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PRAVOBRANITELJ|ICA ZA RAVNOPRAVNOST SPOLOVA

REPORT

ACCESSIBILITY OF HEALTHCARE SERVICES FOR WOMEN IN CROATIA DURING COVID-19 PANDEMIC

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I. INTRODUCTION

From the very beginning of pandemic outbreak and lockdown in Croatia that lasted from 19 March to 10 May 2020. NGO Roda - Parents in Action received numerous complaints from patients that labouring women are forbidden to have company at childbirth, newborns are separated from their mothers, tests and examinations for pregnant women are difficult to get, declining support to breastfeeding, and announced C-section for all labouring women who have suspected or confirmed SARS-CoV-2 infection. Patients were complaining they are subjected to aggravated practices that are not in accordance to relevant professional guidelines and evidence-based medicine.

For many years now NGO Roda and Ombudsperson for Gender Equality have been warning about violation of women's rights and disrespect for evidence-based guidelines in the area of women's reproductive health. Problems in healthcare for women have been piling up long before the crisis caused by the pandemic, with its peak in autumn 2018 during campaign #prekinimošutnju (StopTheSilence). At that time public was made aware of procedures performed without anaesthesia on patients during different gynaecological procedures such as curettage after miscarriage, ovarian punction for oocyte retrieval, biopsy and perineal stitches after delivery.

The occurrence of pandemic has further destabilised the system through introduction of certain measures that are not in accordance with professional recommendations. Although Roda has sent several letters to the Ministry of Health and Croatian professional associations demanding harmonisation of practices in health institutions with professional guidelines, there have not been any changes in practice during complete lockdown.

Furthermore, the Ombudsperson has reacted two times towards the line Ministry of Health pointing to pertinent problems in terms of non-standardised practices applied in health institutions: 1) unequal practices regarding C-section and 2) unequal practices of allowing company during labour and birth. The Ministry of Health has urgently reacted to the first initiative and issued new guidelines, while for the second initiative the Ministry responded that due to different infrastructural and human resources it is not possible to harmonise procedures in different health institutions.

This report has been produced in partnership between NGO Roda - Parents in Action and Ombudsperson for Gender Equality of the Republic of Croatia.

II. RESEARCH METHODOLOGY

This report is based on data collected through:

a) Analysis and comparison of national and international professional guidelines from relevant European, global and Croatian associations and organisations.

b) Processing of data collected through two separate surveys: survey for pregnant women and mothers from 8 July to 20 July 2020, and survey for female patients treated for infertility from 22 July to 28 July 2020. Both of these surveys on accessibility of care for women's reproductive health were jointly prepared by NGO Roda - Parents in Action, and Ombudsperson for gender Equality, in cooperation with the Platform for Reproductive Rights and Centre for Education, Counselling and research (CESI).

Both surveys were anonymous and were made available to participants at websites and in social media.

III. ANALYSIS OF PROFESSIONAL GUIDELINES

This analysis used professional guidelines from global, European and national professional associations. There were obvious differences between these professional guidelines and practice in Croatian health institutions observed during the data analysis. Relevant professional guidelines used in this analysis were mainly the ones published by the British Medical Royal Colleges of gynaecologist and obstetricians, midwives, paediatricians and anaesthesiologists, as well as by the World Health Organisation.

At the end of March, Croatian Association for Gynaecology and Obstetrics (HDGO) published S2K guidelines on procedures during childbirth when labouring woman have confirmed or suspected SARS-CoV-2 infection. These guidelines are mainly based on recommendations from the abovementioned British Medical Royal Colleges. Contrary to these guidelines, pregnant and labouring women in Croatian health institutions received different information from health workers, health care was not equally available to all women, and practices were inconsistent.
We found a significant gap between professional guidelines and Croatian practice.

