality care for women and their babies. Needs that were overlooked related to breastfeeding support; caesarean section aftercare; unexpected complications during and after labour; women's long-term health conditions; mental health and wellbeing; pain management; mothers being separated from newborn babies; and experience of sexual assault. Many of these highly gendered issues relate to Section 5 on 'Wider issues' within this report but should also be considered within examination of the maternal healthcare that women received during the pandemic.

Recommendation

Scottish Government and relevant health bodies should:

- Integrate the need for a holistic approach to labour and delivery into crisis management planning and maternal health policy and guidance frameworks.

Findings: Ongoing Implications

4. Findings: Ongoing Implications

This section of the report sets out some of the ongoing impacts that women continue to experience as a result of changes to pregnancy and maternity services during Covid-19. These issues are explored under the following headings:

- Missed opportunities and support
- Mental health and wellbeing
- Lasting trauma

4.1 Missed opportunities and support

As a result of Covid-19 restrictions and mitigation strategies, numerous respondents felt that they had missed opportunities and support from midwives and healthcare professionals, as well as from other expectant parents, friends and family. For many, this meant that they missed out on practical guidance, such as support with breastfeeding and the opportunity to meet and learn from other new parents. This has potential implications for long-term mental and physical health, for both mothers and their children, including in terms of bonding and development.

"As it was my 1st pregnancy I didn't know what to expect and did feel my midwife did not give much support. I felt I missed out on so much as we only had the minimum appointments."

"There was no antenatal appointments offered so no advice on labouring or how to look after baby following birth. No opportunity to create a new network with other families which is vital for new mums."

"Restrictions had a massive impact, it is only really with hindsight I see how much this impacted us. There was no in-person breastfeeding support available, no baby groups to meet other mums etc. [...] The days were long, and it was extremely isolating."

Respondents described the long-term impact that restrictions had on partners, both in terms of their mental health and wellbeing and capacity to provide support.

"It felt like fathers were forgotten about during the decision to exclude them from antenatal appointments etc. which could significantly impact their mental health and the support they can offer to the mother."

As a result of missed opportunities, several respondents described a lasting feeling of 'resentment' and feeling 'robbed of experiences' and 'special moments'.

"I still feel really resentful that my partner and I were alone for so long in the early days of having our baby. Being unable to have visitors and family for support was really challenging, although at the time we just got on with it. Now when I look back it upsets me and I feel very resentful - I wish we hadn't adhered to the rules so strictly and allowed our parents to be with us. That was my one and only experience of having a newborn and Covid had such an impact."

"I was unable to have any family come and visit me and my first son, something special I will never get back or have again which makes me sad because it's a special moment."

Importantly, the survey findings highlighted that - as of November 2022 - some women continued to miss opportunities such as baby groups despite Covid-19 restrictions being withdrawn. Survey respondents cited long-term reductions in community services, as well as continued anxiety around Covid-19 infection, as key reasons for this:

"No groups were running whilst I was pregnant, and still aren't now."

"I did not and still don't feel confident going to baby groups etc. due to concerns over Covid."

This lack of opportunities for learning and forming peer support networks intersects with a number of structural and intersectional gender inequalities. Women's access to social and cultural spaces is undermined by lesser financial security, leisure time, and perceptions of security in public spaces. Domestic abuse, unpaid care work for disabled and older people, childcare for other children, single parenthood, insecure income, and time poverty shape opportunities for women to access peer support. Many of these issues are heightened for women of colour, disabled women, and refugee and asylum-seeking women, amongst others that experience intersecting forms of marginalisation.

At the same time, structured support groups can be particularly crucial for certain groups, including some disabled women, women with insecure immigration status, women experiencing poor physical or mental health, single mothers, and young women.

4.2 Mental health and wellbeing

Mental health and wellbeing are profoundly gendered. Women and girls are diagnosed with depression and anxiety disorders in greater numbers than men and experience differences in diagnosis, treatment, and access to health and support services. Poor mental health was on the rise amongst women and girls prior to the Covid-19 outbreak,[48] and mental health impacts of the pandemic have been experienced disproportionately by women, particularly by disabled and young women.[49] Depression and anxiety in women is also significantly higher among unpaid carers, lone parents, low-income women, LGBT women, victim-survivors of gender-based violence, and women in the criminal justice system.[50]

In this context, the impacts of Covid-19 on mental health and wellbeing during pregnancy and early motherhood was a strong theme to emerge in our survey, both in response to targeted questions and more broadly. Only 25 per cent of participants said that their mental health had not been affected while pregnant or trying to become pregnant during Covid-19, with 62 per cent stating that it had. Our findings also highlight that women with experience of pregnancy and maternity services during Covid-19 have experienced long-term negative mental health impacts.

We asked whether participants were offered any support for their mental health or wellbeing during or after pregnancy, or while trying to become pregnant during Covid-19. Only 31 per cent answered 'yes', with 62 per cent answering 'no'.

4.2.1 Anxiety

Respondents were invited to share their experiences of perinatal depression and anxiety. Several women described experiencing higher anxiety when pregnant during Covid-19 compared to earlier pregnancies.

> *"Anxiety levels were just a lot higher than with my first. After my 10 days of isolation with Covid I went for a walk on the first evening I was able to leave the house and I just cried as I was so relieved I'd got through it alive."*

The findings highlight that pregnancy-related anxiety was exacerbated by Covid-19 and that this masked underlying worries that women consequently downplayed.

"A confusing time – never sure if the feelings were normal after giving birth or as a result of the worry re: the pandemic. A difficult time which I look back on and think I definitely should have reached out for more help."

"I think with hindsight I was probably suffering from anxiety, but didn't recognise it and didn't seek support for it - I didn't know what it was and thought it was a normal part of becoming a parent. It was such a strange time that it was difficult to know what was related to Covid and what was related to having a new baby. I think with hindsight it would have made sense to keep a closer eye on new parents but that wasn't something that felt like a priority at the time."

"I felt my mental health issues were situational, so didn't feel referrals to specialist support or medication etc. were appropriate. In hindsight I could perhaps have thought about this differently."

