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So close, so far: sexual and reproductive rights in the COVID-19 era

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ABSTRACT
The transformation that human societies are undergoing due to COVID-19 has significantly impacted the sexual and reproductive rights of women and their infants. Pregnant and puerperal women, as well as their babies, are victims of the gynaecobstetric patriarchal paradigm, which prevails —and even becomes amplified— in times of pandemic. In this chapter we present an analysis of the right to autonomous and respected childbirth, which includes lactation rights, as well as to abortion processes, which have been specifically compromised since the beginning of the pandemic. Despite the disparities between both situations, which each entail different needs, timing and responses, we argue that they coincide in the lack of recognition of pregnant women's sexual and reproductive

[1] This order is alphabetical. Both authors have contributed to this work equally (50%).

rights, as the measures adopted respond to healthcare inertias and ideological interests rather than to public health needs. This lack of recognition also affects their infants, to the extent that they are intrinsically interdependent on their mothers. The demand to reflect on sexual and reproductive health rights arises within an epistemic framework that includes the implications of both gendered dimensions as well as other potential sources of vulnerability in relation to the virus. Applying both intersectionality and the obstetric violence paradigm as a methodological approach, we claim that pregnant women's rights can be protected during the pandemic by ensuring their freedom of choice, without significantly threatening public health safety. We hold that the crisis unleashed by COVID-19 can be an opportunity to bring visibility to situations of sexual and reproductive injustice and to promote changes aimed to avoid it.

KEYWORDS: abortion, pregnancy, childbirth, obstetric violence, intersectionality.

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1. Sexual and reproductive rights in times of pandemic: a luxury or a right?

The unprecedented and radical transformation that human societies have been experiencing since the advent of the COVID-19 has significantly impacted the rights of women and their infants. Pregnant and postpartum women and their babies are becoming victims of the paradigm of gynaecobstetric patriarchy and its particular brand of biopolitics. In this paper we present an analysis of the right to autonomous and respected childbirth and abortion[2] processes, which have been specifically compromised since the beginning of the pandemic. Despite the disparities between both situations, which each entail different needs and responses, we argue that there has been an analogous lack of recognition of pregnant women's sexual and reproductive rights, as the measures adopted respond to healthcare inertias and ideological interests rather than to public health needs.

The understanding of sexual and reproductive rights our argumentation is based on stems from an intersectional perspective, which will be developed subsequently (Crenshaw, 1991; Kapilashrami, 2020). The term "rights" in and of itself is subject to considerable debate regarding interpretation, especially in the context of feminist and gendered perspectives. Classic feminist studies distinguish between formal or functional *equality* (reflected in laws) and functional *equivalence* (reflected in social roles) (Fraser and Honneth, 2003), which is linked to the theoretical differences between redistribution (on a more formal level) and recognition (on a more social and symbolic level) (ibid.). This double gaze is further reflected in Valcárcel's approach: equality is *ethical* and equity is *political* (Valcárcel, 1993); we wish to include both of these understandings of equality and equity. The achievement of full equity should imply a consideration of equality without obscuring the differences between agents involved in deliberative and decision-making processes.

In this sense, the theoretical approach of intersectionality includes not only a *formal* recognition of rights reflected in laws, but also their *social* recognition, as well as the material conditions for women —all women— to exercise their rights, as have been recognized in the Sustainable Development Goals[3]. Together with the universal condition commonly applied to sexual and reproductive rights from a human rights perspective, an intersectional view may add a more nuanced assessment of how institutions can provide a better response to the sexual and reproductive needs of those who are in a more underprivileged position and may thus remain excluded from mainstream policy and planning.

It is a fact that sexual and reproductive freedom is not the same for all. The history of women's fight to achieve this freedom is both long and on-going, as sexual and reproductive practices have long been sites of power contestations within families, societies, cultures, and politics, aggravated by economic, ethnic, administrative status, and other sources of inequality (Crenshaw, 2001). These axes of inequality influence who is allowed access to abortion, birth control, preventive healthcare services, childbirth care, or the means to have children and care for them as needed. Depending on their position in society, women are differently situated in their ability to implement their sexual and reproductive rights; this situation, crucially, has been aggravated by the COVID-19 crisis (Lokot and Avakyan, 2020).