	British Medical Royal Colleges, version 10.1. (19 June 2020)	Croatian Society for Gynaecology and Obstetrics, 2020	Croatian Association for Perinatal Medicine	Opinion of the Croatian Society of Gynaecologists and Obstetricians of the Croatian Medical Association	UNICEF	World Health Organisation (WHO)	United Nations Population Fund (UNFPA)
Title of the document and its source	Coronavirus (COVID-19) infection in pregnancy Royal College of Obstetrics and Gynaecology; Royal College of Midwives; Royal College of Paediatrics and Child Health; Royal College of Anaesthetists https://www.rcog.org.uk/globalassets/documents/guidelines/2020-06-18-coronavirus-covid-19-infection-in-pregnancy.pdf	Croatian Society for Gynaecology and Obstetrics, Section of gynaecologists in primary health protection Coronavirus infection in pregnancy, S2K guidelines for suspected / confirmed coronavirus infection in pregnancy Consensus 2020 http://www.hdgo.hr/Default.aspx?sifraStranica=1169	Coronavirus (COVID-19) infection in pregnancy Information for health workers Information was adapted from the sources of Royal College of Obstetricians and Gynaecologists and Croatian Institute for Public Health http://www.hdpm.hr/files/COVID%2019/Zbirni_tekst_o_antenatalnoj_skrbi_i_Covid-u_19.pdf	COVID-19 infection in pregnancy Opinion of the Croatian Society of Gynaecologists and Obstetricians of the Croatian Medical Association http://hdpm.hr/files/COVID%2019/MZ_i_HLZ_-_Smjernice_za_zbrinjavanje_trudnica_COVID-19.pdf	UNICEF's project team for Baby Friendly Hospital Initiative, 5 March 2020 COVID-19: Breastfeeding recommendations http://hdpm.hr/files/COVID%2019/UNICEF_-_Preporuke_o_dojenju.pdf	Clinical Management of COVID-19 Interim Guidance 27 May 2020 https://www.who.int/publications/i/item/clinical-management-of-covid-19	COVID-19 Technical Brief Package for Maternity Services Update 1: May 2020 https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Maternity_Services_TB_Package_04052020_FINAL.pdf
Care for pregnant women	Basic assessments such as blood pressure and urine testing, are still required. Some appointments can be conducted virtually but the limitations of virtual consultation methods should be recognised. There should be a system in place to identify, support and follow up women who have missed appointments. Detailed instructions for modified schedules for antenatal appointments: https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-10-guidance-for-antenatal-and-postnatal.pdf	Pregnant women who had contacts with infected person, pregnant women with confirmed infection without symptoms, or those who are recovering from mild symptoms should be supervised to undertake additional ultrasound biometry and Doppler velocimetry tests. Pregnancies with coronavirus infection should be considered high-risk, and mothers, foetus and newborn development should be under strict supervision.	There is general advice that health workers should share with pregnant women regarding travel and regrarding conditions for pregnant women who are in self-isolation. Routine examinations (foetal growth monitoring, OGTT) for women with suspected or confirmed COVID-19 infection should be postponed until after the isolation. In case of unplanned/urgent antenatal examinations of pregnant women with suspected/confirmed COVID-19 infection, should be advised via telephone whenever possible.	Antenatal and postnatal care are essential care, therefore the examinations during pregnancy should be done based on previously defined guidelines. Routine examinations (foetal growth monitoring, OGTT) for women with suspected or confirmed COVID-19 infection should be postponed until after the isolation. In case of unplanned/urgent antenatal examinations of pregnant women with suspected/confirmed COVID-19 infection, should be advised via telephone whenever possible.		Pregnant women should receive basic information on symptoms of COVID-19 for pregnant women, mothers and newborns. Institutions should revise and change instructions so that pregnant women can know exactly where they can ask for care. For pregnant women currently in isolation routine examinations should be postponed, and they should be done at woman's home, via telephone or in telemedical manner.	Whenever possible, care for pregnant women should be provided separately from care to other patients from general population: the number of people present during appointment should be reduced as much as possible so that there are only health worker, pregnant woman and one person in company without symptoms. Reduced number of antenatal appointments in a health institution with the aim to reduce crowding and possibility of virus transmission; virtual care should be provided via telephone, WhatsApp, Skype. Recommendation for reduced number of appointments is currently in preparation. Models of care such as continuous midwifery care throughout pregnancy, birth and after birth reduce number of health workers in direct contact with the woman as well as chances of spreading COVID-19 in hospital; this model of care should be used whenever possible.
Place of birth	For women who test positive for SARS-CoV-2 but are asymptomatic and wish to give birth at home or in a midwifery-led unit, it is recommended that an informed discussion around place of birth takes place with the midwife; women with confirmed or suspected COVID-19	No information available	No information available	No information available		There is no explicit information although there is one mention of the fact that pregnant and labouring women should have access to midwifery care.	No information available