"I was diagnosed with postnatal depression and anxiety. It is very difficult to distinguish between mental ill health connected to birth trauma/ sleep deprivation and new parenthood, mental ill health during a period of extremely isolation due to Covid-19 lockdowns and restriction, and mental ill health due to the deaths of close friends and family members. Realistically all of the above played a part, but managing new parenthood solo (with, to be fair, a supportive partner) during the isolation of lockdown was likely a significant factor. That's no denigration of my partner, but one equally exhausted person cannot form a community support network."

4.2.2 Positive experiences

Various respondents cited positive experiences of support for their mental health, particularly from community midwives, health visitors and GPs.

"My named midwife was very supportive throughout my pregnancy and I got on great with my heath visitor so feel I can be honest about [how] I'm feeling to her."

"I feel very lucky to have had the health visitor I did. Without her I think it may have been a different story for my mental health and I could have found it much harder than I did."

"We were offered and used a counselling service for those undertaking fertility treatment. Due to Covid-19 these sessions took place on video calls and phone appointments. I think they worked really well and actually being able to remain at home during the appointments made accessing them so much easier. We had 3 sessions as a couple and I had 1 session on my own - for this session I went for a walk and spoke on the phone with the counsellor - this was a great experience and I really appreciated the flexibility."

However, such experiences were not consistent. Indeed, where mental health support was received, it was sometimes described as being an exception to the rule, with women feeling 'very lucky' to be offered support for postpartum anxiety.

"I was very lucky to be offered CBT for my postpartum anxiety, I had severe trauma from my birthing experience and this helped me somewhat."

4.2.3 Lack of mental health support

Respondents reported experiencing a lack of proactive or suitable mental health support, with the perception that there was very minimal support available. This was felt across experiences, including those accessing antenatal and postnatal support.

"During antenatal appointments, the only time I was offered mental health support was after I questioned the birth plan I was given by consultant and asked to discuss it. It felt very confrontational and not supportive when I could really have done with support."

"I was never diagnosed because I was never assessed. I begged for mental health support for depression and was told they could refer me but I wouldn't be accepted. I was told to think positively and remember that I will have a baby at the end of this. That made me feel worse because I had not forgotten I was having a baby and they made it sound like I had lost sight of what was important when actually my wellbeing was important too."

Lack of integrated mental health support also impacted specifically on people who were accessing fertility treatment, or who had experienced miscarriage or baby loss.

"2 years trying to conceive was a struggle in terms of mental health as it is such an isolating time. I also experienced a miscarriage with no follow up mental health support offered. I have been most supported during my pregnancy with regular checks with midwife."

"There is absolutely no automatic mental health support in the 12 months after pregnancy which resulted in a stillbirth."

"I lost my son at 18 weeks in July 2020. I did not receive any mental health support from the NHS."

4.2.4 Reliance on alternative provision

Due to a lack of suitable support, several survey respondents reported relying on alternative resources such as occupational health, third-sector services, private support, and their own friends and family.

"I went to the GP suspecting I had post natal depression/ anxiety/rage and they told me to go and try self-help websites and forums and come back in three weeks if I did not feel better. Thankfully my partner was a massive help and support and I did not go back to my GP, but I did not feel that they helped at all."

"I was able to get six sessions of counselling through Occupational Health at work, and I spoke to a volunteer at Sands but these are avenues I sought out myself."

"I ended up just going privately to speak to a therapist about my anxiety."

"I received support from a local charity, primarily remotely, which continued into my second pregnancy. I don't know what I'd have done without it and I think the support has prevented a deterioration in my mental health this time round."

Inadequate funding and resourcing clearly have a significant impact on the availability of mental health service provision. The third sector and community organisations are recognised as key providers of person-centred care, however, these organisations face the challenge of securing sustainable and adequate funding. There is also a lack of available specialist services for women. Investment is required in perinatal mental health services that are designed to meet the needs of different groups.

4.2.5 Systemic challenges

Several respondents highlighted that a lack of suitable mental health support was not unique to the Covid-19 pandemic but rather was indicative of wider systemic issues.

"I was anxious in my first pregnancy too and the healthcare offered for each pregnancy wasn't much different. It may have been slightly better during Covid."

"I don't think there is enough support in general to prepare new mums about life after having a baby and the hormones/emotions."

4.3 Trauma

Many participants described the stress and anxiety of pregnancy during Covid-19 as acute, with ongoing impacts of trauma for some women. Women cited Covid-19 restrictions, isolation, lack of postnatal support, and attending appointments or giving birth alone as key factors which were having a longstanding impact on mental health and wellbeing.

"Having your baby during the Pandemic was incredibly traumatic and has left lasting trauma."

4.3.1 Attending hospital

"I am still dealing with the consequences of my partner only being allowed to be with me for 1 hour per day while me and my daughter were in hospital - and I kept being told that I was lucky that I could have this hour! It feels like the world has moved on, while myself and other mums are still dealing with the emotional trauma of separation during what should have been the happiest times of our lives. It has stopped us trying for another baby."

4.3.2 Baby loss

"I have been both fortunate and unfortunate enough to have experienced trying to conceive, pregnancy, baby loss, infertility and then a successful pregnancy throughout the Covid-19 pandemic. I felt that NHS staff did the best that they could during a very difficult time, but some aspects of my care (not being able to have my partner come in to have my son's heartbeat checked, to then be told our son had died whilst my partner and children waited outside in the car, restrictions in labour, lack of face-to-face appointments etc.) truly did make an already heartbreaking time all the more challenging. I feel very fortunate to have made it out of the other side with a healthy 4-month-old daughter now, but I know that the impact on all those who experienced pregnancy, loss or infertility throughout the pandemic will be lasting and significant."

4.3.3 Postnatal isolation

"When I look back on my maternity leave, it is a time of trauma, abandonment and isolation. The one walk we were allowed a day to see other people was an absolute lifeline, which I clung to for 8 months. There were no baby classes, no cafes, no going inside to see other people. The only person who came into my house was my health visitor. This was made all the harder by the inconsistency where in England a parent with a child under 1 year was able to form a 'bubble' with another household - when myself and my daughter, because we were in Scotland, had to cope alone. I went back to work in April 2021 - the same week that lockdown was eased in Glasgow."

"I am still on antidepressants following my experience. It was isolating and difficult. I had to fight to be heard and feel my health visitor really understood me. My GP said because I looked great and had a healthy baby I must feel great. But I didn't, I was newly disabled by SPD [symphysis pubis dysfunction, or pelvic girdle pain] and had lived my life in a tiny flat for a year and now had a baby."

Summary and recommendations

Our research indicates that experiences of accessing pregnancy and maternity services during Covid-19 have led to long term and ongoing impacts for many women. Respondents cited a lack of support for expectant and new parents, emphasising the vital role of community services such as baby groups. The survey findings highlight a substantial gap in proactive and consistent mental health and wellbeing support and pathways across all pregnancy and maternity services. There is also a clear need for recognition and accessible support regarding the trauma and other longer-term mental health issues that women are experiencing in relation to Covid-19. Broadly, the survey findings indicate a need for improved and holistic support and resources for expectant mothers that respond to some of the concerns raised during Covid-19.

Recommendations

Scottish Government and relevant health bodies should:

- Ensure consistent access to dedicated mental health and bereavement support in relation to pregnancy, the postnatal period, abortion, fertility, miscarriage, and baby loss.
- Develop capacity-building to ensure that pregnancy and maternity care is gender-sensitive, trauma-informed, accessible, inclusive, and culturally competent.

Findings: Wider issues with pregnancy and maternity services

5. Findings: Wider issues with pregnancy and maternity services

In response to our survey, women highlighted a range of issues linked to wider or systemic problems within pregnancy and maternity services. We do not cover these in detail here to retain a focus on the specific implications of the pandemic and our input to the Scottish Covid-19 Inquiry. We hope to explore some of these wider issues in further work on pregnancy and maternity services in due course.

Systemic issues raised throughout the survey are therefore briefly set out under the following headings:

- Antenatal support
- Bereavement support
- Dismissal of women's health issues
- Medicalisation and lack of choice
- Mental health and wellbeing
- NHS funding
- Postnatal care
- Pregnancy loss

5.1 Antenatal support

Antenatal support included sexist and heteronormative material that assumed women would be primary caregivers, under-emphasised women's paid work and men's caring roles, and included a focus on body image. This reflects similar issues women have raised with Engender prior to the pandemic.

"Substituting a very dated two-hour (TERRIBLE) film for antenatal classes was particularly poor. It contained such highlights as informing women that the best reason to breastfeed was "to lose weight quickly!", only mentioned fathers during the section about juggling work and new babies (what about working mothers, or families that don't fit the one mum/one dad picket fence model?!), contained no information about bathing or changing babies (this is not something I had a clue about, and "maternal instinct" isn't a magic button), and nothing on what to do if you cannot or do not want to breastfeed. No online antenatal classes were offered in [our] health board for first six months of pandemic, nor even any Q&A zoom sessions etc. Very poor."

Women also flagged a lack of appropriate support in early pregnancy that was unrelated to public health restrictions.

"In addition, in advance of my booking appointment - and ultimate miscarriage - the ONLY information I received from maternity services was a leaflet on the various tests [...] There was nothing about pregnancy, what my body was going through, what is normal, what is a concern etc."

5.2 Bereavement support

Women were not systematically offered bereavement support following baby loss or miscarriage. This is linked to a lack of integrated mental health signposting across pregnancy and maternity services (see Section 4.2 on 'Mental health and wellbeing') and merits specific further investigation.

"Following the stillbirth of our son at full term we were given a Sands leaflet in an envelope from the hospital, that was all. We then had to fight with the NHS for counselling which was eventually given 8 months after the death of our son in July 2020. Following a missed miscarriage in February 2021 we were given the same leaflet- I find this appalling that at two extreme ends of the spectrum of baby loss this is the support given by NHS (and Sands isn't even an NHS organisation, its a charity!! Thank god for these charities to support families!!)."

"My son died after 20 days and I wasn't really offered any mental health support from the NHS."

5.3 Consent

Some women described situations where medical procedures were administered without their consent. This chimes with broader issues with women not feeling heard whilst accessing healthcare, or less involved in planning their treatment than men.[51] This can be particularly problematic for disabled women, both for those with physical impairments and for learning disabled women, many of whom have experienced paternalism and/or infantilisation when accessing reproductive health services in Scotland.[52] Learning disabled women continue to be coerced into sterilisation or long-term contraception use, such that consent is not always fully secured.[53]

"I had been told to wear a mask, which made breathing exercises difficult, and told that I could not leave my bed due to Covid-19 restrictions (with catheter installed without request or explanation to prevent me needing to walk to bathroom). Essentially this felt like I was chained to the bed, with a curtain for privacy, in pain and alone [...] I was not able to walk, which likely extended my labour, and I had no food or drink for the 8 hours of my hospital labour before moving to the active labour ward/rooms [...] Had my partner been there he could have passed me supplies or agitated on my behalf. Midwives also reported that they had to minimise contacts and checks, so I had even more limited human contact during labour. Some of the above are reasonable risk mitigations for stretched staff – but others were unnecessary."

"I was also upset that during this hospital stay a doctor used a speculum on me without asking for my consent first, this set back my healing quite significantly and has probably impacted difficulties I've had since getting a smear test (2 attempts without going through with it)."

5.4 Dismissal of women's health concerns

Linked to issues with consent, women raised examples of their concerns being downplayed or ignored in pregnancy and maternity care. Respondents had to fight for support, reflecting structural issues that lead to women's symptoms and pain being dismissed by health practitioners. This is a highly gendered

and well-documented phenomenon regarding women's access to healthcare in the UK and more broadly.[54]

"GP services were non-existent. Getting any support or help was impossible unless for the baby. I was very unwell and told repeatedly on the phone it was just what happens after birth. I had a severely overactive thyroid. It took 5 months of persistence to get any treatment."

"Immediately after birth, my symptoms of infection were dismissed as standard postnatal issues by the health visitor, community midwife and hospital staff."

We also touch on these issues in Section 3.2 on 'Attitudes and treatment from staff' and Section 3.6 on 'Narrow focus on delivery and urgent postnatal care'.

5.5 Medicalisation and lack of choice

Person-centred care was lacking at the height of the pandemic, including a medicalised approach to pregnancy and childbirth. Options for natural births (e.g., home births) were curtailed, and women were pressurised into procedures, including induction, in contrast to their birth plans. This prevalence of medical approaches and the use of interventions during labour and delivery represents a wider issue across the provision of perinatal care.[55]

"I also wanted a home birth as I find hospitals v. frightening. Home birth was not allowed. Reintroduced just before my baby's birth but then no midwife was available, forcing me to attend hospital. I find this very distressing."