	infection should be recommended to have hospital birth. There is also special guidance for low-risk pregnant women who will birth at home or in a midwifery-led unit (version from 10 July 2020) https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-10-guidance-for-provision-of-midwife-led.pdf						
Induction and/or expediting birth	Induction of labour requires longer stay at the hospital therefore it is important to assess whether benefits from induction justify greater risk of infection. A positive COVID-19 result in an otherwise well woman, when there is also no evidence of foetal compromise, is not an indication to expedite birth.	Whenever possible, priority should be given to vaginal birth with induction and possible surgery in order to avoid exhaustion in mothers.	No information available	No information available		Interventions for expediting birth (augmentation, episiotomy, vacuum) should be used only if there is a medical indication for this.	No information available
Mode of birth	There is currently no evidence to favour one mode of birth over another in women who are SARS-CoV-2 positive, unless the woman's respiratory and general condition demands urgent intervention for birth. Water birth is not recommended due to possibility of COVID-19 infection through the stool.	Whenever possible, priority should be given to vaginal birth with induction and possible surgery in order to avoid exhaustion in mothers.	Pregnant women with mild COVID-19 symptoms and far apart contractions (in latent stage) should be motivated to stay at home a bit longer, as is common practice. There is currently no evidence to favour one mode of birth over another, so mode of birth should be discussed with the woman, taking into consideration her preferences and any obstetric indications for intervention. Presence of COVID-19 should not impact the way pregnancy will be ended, unless woman's respiratory status requires urgent completion of pregnancy. Mode of birth should be based on individual assessment without obstetric contraindication. C-section should bi indicated depending on the state of pregnant woman and foetus, as is common practice.	There is currently no evidence to favour one mode of birth over another, so mode of birth should be discussed with the woman, taking into consideration her preferences and any obstetric indications for intervention. Presence of COVID-19 should not impact the way pregnancy will be ended, unless woman's respiratory status requires urgent completion of pregnancy.		Induction of labour and C-section should be done only in cases when there is medical indication for this. COVID-19 infection by itself is not an indication for C-section.	Mode of birth should be adapted to individual needs of each woman based on obstetric indications and woman's wishes. These decisions should not be impacted by COVID-19 status unless there is urgent indication for mother or baby.
Company during labour and childbirth	Women should be supported and encouraged to have a birth partner present with them during their labour and birth. Having a trusted birth partner present throughout labour and birth is known to make a	No information available	No information available	No information available		Woman-centred care also means that a woman has a right to choose company at birth.	One person without symptoms should be in the company of pregnant women throughout labour and birth. If the accompanying person has symptoms, it is not possible for this person to be at birth. When