"After some light bleeding I was pressured into an induction by a consultant and told I could not have my partner with me. As a survivor of assault this was very difficult."

5.6 Mental health and wellbeing

Consideration of perinatal mental health, which worsened significantly during the height of the pandemic, is integrated throughout this report. Many of the issues raised clearly relate to wider barriers to good mental health and wellbeing in pregnancy and early motherhood. These include investment in mental health support, staff training, consistent signposting, and joined-up services. Many participants in this research raised the need for better perinatal mental health and wellbeing support outwith the context of the pandemic.

Coupled with structural mental health inequalities for women and girls, this underscores the urgent need for decision-makers in health to take a holistic look at perinatal mental health and provide the necessary resource and supports in dialogue with those most impacted.

"I'm currently 36 weeks pregnant. Other than the pregnancy book, there's been no discussion of mental health by midwife or others. No one has asked how I am."

"I struggled with my mental health and despite going to the GP for help and support was referred to peer support rather than professional support. I gave up with the telephone based peer support [...] There was little support available."

"Didn't feel like this was any different to pre-Covid pregnancy experience."

Abortion care must also be trauma-informed and holistic. Appropriate mental health and wellbeing support should be signposted, and pain and pre-existing conditions should be managed appropriately.

"I was seen in a room for five minutes and sent home with pills. No offer of help or support. I had an abortion because I was sexually assaulted and was offered no help with this. The pain from the pills was excruciating - I live with chronic pain so for me to say something is bad pain-wise, means it is very bad. I was offered ibuprofen."

5.7 NHS capacity

The degree to which NHS services were stretched prior to the pandemic was raised by participants as a key concern. Women with previous experience of pregnancy and maternity services raised increasing pressures on the NHS as a key issue that impacts on experiences of antenatal support, birth, and aftercare

"The discourse around the underfunding and stress on the NHS is really anxiety inducing. Maternity services in 2018 were already very limited with poor aftercare, I'm already dreading being in hospital this time round as I've no idea what standard of care there will be (or lack of). My midwife is very disorganised but is at least a point of contact (as GP is totally inaccessible).

I'm very worried about my wellbeing and the baby's when it is born and have looked into purchasing private services but none seem to exist in Scotland. And with COL [cost of living] crisis I don't think we'd be able to afford them even if there was an option (even just paying for a health care assistant in the hospital to ensure someone can help me use the toilet or bring me water- there were no night staff available during 2018 pregnancy so am expecting it to be even worse this time). Very stressed."

"Only that it was horrific at times and I think proper investment into [early years/family] support needs to be provided as both women and our babies health were badly affected."

5.8 Postnatal support

Several participants described a lack of postnatal support, which they felt was unrelated to the procedural impacts of the pandemic. This reflects a general theme that emerged throughout our survey; the need for holistic and joined-up approaches across services.

"Any issues that I did encounter were related to more deep-rooted issues with maternity care and not Covid related. For example- I was incredibly disappointed with my 6 weeks check-up where I was not physically examined. No healthcare professional has examined me since a week after I gave birth. Whilst I have not experienced any significant issues I did go to a specialist physio to ensure that everything was OK."

"Mixed. General focus was on my baby rather than on both my baby and I, which meant some key checks were missed (e.g., stitches) as "you're not my problem". Not sure that had anything to do with Covid-19 though!"

"I was however suffering from urine retention after birth and this was only recognised by the last midwife I saw post-birth (after seeing multiple others who each did feel on my stomach). I was sent to hospital and it was quite serious."

5.9 Pregnancy loss

Co-location of pregnancy and maternity services and the impact of this on those who suffer miscarriage was also highlighted. This reiterates the need for the 'compassionate miscarriage service' that Scottish Government has committed to delivering within the Women's Health Plan and the SNP 2021 manifesto,[56] including dedicated facilities for women experiencing unexpected pregnancy complications.

"Early pregnancy advice unit being co-located with general maternity services is appalling. To leave my scan knowing I had miscarried to be immediately faced with babies and pregnant women was harrowing. I understand the need to have midwifery services in one place, but at the very least alternate entrances/exits/waiting rooms should be in place."

Summary and recommendations

Many participants raised pre-existing or systemic issues with pregnancy and maternity services while completing the survey. We do not explore these in detail but include a summary to indicate the breadth and depth of issues that women have encountered whilst accessing vital services. These relate to antenatal support, bereavement support, consent, dismissal of women's health concerns, medicalisation and lack of choice, mental health and wellbeing, NHS funding, postnatal care, and pregnancy loss. We recommend that Scottish Government and relevant health bodies undertake a range of actions to better understand women's experiences and needs regarding pregnancy and maternity services, review existing frameworks, act to fulfil commitments on women's health, and invest in quality perinatal care.

Recommendations

Scottish Government and relevant health bodies should:

- Commission intersectional and community-based research on access to pregnancy and maternity services across Scotland's health boards.
- Ring-fence investment in pregnancy and maternity services, and invest in community and third sector organisations that provide perinatal support.
- Use learning from women's experiences of accessing pregnancy and maternity services during Covid-19 to inform maternity and neonatal care policy.
- Implement the Scottish Mental Health Law Review recommendation to broaden the perinatal mental health duty in the Mental Health (Care and Treatment) (Scotland) Act 2003.[57]

- Implement action on women's right to health in Scotland's second National Human Rights Action Plan, including investment in research, intersectional data collection, and gender-competent professional development.
- Enact commitments to establish a compassionate miscarriage service, including dedicated facilities for women experiencing unexpected complications, and work with health boards to ensure consistent implementation across Scotland.
- Fulfil the 2021 manifesto commitment to support the development of a Scottish Institute for Women's Health, to drive changes to policy, guidance and medical training and provide funding to dedicated research into women's health.

Conclusion and recommendations

6. Conclusion and recommendations

This report is based on experiences of accessing pregnancy and maternity services in Scotland at the height of the Covid-19 pandemic. Our survey was distributed widely across Scotland and through organisations working with marginalised groups of women, asking questions that covered antenatal, fertility, abortion, miscarriage, maternity and postnatal care, in healthcare settings and in the community. Respondents also shared their views regarding perinatal healthcare and support more broadly.

A wide range of key themes related to Covid-19 mitigation measures emerged from the data collected. These include communication and information, standard of care, isolation, inconsistency across health boards and between healthcare settings, lack of flexibility and options, a narrow focus on delivery and urgent postnatal care, implications for ongoing support networks, mental health and wellbeing, and trauma. Pre-existing or systemic issues related to pregnancy and maternity services were also raised by many participants in relation to antenatal support, bereavement support, consent, dismissal of women's health concerns, medicalisation and lack of choice, mental health and wellbeing, NHS funding, postnatal care, and pregnancy loss.

We have set out women's stories, frustrations and concerns alongside some initial gender and human rights analysis. Though evidence relating to intersectional experiences is limited, we likewise indicate where issues are likely to have a particular or acute impact on marginalised groups. A key recommendation to emerge from this work is the need for targeted research on access to pregnancy and maternity services for different groups of women and pregnant people. Full recommendations are found below.

This report will be submitted as evidence to the Scottish Covid-19 Inquiry and is intended as a springboard for further work on wider aspects of good pregnancy and maternity care in Scotland. Our huge thanks and appreciation go to everyone who took part in the research and to the organisations that helped to shape and disseminate the survey.

6.1 Recommendations

Our recommendations are aimed at the Scottish Covid-19 Inquiry, with a view to informing its report and recommendations, and at decision-makers in Scottish Government and relevant health bodies. They are based on the evidence gathered for this research and are in line with Scottish Government's commitments to advance intersectional gender equality, realise human rights, and uphold Scotland's Health and Social Care Standards.

The Scottish Covid-19 Inquiry

The following recommendations emerged from women's experiences of pregnancy and maternity services directly in relation to Covid-19.

Learning from the pandemic and in any future public health crisis, Scottish Government and relevant health bodies should:

Communication and information

1. Ensure that tailored information and advice for pregnant women is clear, timely, inclusive and accessible, and is communicated consistently across health boards and health settings.
2. Create mechanisms to ensure that practitioners understand guidelines for pregnant women, including regarding vaccination, and that these are consistently implemented across health board areas.

Standard of care

3. Review perinatal support throughout the pandemic and explore alternative support models that could be applied during any future period of restrictions.
4. Embed human-rights based practice across services, learning from Covid-19 through co-design and co-production with service users and practitioners.

5. Use intersectional gender analysis, Scotland's Health and Social Care Standards, and principles of the maternal and neonatal care plan to underpin development of any future guidance regarding pregnancy and maternity.

Isolation

6. Explore how perinatal isolation, and therefore poor health outcomes, can be mitigated within any emergency public health guidance and more broadly.

7. Apply mitigations to allow women attending non-routine appointments, giving birth, or experiencing miscarriage or baby loss to be accompanied in any future public health crisis.

8. Produce intersectional guidelines to ensure that postnatal support needs are met, including for disabled women and those with health conditions, and with regards to c-sections, arising complications, and perinatal mental health.

Inconsistent application of guidelines

9. Develop an approach to standardise and communicate the application of emergency public health guidelines across health boards and between health settings, and to implement corrective action if needed.

Flexibility and options

10. Retain a clear focus on person-centred and trauma-informed care within any future emergency response, including prioritisation of birth plans and support preferences wherever possible.

Narrow focus on childbirth

11. Integrate the need for a holistic approach to labour and delivery into crisis management planning and maternal health policy and guidance frameworks.

Ongoing implications and wider issues

The following recommendations emerged from broader aspects of women's experience of pregnancy and maternity services, many of which were exacerbated by the Covid-19 crisis.

Scottish Government and relevant health bodies should:

Ongoing implications

12. Ensure consistent access to dedicated mental health and bereavement support in relation to pregnancy, the postnatal period, abortion, fertility, miscarriage, and baby loss.

13. Develop capacity-building to ensure that pregnancy and maternity care is gender-sensitive, trauma-informed, accessible, inclusive, and culturally competent.

Scottish Government should:

Access to quality services

14. Commission intersectional and community-based research on access to pregnancy and maternity services across Scotland's health boards.

15. Ring-fence investment in pregnancy and maternity services, and invest in community and third sector organisations that provide perinatal support.

16. Use learning from women's experiences of accessing pregnancy and maternity services during Covid-19 to inform maternity and neonatal care policy.

17. Implement the Scottish Mental Health Law Review recommendation to broaden the perinatal mental health duty in the Mental Health (Care and Treatment) (Scotland) Act 2003.

Existing commitments

18. Implement action on women's right to health in Scotland's second National Human Rights Action Plan, including investment in research, intersectional data collection, and gender-competent professional development.

19. Enact commitments to establish a compassionate miscarriage service, including dedicated facilities for women experiencing unexpected complications, and work with health boards to ensure consistent implementation across Scotland.

20. Fulfil the 2021 manifesto commitment to support the development of a Scottish Institute for Women's Health, to drive changes to policy, guidance and medical training and provide funding to dedicated research into women's health.

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Appendix [1]: Supporting Quotes

This appendix of supporting quotes has been provided to further illustrate the personal experiences and impacts on women and pregnant people during the Covid-19 pandemic. Quotes are organised thematically, however, many relate to multiple themes and findings.

Communication and information

Lack of communication

"While pregnant in 2020 advice surrounding Covid from my midwife was near non-existent apart from to completely isolate (which was the period of time we had to stay at home but regardless there was no information for pregnant families)."

"I was not clearly advised of the increased risks in my third trimester (Dec 21 - Feb 22). I did not know about the risk of stillbirth (associated with Covid-19) until after I had given birth."

"I've also been ordering the free Covid tests via gov.uk website but again this is all off my own bat, there's been no communication from midwife or through the post about what I'm entitled to and how to access these services while pregnant."

"Some appointments changed to telephone appointments. This is fine in principle; in practice, organisational communication was poor, with automated texts indicating video software should be downloaded and used, but midwives indicating telephones would be used. The app (Badger) was terrible, listing the wrong time and not open to editing."

"My GPs gave me literally no information at all about the impact of Covid-19 on waiting lists for conception support nor on how the Covid vaccine would affect me, despite knowing I'd been trying to conceive for over a year. I spoke to three different GPs about not getting pregnant despite trying for more than 12 months and no one mentioned Covid or vaccines at all."