	significant difference to the safety and well-being of women in childbirth. At a minimum, one asymptomatic birth partner should be permitted to stay with the woman through labour and birth, unless the birth occurs under general anaesthetic. On attendance to the maternity unit, birth partners should undertake epidemiological survey and be COVID-19 symptom-free in the preceding 7 days. If the symptoms are present (other than persistent cough), they should not enter maternity unit. Birth partners should be asked to remain by the woman's bedside, to not walk around the ward/hospital and to wash their hands frequently. It is necessary that birth partners are given clear advance guidance on what is expected of them should they need to accompany the woman during C-section.					Birth partner should undergo screening according to standard definitions for COVID-19. If the birth partner has suspected/confirmed COVID-19 it is necessary to find another, healthy person to accompany the woman according to her wishes.	planning who is going to accompany them at birth, pregnant women should be informed to have a backup person in case the first person develops symptoms.
Respect and consent	Women must still be able to make decisions about the care they receive in line with the principles of informed consent.	No information available	No information available	No information available		Pregnant women with suspected or confirmed COVID-19 infection should have access to professional care during which woman's rights are respected and woman is at the centre of attention, including midwifery, obstetric and neonatal care, as well as support to mental health.	All women have right to compassion, dignity and respect. Every woman has the right to get information, give consent, refuse consent and have her choices and decisions respected and supported. This includes moving about during labour and choosing birthing position.
Foetal surveillance during labour	Routine continuous surveillance of foetal heart and movement with CTG is not recommended for woman with confirmed asymptomatic COVID-19 infection unless there is another reason for this; Recommend continuous EFM for women who are symptomatic of COVID-19.	No information available	No information available	Continuous CTG monitoring is recommended for all women with COVID-19 infection.		No information available	No information available
Pain relief	Epidural analgesia should therefore be recommended in labour to women with suspected or confirmed COVID-19 to minimise the need for general anaesthesia if urgent intervention for birth is needed. Epidural or use of Entonox for pain relief is not contraindicated if the labouring woman has COVID-19 symptoms or diagnosis.	No information available	There is no evidence that epidural or spinal analgesia or anaesthesia is contraindicated in the presence of coronavirus. Epidural analgesia should therefore be recommended in labour to women with suspected or confirmed COVID-19 to minimise the need for general anaesthesia if urgent intervention for birth is needed. If using a mixture of gases, nitrogen oxydul and oxygen may increase aerosolization and spreading of the virus.	There is no evidence that epidural or spinal analgesia or anaesthesia is contraindicated in the presence of coronavirus. Epidural analgesia should therefore be recommended in labour to women with suspected or confirmed COVID-19 to minimise the need for general anaesthesia if urgent intervention for birth is needed.		Woman-centred care means that a woman has the option to take pain relief medication, that she can move during labour and choose her birthing position.	All women have right to compassion, dignity and respect. Every woman has the right to get information, give consent, refuse consent and have her choices and decisions respected and supported. This includes movement during labour and choosing her birthing position.