"I wish I'd had more information about the effect of Covid-19 in the first two trimesters - it would have saved a lot of worry and anxiety."

Information about the vaccine

"The vaccines were just being introduced when I was pregnant and initially, we were advised not to get them, then there was a complete U-turn, and we were advised to get them and told it was totally safe. I was sceptical that they knew enough about a brand-new vaccine and its effects on an unborn child and the child's later development. They couldn't possibly know that 100%. I opted not to get it."

"Information about vaccine safety in pregnant and breastfeeding women was unclear at the start. Lots of pregnant women in my peer group were put off getting the vaccine or went ahead but were anxious about their choice."

"I was applauded for coming forward to be vaccinated while pregnant, the suggestion being that pregnant women were being negligent by not getting vaccinated. I felt this was unfair given how difficult it had been for me to get my first dose - I was very pro-vaccination so I can only imagine how many women who were maybe more on the fence were put off. As it happened I got Covid when I was 34 weeks pregnant and I'm so thankful I persevered with vaccination."

"Every health professional I spoke to during my pregnancy had different information regarding Covid, often conflicting."

"The communication around the vaccine when it first became available for pregnant people was awful. I felt completely on my own in deciding whether to have the vaccine, and some midwives seemed surprised that I had chosen to do so. All that was available at first was a leaflet drawing the pros and cons and leaving women completely on their own to decide."

"The Covid vaccine was introduced during my pregnancy and at the time it was a personal choice to receive it rather than a recommendation. I felt I had to read between the lines of the official information about whether it was safe or not. The consultant and midwives also wouldn't directly say one way or another, which was frustrating and felt like a lot of personal pressure, and guilt if a negative consequence happened to the baby. I did my own research and found an academic via Twitter who had compiled the research on the impact of the vaccine in a much clearer way, helping me make an informed decision."

*"At first vaccination appointment I had a *very* vaccine-hesitant woman giving me it. Thankfully, I had read the materials myself (and have a scientific background, so have a reasonable understanding of vaccinations), although*

I didn't appreciate her 'well, it's not been tested on that many women' comment as she administered it. Had I been apprehensive or worried in any way, she would have done nothing to convince me it was the right thing getting vaccinated. Prior to the appointments, it would have been more useful to send out the relevant information rather than throwing it at me five minutes before getting the vaccine."

"I had my midwife say she would not advise whether the vaccine was safe. At the time the guidance was pregnant women could not get it - it changed a week after I gave birth. I even struggled to be vaccinated whilst breastfeeding despite clear guidance and sat waiting for a long time to get senior sign off."

"There was an inaccessible leaflet from the Royal College of Obstetricians or Gynaecology that just listed the pros and cons. I also experienced some midwives acting surprised that I had chosen to be vaccinated and making comments that 'it's understandable people don't want to be vaccinated as you don't know the effect on your baby'. I felt all of this was very unsettling, and no medical professionals would give any advice or information other than that I had to make up my mind myself."

"There was confusion from front-line staff at vaccine centres when I arrived for scheduled vaccine appointments. Both nurses giving me the vaccines (for first and second dose) insisted they needed confirmation from management that they could give me the vaccination in case something happened to the baby. One nurse said she would be 'unable to forgive herself' if something happened to the baby which made me feel irresponsible, upset, and guilty, even though I'd already done a lot of research and given the choice a lot of consideration. If I hadn't been so sure going in, I think I might've left and not gotten the vaccine at that point."

"It took a longer time for younger people to access Covid vaccines. Then I had to travel really far from home by bus to get one while I was still breastfeeding."

"I've heard nothing about getting the booster. I'm now 36 weeks pregnant and need to chase this up. But it's hard when still working, various other midwife appointments, and a child already. I got the flu and whooping cough jab in an antenatal appointment so why aren't they offering the booster in the same way?"

Standard of care

Lack of in-person care

"Partner was not allowed to come into midwife appointments and my booking appointment was over the phone rather than in person. I didn't see a midwife in person until well after my 12-week scan. As someone who was pregnant for the first time, having no advice or observation until that stage made me nervous."

Poor access to antenatal and postnatal care

"No antenatal classes or just online support available. No opportunity to meet other local parents also pregnant or build local network of friends experiencing pregnancy."

"Antenatal care in terms of education was woeful. Classes were cancelled, and when I asked I was given a leaflet about some e-learning developed in Solihull which was mainly public information (don't smoke while pregnant, etc.) which did not meet my needs at all. We are very fortunate and paid for a remote NCT class - I am not exaggerating when I say that this class and the people, I met virtually were a literal lifeline. I felt completely abandoned by the NHS."

"Maternity appointments were cancelled and delayed. This meant that some problems with my pregnancy were caught later than they would have been previously, with subsequent impacts on my health. Fortunately, my baby was not adversely affected, but I did end up hospitalised at one point following slow diagnosis of an issue".

"This was my first chosen pregnancy, there were complex risk factors for me. The main issue was my SPD, debilitating pelvic pain. I could not attend manual therapy and all physiotherapy was on the phone. The condition was worse and worse without support and by my birth I couldn't walk. It's two years on and I still don't have many days without pain. At the time I weighed up the Covid risk as an asthmatic person and made what I felt was the best choice."

Attitudes and treatment from staff: Negative

"It was easy to blame the Covid-19 pandemic for poor care and lack of empathy experienced."

"Not very helpful due to their fear over contact with others, which was understandable at the time."

"Hospital staff great with my baby, but did not care for me."

"I did feel a bit more overlooked than I had with my previous pregnancy (which was prior to Covid)."

"Health visitor support was remote and seemed very strained. I wasn't in need of much health visitor support but if I had been I worried that this might be difficult to access."

"I had a bereavement course who I could contact but had no other NHS support."

"I was Covid positive before I went into hospital, but was out of isolation a week. I spiked a temp after having my baby and losing a lot of blood. I was treated disgusting in hospital after this. Every person who walked into my room asked me about Covid, when I had it etc., totally took the glory away from having my baby. They left a table at the door and just put my tablets or my food there. I was glad to get home as it made me so anxious."

Attitudes from staff: Positive

"I was very impressed with the quality of care that I received even when it was clear NHS staff were stretched and working under immense pressure."

"I received amazing and incredibly compassionate care during my pregnancy by all NHS staff. I understood that a lot of the uncertainty and restrictions were due to Covid and not a reflection on the staff or board."

"Very good - community midwives, GP and health visitor all extremely supportive and attentive, this was reassuring at a difficult time. GP followed up with health visitor after appointment so felt care was very joined up."

"Could not fault. On the end of the phone if needed. Some appointments were later than the recommended time limit."

"Postnatal midwife care was excellent, the visits at 3 and 5 days were really helpful. Midwives seemed much more willing to visit and continue in spite of the pandemic, however health visiting was not as reliable when they took over."

"Could not fault the care we received in the antenatal and postnatal period from the midwives in Shetland. They were incredibly supportive. For labour and birth, I was in Aberdeen and I also can't fault the care we received there either. Very positive experience all round."

"Postnatal care once discharged from hospital was excellent - both the midwife and health visitor. They were a lifeline as we were in lockdown and couldn't have other visitors."

Staffing and capacity issues

"I lost trust in the health system through my experience in this pregnancy and birth. At times it was cruel and inhumane. I watched other women go through even worse experiences, especially those for whom English was not their first language and disabled women. I was shocked and appalled at times at the standard of care and hope to see this covered in the Covid enquiry."

"At the beginning of my pregnancy I was told I would have a dedicated midwife who would support me. She was put onto the shielding list, and I never saw her again. Every time I had an appointment there was a new midwife. I was not allowed to have anyone with me at these appointments."

"Midwifery care was very good but it was unfortunate that the community service was short-staffed the week after my birth and one of my appointments had to be cancelled."

"I was high risk and had to attend antenatal appts every two weeks. These lasted between 3-4 hours, the majority of which were sitting alone in a hot waiting room with a mask on. I was told Covid measures caused the delays. It was very uncomfortable/stressful and caused me problems having to take so much time off work."

"All in all my care was good and wasn't that interrupted by Covid restrictions. I am rhesus negative and bashed my bump whilst I had Covid. Maternity triage arranged to see me as per normal, just with me attending a different ward. It was reassuring."

Impacts on fertility treatment

"Severe lack of support during fertility investigations and felt I was completely my own advocate."

"I accessed IVF treatment during Covid-19. One of the main impacts of Covid-19 during this time was that if my partner had contracted Covid-19 during treatment, then IVF would have been stopped for three months (even once the hormone treatment had started). It was not clearly explained (I think because it's not clearly understood) the impact of Covid-19 on sperm and subsequent fertility treatment."

"I was due to see the specialist about fertility assistance in March 2020, but the appointment was postponed due to Covid lockdown. It was rescheduled to October 2020 when my treatment started. If it hadn't been for lockdown, perhaps my treatment would have started earlier and we would have become pregnant sooner."

"Felt completely abandoned when all fertility treatment was cancelled."

"Currently trying to get help to get pregnant. Early 2022 the NHS website said if I was 35 and had not yet conceived in 6 months I could get help. In September that changed to 1 year. Guessing it's cause services are stretched due to the pandemic.

"No issues with the service at assisted conception in Ninewells at all - this service was faultless. The holdup was the GP being shut due to Covid when in the process of getting tests for a referral to AC. Re-opening of these GP services was not communicated so months passed, and I didn't know I could return for more testing."

Stillbirth

"Our care during the delivery of our stillborn son was appalling and a disgrace to the NHS - we have raised this with NHS Ayrshire & Arran who are aware of their failings in standard of care (they admitted there was no general care)."

Isolation

Attending appointments alone

"It was very up and down regarding my partner being there. One time he was allowed, the next he wasn't then he was again."

"My partner was not allowed to attend any planned appointments nor was he able to accompany me to triage when I was worried about our baby. He was also not able to attend the hospital when I was admitted for induction."

"My partner was prevented from attending all scans and the majority of appointments. The rules changed whilst I was pregnant but only for certain circumstances and it was disappointing to find out on the day he couldn't attend appointments we were expecting to be at. I cried all the way through one scan, had no idea what the sonographer was saying and could barely even see the screen myself."

"My partner wasn't able to attend. It turned what should have been exciting into an emotional anxiety-ridden nightmare. The constant chopping and changes of rules and regulations meant you had no idea what would happen."

"Partner not allowed to be present. Some midwife appts done by phone rather than in person. But much better service and care than friends who were pregnant in England at the same time received."

"My husband could be in the room for the scan but had to sit far away from the sonographer, so he couldn't hold my hand and it felt like we weren't really sharing the moment together. My booking appt letter (my first midwife appt) was also contradictory in whether I could bring someone with me or not."

"We had an emergency scan just before the 12-week one which my husband could come to, but he was unable to attend the 12-week and 20-week ones meaning I was going in with no support. I was lucky to have had him for the emergency scan otherwise the following two would have been even more stressful."

"I was unable to have my partner with me for any of my IVF treatment or my first scan."

"Not allowing my partner to attend appointments was really isolating and made the process much harder. Especially when we had an unsuccessful implantation and then a miscarriage. It was very upsetting to go into the aftercare appointments alone. He was allowed to attend when the embryo was implemented."

"My partner was there when I miscarried so this was not something that was shocking to me when it was confirmed by the healthcare professional. It was however, extremely upsetting and having my partner there would have been better."

"I needed a Manual Vacuum Aspiration (MVA) and had to attend alone. Staff were outstanding."

Restrictions in hospital around birth

"I was induced and in the hospital for three days prior to active labour and my partner could only visit for 1 hour per day. I was isolated and scared as it was my first pregnancy. I felt that I had no one to advocate for me during distressing experiences in the hospital and I felt very vulnerable."

"I feel that having less people in the maternity ward was a good thing, the first two days after having my son, I was only allowed one visitor and for one specific hour, so there was only one visitor in the ward at one time. I was sitting there with my top off, boobs out, being very stressed, trying to get my head around breastfeeding and I'm glad there weren't many visitors about."

Perinatal isolation

"I feel that after the baby was born you were very much on your own."

"Ten days isolation at home after return from Scottish mainland to Isles. No visitors due to high Covid rate locally. No baby groups. No cafes."

"I had three months of no visitors not even my mother. I live far from family and missed out all groups and friends and family support - this was incredibly difficult."