Care for newborns immediately following birth	Given lack of evidence proving otherwise, delayed chord clamping is still recommended in cases where there is no other contraindication. Child can be wiped and dried off as usual while the chord is still intact.	Newborns of coronavirus positive mothers should be isolated for at least 14 days or until the virus is eliminated.	Routine separation of mothers from healthy newborns should not be done lightly, given the potentially damaging effect to breastfeeding and attachment. It is recommended that mothers and healthy newborns who do not require any additional neonatal care stay together during immediate postpartum period.	Given lack of evidence proving otherwise, delayed chord clamping is still recommended in cases where there is no other contraindication. Child can be wiped and dried off as usual while the chord is still intact.	Temporary separation of mother and child due to medical indication when there is suspected or confirmed COVID-19 infection and staff's activities related to this shall be done according to instructions of CIPH: "Health workers' activities in case of suspected new coronavirus and competent institution providing care to mothers and babies. Temporary separation of mother and baby i.e. no rooming-in is considered medical indication."	Mothers and newborns should not be separated unless a mother is too ill to care for the child. In that case, another healthy family member should take over. Delayed chord clamping (waiting for at least one minute after birth) is recommended. Risk of COVID-19 infection with blood is minimal. There is no evidence that delayed chord clamping allows transfer of virus from mother to newborn. Evidenced benefits of waiting at least 1 to 3 minutes to clamp the chord, are much greater that the possible, for not unevidenced risks. Mother and newborn should be together in *rooming-in* day and night and have skin to skin contact, including kangaroo care, particularly immediately after birth.	Currently there is no evidence that woman with COVID-19 symptoms who recently gave birth should be separated from her newborn. All mothers and newborns (irrespective of COVID-19 status) should be together in *rooming-in*, initiate breastfeeding, have skin to skin or kangaroo care.
Care for mothers and newborns during puerperium	Mothers and newborns who do not require additional medical care should be together after birth.	Newborns of mothers who are COVID-19 positive, should be isolated for at least 14 days or until the virus is eliminated. During mother's isolation breastfeeding is not recommended but instead a healthy person should give the baby mother's expressed milk.	Routine separation of mothers from healthy newborns should not be done lightly, given the potentially damaging effect to breastfeeding and attachment. It is recommended that mothers and healthy newborns who do not require any additional neonatal care stay together during immediate postpartum period.	No information available	Temporary separation of mother and child due to medical indication when there is suspected or confirmed COVID-19 infection and staff's activities related to this shall be done according to instructions of CIPH: "Health workers' activities in case of suspected new coronavirus and competent institution providing care to mothers and babies. Temporary separation of mother and baby i.e. no rooming-in is considered medical indication."	Mothers with confirmed or suspected COVID-19 infection should not be separated from newborns. Benefits of non-separation are far greater from potential (and probably small) possibilities of transmitting COVID-19 to baby. Mothers should be encouraged to continue breastfeeding.	Mothers who have symptoms of COVID-19 should be separated from other women and newborns and use all procedures to reduce the possibility of virus transmission: washing hands, wearing masks, skin to skin contact with the child. Mothers and babies should have at least four contacts with health staff during puerperium. Postpartum anxiety and depression are very common in new mothers and their partners. Isolation and financial consequences of the pandemic may increase that risk. New parents should be encouraged to spend time with family members and other parents in safe ways (via telephone or online where possible). They also must have access to specialised care if they need support for their mental health.
Breastfeeding recommendations	Breastfeeding benefits by far exceed potential risk of virus transfer through mother's milk. Parents should be informed how to reduce the risks of transmission during breastfeeding (washing hands before touching the child, the breastpump or bottle; avoid coughing	Newborns of mothers who are COVID-19 positive, should be isolated for at least 14 days or until the virus is eliminated. During mother's isolation breastfeeding is not recommended but instead a healthy person should give the baby mother's expressed milk.	Main risk for breastfed infants is close contact with the mother who can infect the infant with respiratory droplets. In light of current evidence, we advise that breastfeeding benefits exceed potential risks of virus transfer through mother's milk. Health workers should discuss with the breastfeeding mother risks and	No information available	Considering all the benefits of breastfeeding and feeding with mother's milk, in case of mother's suspected COVID-19 infection it is recommended to continue breastfeeding while applying general measures of protection. Mother should be taught how to apply general protective measures during breastfeeding in order to avoid	Early start of breastfeeding has many benefits. This is important for mothers who birthed via C-section or after anaesthesia or whose health situation after birth requires that initiation of breastfeeding must be delayed for more than an hour after birth. In case when mother is not able to directly breastfeed the child, the	Breastfeeding should be encouraged and supported.