"I had no visitors for the first few months, which made me feel quite sad and isolated. We made a 'bubble' with my parents though, so they helped a bit, which really helped. But I felt sad that I couldn't do the usual things like baby massage, meet other Mums, take my baby to Bookbug in the library (something I LOVED doing every week with my firstborn), even just going to a cafe with other Mums."

"I could not see any friends or family after giving birth for multiple weeks due to Covid restrictions and advice. I suffered significantly as a result of this, feeling overwhelmed and isolated."

"I live far from my family, so did not see them at all when I was pregnant. I finally saw my best friends when I was seven months pregnant. It was the first time anyone but my partner had fussed over or touched my bump and the impact was so much greater than I could have imagined. I instantly felt more connected to my baby just having people that love me acknowledge and be excited about my pregnancy and body in person."

Flexibility and options

Treatment options

"My options changed for delivery to provide more, home births for example had just become an option again. Also I feel it is important to note that literally about a week before I had my baby the rules changed so I was able to have two birth partners and my mother was able to come in too. I had been really worried about not having her there and it was a massive relief when the rules changed."

"I had to deal with a missed miscarriage and was told that certain treatment options weren't available due to Covid. This was not communicated until I had already chosen that option."

Mental health and wellbeing

Anxiety

"After falling pregnant after a loss, I was very anxious in my last pregnancy, and it was brushed under the carpet as if that's understandable! I wanted them to talk about it more and help me. I went to my health visitor and spoke to her who offered me support and got me into contact with therapy services."

"I was so excited and found the time on maternity leave from work isolating, lonely and scary (first time mum worries and no local network or opportunity to meet other new parents and understand what is normal). I have not had poor mental health before and really struggled to access support or help myself. It was a very tough time."

"I had a previous traumatic birth and was given an appointment with a specialist midwife, I think they are called birth reflections midwives. This was because I was experiencing anxiety about upcoming labour. The appointment was on the phone and I do feel it would've been better to have this face-to-face."

Lack of mental health support

"Was quickly discharged without really being seen despite HV repeated requests. Staff shortages so (PND) Postnatal depression and traumatic birth never really addressed."

"My GP was very supportive. The only issue is the very long waiting lists for counselling, and the short-term nature of it (6 sessions, remotely, or else just being signposted to mental health group courses/webinars). I ended up just going privately to speak to a therapist about my anxiety."

Trauma

"I was able to have a support bubble with my family. Once my son was a couple of months old there were some parent and baby group options but they were socially distanced, with masks and there were often long wait lists. At the time I just got on with it and was thankful for the friends and family I have who live close by. But 18 months on and seeing others go through pregnancy and the early days of parenthood I realise how isolated we were and how difficult it was."

"Experiencing a loss during Covid was horrendous, I have nothing to compare it to but the experience will forever haunt me."

Feeling Heard

"I think the opportunity to share our stories is really important - people think we had more time with partners, more time to bond with our babies - but for those of us with partners who were key workers, there was no let up for eight months. Sharing these experiences will, I hope, help me finally move on."

"It was HARD! And any kind of recognition of this really helps women with the aftermath. Discussion of it feels cathartic and also reassures us of just how strong we are to have come through it. It was a very traumatic time to have a baby."

"It is essential that Scotland learns from people's experiences during the pandemic to improve maternity services and public health messaging. To do otherwise would be to fail, and further compound the trauma, of thousands of parents over the last few years."

Appendix [2]: Supporting evidence

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Blog series

As part of the survey, participants were asked if they wanted to share their individual experiences through published blogs. The following blogs were used to help promote the survey and to encourage a higher response rate.

Hannah Tweed reflects on her experience of pregnancy services in 2020.

- 26th October 2022 GUEST BLOG: Maternity and pregnancy services during Covid-19 | Engender blog | Engender

Eilidh shares her experience of post-partum support during the pandemic.

- 9th November 2022 GUEST BLOG: Lockdown (maternity) leave | Engender blog | Engender

Sarah Robinson Galloway looks back on pregnancy in the early stages of the pandemic.

- 24th November 2022 GUEST BLOG: My "unremarkable" pandemic pregnancy | Engender blog | Engender

Kirsty Kinloch talks about the uncertainty surrounding Covid-19 and pregnancy in 2020.

- 1st December 2022 GUEST BLOG: Pregnancy in lockdown: Leaving joy out of it | Engender blog | Engender

Barbara Flynn shares her experience of giving birth in the summer of 2020.

- 13th December 2022 GUEST BLOG: Pregnancy and parenthood in a pandemic | Engender blog | Engender

Kerry Walsh reflects on navigating pregnancy and grief alongside the challenges of the pandemic.

- GUEST BLOG: Pregnancy and bereavement during Covid-19 | Engender blog | Engender

Madeline Cross explores her experience of becoming a first-time mum during the pandemic.

- 26th January 2023 GUEST BLOG: Pregnancy and parenthood in a pandemic | Engender blog | Engender

About Engender

Engender is Scotland's feminist policy and advocacy organisation, working to increase women's social, political and economic equality, enable women's rights, and make visible the impact of sexism on women and wider society.

We work to dismantle structural sexism to create a Scotland in which women have equal opportunities in life, equal access to resources and power, and are equally safe and secure from harm. We believe in intersectional, inclusive feminism, and seek to conduct our work through an intersectional lens. We work at Scottish, UK and international level to produce research, analysis, and recommendations for intersectional feminist legislation and programmes

About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for health and social care, bringing together a diverse range of people and organisations who share our vision, which is a Scotland where everyone has a strong voice and enjoys their right to live well with dignity and respect.

Our purpose is to improve the wellbeing of people and communities across Scotland. We bring together the expertise of people with lived experience, the third sector, and organisations across health and social care to inform policy, practice and service delivery. Together our voice is stronger and we use it to make meaningful change at the local and national level.

About the Health and Social Care Academy

The Health and Social Care Academy (the Academy) is an ALLIANCE programme that helps drive positive and radical change in Scotland's health and social care, through the voice of disabled people, people living with long term conditions, and unpaid carers. The Academy's 'Five Provocations for the Future of Health and Social Care' was created based on the vision from the Think Tank of Scottish senior leaders from across the public sector, third and independent sector leaders, and people who use health and social care services.

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Published September 2023