	while feeding the child; carry a mask during feeding).		benefits of breastfeeding, including the risk of having a child in immediate vicinity of the mother.		virus transmission unto newborn child, such as washing hand every time before touching the newborn and starting breastfeeding, wearing a bask during breastfeeding and whenever in child's immediate vicinity.	mother should be encouraged to express her milk and feed her child with it according to recommendations (washing hands before touching the child, etc.)	
Additional	All women who are admitted to hospital in England should be offered testing for SARS-CoV-2 infection, including their birth partners regardless of whether they have symptoms. In case a birth partner tests positive, it is recommended that they do not accompany the woman (special document, 28 May) https://www.rcog.org.uk/globalassets/documents/guidelines/2020-05-29-principles-for-the-testing-and-triage-of-women-seeking-maternity-care-in-hospital-settings-during-the-covid-19-pandemic.pdf	Delphi consensus was published on 16 March, as can be seen in the text: http://www.hdgo.hr/Default.aspx?sifraStranica=1169 although date of publication is not known. April 6, 2020 - President of Croatian Society for Gynaecology and Obstetrics (HDGO) Ante Ćorušić and Gordan Zlopaša from the Institute for perinatal medicine at the Clinic for women's illnesses and births at the Clinical Hospital Centre Zagreb stated for the media: "If a pregnant woman due to give birth comes in, we do a swab test for COVID-19. If she tests negative, she will have a regular birth, and if she is positive a C-section will be done. Testing takes five or six hours, therefore if the labour proceeds quickly and there is no time to wait for the test results or there is no time to take a swab test, the woman shall be treated as if she was COVID-positive, therefore she will undergo C-section with all the protective gear for health staff." This position was also confirmed by Krunoslav Capak, Member of the Civil Protection Headquarters. https://www.vecernji.hr/vijesti/rodilje-pozitivne-na-covid-19-ici-ce-na-carski-rez-da-se-djeca-ne-inficiraju-1392044 https://www.telegram.hr/zivot/sef-rebra-kaze-da-ce-rodilje-pozitivne-na-covid-19-ici-na-carski-rez-da-se-bebe-ne-inficiraju-pri-porodu/	Document is not dated but from a detailed review it is obvious that it is based on RCOG Guidelines from 13 March 2020. It says in the description of the document that it will be updated but this was not done until the date of this analysis (24 July 2020).	The Ministry sent this document to all maternity wards on 10 April 2020. Document is based on the document *Coronavirus (COVID-19) infection in pregnancy* of the Croatian Association for Perinatal Medicine, but everything from chapter 3.7.1 onwards is missing (i.e. information on care for pregnant women who are still not in labour, who need care in labour, on neonatological care, on feeding infants and on hospital discharge and re-admittance to hospital). Instead of these important parts of the document regarding care for women during pregnancy, labour and puerperium, other literature was placed here, which makes this document shorter that the one from HDPM. It is assumed that after this, a part of the HDGO's S2K guidelines were copied, although it is not clearly stated but the Minister referrers to them in his introductory letter.		Recommendation was issued after the first pandemic wave in Croatia; therefore, it was not used in preparation of Croatian guidelines which were mainly not revised since March/April 2020.	Recommendation was issued after the first pandemic wave in Croatia; therefore, it was not used in preparation of Croatian guidelines which were mainly not revised since March/April 2020. Detailed guidelines for maternity care in pregnancy and puerperium will be published soon.

IV. RESEARCH RESULTS

1. HEALTHCARE FOR PREGNANT AND LABOURING WOMEN AND MOTHERS

There were 1357 participants who took part in this survey, out of which 78.6% are aged 25 to 35, 14.5% are aged 36 to 41. There were 5.7% participants aged 18 to 24, and only 1.2% have more than 42 years of age.

A total of 74% participants have a university degree, including bachelors, masters and PhDs. 17.8% participants have high-school education. 86% of participants live in cities and towns, and 14.1% live in rural areas.

Out of 1357 participants, 5.4% live on islands or in remote mountain areas, and 1.3% belong to a vulnerable or marginalised group.

1.1. HEALTHCARE FOR PREGNANT WOMEN

Almost half of participants (48%) encountered certain difficulties in terms of access to healthcare, while 52% did not have such experiences. Difficulties mainly refer to long waits in overcrowded health institutions, no one returning patients' calls or emails, relying on personal connections to get a service, referrals to other health institutions because their institutions were overcrowded, or no possibility to ensure implementation of epidemiological measures. (n=1287)

Majority of participants had to accommodate certain requirements at the time of pandemic in order to access health institutions: **50% of women had to buy protective gear, while 34% had to obtain a pass to be allowed to reach the health institution out of their place of residence.** Negative result on COVID-19 test was a requirement only in exceptional cases (1%). Only 29% did not encounter any of these requirements. (n=1287)

Majority of participants (63%) managed to do all necessary tests and examinations (n=1287)**.** However, **there was a significant percentage of participants (27%) who could not have their regular gynaecological examinations in pregnancy.** Tests and examinations that women most often could not have were blood and (or) urine tests (16%) and regular gynaecological examination (16%). Furthermore, women were sometimes unable to do one of three recommended ultrasounds (8%) and specialist examinations related to potential or existing complication in pregnancy (7%). Screening test could not be done in 2% of cases.

Company during examinations in pregnancy was mainly not permitted in the period from 19 March to 10 May 2020 – 80% of women stated they could not be accompanied during any of their examinations. (n=1287)

When asked about their experiences with healthcare accessibility in the period from 19 March to 10 May 2020 and about how they felt, respondents gave answers that can be grouped in three basic categories: **33% of women had mainly positive experiences, 36% did not have a positive or negative experience, while 31% of women had mainly negative experiences**. (n=1287)

1.2. HEALTHCARE FOR LABOURING WOMEN

22% of participants had company while in labour, while 78% did not. Participants who were not accompanied in labour stated that the unfavourable situation with the pandemic was the reason for this – this was the answer chosen by 79% of unaccompanied participants. (n=661)

Approximately half of participants (49%) stated that their birth partners did not have to meet certain requirements in order to accompany them during labour, while the other half of participants (51%) stated that they had to meet certain requirements. (n=143)

Main requirements that they had to meet were about bringing their own protective gear (59% of participants) and certificate from the antenatal course (40%). Only in 5% of cases the person who was accompanying labouring women had to take COVID-19 test. (n=85)

More than one third of unaccompanied participants (34%) stated that they had a bad birthing experience due to the fact they were unaccompanied, while one third of participants believes this did not impact their birthing experience (35%). (n=503)

Participants' responses confirm that unfortunately birthing conditions are often not very accommodating to labouring women. Majority of participants stated that during labour and(or) birth **they could not move freely (51%), they could not choose the position they would like to take (52%), they had to lie in bed (53%), they couldn't choose a position to push and/or to birth (77%) and they had to wear a mask (31%)**. (n=661)

The following procedures were applied during labour in more than 50% of cases: cannula insertion (90% of participants), hormone drip (62%), receiving pain killers (57%), enema (55%) and amniotomy (51%). Little bit less frequent were episiotomy (37%) and Kristeller manoeuvre (35%). Also 28% of participants stated they were not allowed to eat or drink, and 26% reported their pubic hair was shaved. (n=661)

Prior to receiving stitches after delivery 63% of participants (who needed stitches) got anaesthesia/analgesia and did not feel any pain. On the other hand, **37% of women felt pain while receiving stitches (**because they did not receive anaesthesia/analgesia, or they did receive it but they still felt the pain). (n=661)

When asked about how they felt during labour in the period from 19 March to 10 May in these pandemic conditions, participants gave varying responses that can be summed up in three categories: **38% of women felt predominantly good, 32% women felt neither good or bad, while 30% of women felt predominantly bad**. From all the participants who had negative experiences, 8% stated they felt like they totally lost their dignity, 17% stated they felt *ashamed but that it was important to them for everything to be over as soon as possible*, and 5% listed other negative feelings. (n=661)

1.3. HEALTHCARE AND SUPPORT TO MOTHERS AND NEWBORNS

This part of questionnaire was filled out by a total of 661 labouring women, however for the purpose of this research study we considered the data from labouring women who gave birth during lockdown from 19 March to 10 May 2020.

All maternity wards in Croatia are Baby-Friendly Hospitals, where skin-to-skin is one of the key steps in implementation of this program. In order to meet the criterium of the 4th step in Baby-Friendly Initiative, the maternity ward needs to ensure that at least 80% of mothers who birthed vaginally or by C-section without general anaesthesia, had skin to skin contact with their babies, and if taking into account mothers whose babies were delivered with a C-section in general anaesthesia, at least 70% of children should have skin to skin contact.

If we look at the total sample of participants who birthed in hospitals during lockdown, out of 426 participants only 19.48% of them had skin to skin contact with their babies within several minutes from birth and lasting for at least 1 hour.

109 participants whose children received combined feeding (formula and breastfeeding/expressed mothers' milk) or were not breastfed at all, managed to achieve breastfeeding at home.

These participants most often did not have a say in the decision to introduce breast-feeding supplements but instead the staff made this decision for them.

426 participants answered to the question about the first visit from community nurses. **Out of 426 participants, 14% of them i.e. 60 participants were never visited by the community nurse after delivery.** 40% of mothers or 172 of them received community nurses' care the very first day following hospital discharge, while additional 40% or 169 mothers received this care in two to seven days following the hospital discharge. 4% of mothers or 19 of them waited for eight or more days following the hospital discharge to be visited by the community nurse.

It can be concluded from the responses of 426 mothers that there are great differences between the counties in terms of availability of community nurses. While in some counties community nurses did not often offer care to mothers after birth, in other counties the situation was different or even totally opposite. Differences in availability of care during pandemic were also visible within each county

1.4. HUMAN RIGHTS AND INFORMING PREGNANT AND LABOURING WOMEN ABOUT EPIDEMIOLOGICAL SITUATION

Although majority of participants spoke favourably about the conditions in health institutions and staff's attitudes, part of them (30%) emphasise that the biggest problem was that predominantly or completely they had no right to participate in all decision-making process. Furthermore, 25% of participants predominantly or completely did not feel safe because of undertaken epidemiological measures, 24% of participants predominantly or completely were not informed by staff what they should do at each moment, 23% of participants predominantly or completely did not get an understandable answer to each question, 23% of participants predominantly or completely did not feel that their privacy and intimacy were respected, 17% of staff predominantly or completely did not feel that healthcare staff was treating them with respect, and 7% of participants predominantly or completely felt discriminated against. (n=1350)

2. HEALTHCARE DURING MEDICALLY ASSISTED REPRODUCTION PROCEDURES

There were 128 participants in this survey, out of which 66% are aged between 25 and 35, and less than 30% are aged 36 to 41.

Out of 128 participants, 70% have higher education, while 18.8% have secondary education, and 26.6% live in remote and rural parts of Croatia and(or) belong to a vulnerable group.

In the period from 19 March to 4 May 2020 when according to Ministry's instruction all procedures were interrupted, 72% of participants stated that their medically assisted reproduction procedures were either postponed or stopped, while 28% of participants stated that they were done regularly. (n=128)

Out of all the different procedures for medically assisted reproduction, in the period from 19 March to 28 July 2020, the participants most often needed or waited for IVF/ICSI procedure (49% participants). Other procedures that they waited for: FET (26%), natural IVF/ICSI procedure (13%), insemination (10%), procedure abroad (2%). (n=92)

Uncertainty that resulted from postponed procedures has negatively impacted patients who expected implementation of required healthcare services. **Participants emphasised that lack of information and not knowing when and how medical procedure will continue has impacted them in a way that**

they felt numerous negative emotions: worry, disappointment, helplessness, anger, uncertainty, hopelessness, fear, sadness, frustration, panic, despair, discouragement, anxiety, emptiness, powerlessness. (n=92)

59% of participants stated that in the period from 19 March to 4 May 2020 validity of all or some test results expired for them or their partners (so they had to repeat them if they wanted to get the service they need), while 41% of participants did not have that experience. Out of all the participants whose test results expired, 39% of them had additional costs because of that (n=92).

Majority of participants (96%) continued their procedures after the clinics reopened on 4 May 2020 (n=128).

When asked about the sources of information on how COVID-19 impacted them and their health situation, and how useful this information was to them, participants mainly complained about their primary gynaecologist – 30% of them stated that they did not get any information at all or that information provided was not useful at all. On the other hand, they assessed the information given to them in public (25%) and private clinic (19%) for medically assisted reproduction to be very useful and extremely useful.

Although majority of participants expressed favourably about healthcare institutions and staff's attitudes, some of them were not satisfied with different aspects of health services. The biggest problem is that 27% of participants predominantly or completely did not have a right to participate in decision-making processes during all procedures. Furthermore, 22% of participants predominantly or completely were not informed by staff what they were doing at each moment, 22% of participants predominantly or completely did not get an understandable answer to each question, 19% of participants predominantly or completely did not feel that healthcare staff was treating them with respect, 13% of participants predominantly or completely did not feel safe due to undertaken epidemiological measures, 13% of participants predominantly or completely did not feel that their privacy was respected, and 13% of participants predominantly or completely felt discriminated against.