[2]The term "abortion" includes different forms of termination of pregnancy. For the purpose of this work, it will refer fundamentally to the intentional termination of pregnancy in any of its stages and will be used interchangeably with the expression "interruption of pregnancy". The term "voluntary interruption of pregnancy", used in the legal regulation of this practice, has been intentionally avoided to the extent that the nuance of voluntariness may connote that it is a non-priority or essential modality, which is an idea which is put into question in this paper. In relation to this topic, see "Why We Should Stop Using the Term 'Elective Abortion'" (2018), by Katie Watson.

[3] Specially Goals 3, 5 and 10; see: https://www.unfpa.org/sdg#:~:text=This%20goal%20calls%20for%20achieving,childbearing%20age%20in%20developing%20countries.

In terms of pregnancy, the protocols for limiting the accompaniment of women during childbirth in the pandemic situation —protocols not supported by any scientific evidence— have led to serious complaints of human rights violations. Protests, manifestos, and specialised studies have attempted to draw attention to the impact the COVID-19 crisis has had on sexual and reproductive justice from an intersectional perspective.

With regards to abortion, the displacements required to access such services are contradictory to the attempt to minimize exposure to the virus. Different sectors –healthcare professionals, activists, and NGOs– have claimed that some procedures, such as compulsory informative sessions, can be carried out from a distance and that safe access to medical abortion should be available. Likewise, they have appealed to the need for COVID-19 not to become an excuse to violate the right to abortion and hinder its exercise.

The demand to reflect on sexual and reproductive health justice arises within an epistemic framework that includes the implications of gendered dimensions in relation to the virus (Lokot and Avakyan, 2020). We argue along with Tran et al. (2020) that sexual and reproductive health issues cannot be considered a luxury or non-essential, and wish to stress that a pandemic should reinforce rather than undermine this service. The gendered conditions of sexuality and reproduction of gynaecobstetric patriarchy render women's medical needs secondary. This response, supposedly based on a scientific and medical approach, conceals social and intersectional biases which extend the notion of “pandemic” to the broader concept of the “syndemic”.

Central to our analysis is the argument that a social and political awareness of this panorama can become an opportunity to bring attention to these situations of sexual and reproductive injustice, to analyse false beliefs, and to review scientific evidence linked to childbirth and abortion, all in order to guarantee women’s freedom of choice and to advance down the path of female bodily sovereignty.

Following this introduction, the chapter presents the theoretical framework we propose in order to analyse the particular situation of sexual, reproductive, and infants’ rights compromised during the pandemic. In this section, we defend the argument that an intersectional approach, together with the understanding of the paradigm of the gynaecobstetric patriarchy crystallised in obstetric violence, can explain the policies and practices applied during the COVID-19 crisis. On the one hand, we connect the intersectional approach (Crenshaw, 1991) to the concepts of vulnerability and subalternity, as it attempts to map out the varied forms of discrimination and exclusion structured around the dichotomy of ‘oppressions/privileges.’ On the other hand, we highlight the fact that obstetric violence itself shows how control over women’s bodies and their infants has erased women’s autonomy, nullifying their condition as worthy epistemic agents. Both perspectives emerge in a context of *syndemic*, which needs to be considered for a more complete understanding of the crisis. Once the theoretical framework is established, we analyse the situation of abortion access, childbirth, and early childhood practices during the pandemic, using examples which are by no means exhaustive, but rather landmarks intended to illustrate our arguments. Finally, we conclude by appealing for the pandemic crisis and its response to be considered an opportunity to bring visibility to the discourses and practices which need to be changed in such a way that sexual and reproductive rights are guaranteed for women’s equity and equality.

Before moving on to the next section, we wish to clarify that each author’s contribution to this text stems from a different academic background, thus understanding the construction of knowledge as a collective process. We affirm the belief that there is an intrinsic value in *epistemic mixture* –even *epistemic disobedience* (Mignolo, 2010)– as well as in what is heterogeneous and dissimilar, in hybrid and impure epistemologies, and in the ecology of knowledge that decolonial authors such as

Boaventura de Sousa Santos argue for (2010, 2012). Thus, we hope that ultimately the academic hybrid which forms the base of this article acts as a source of analytical richness and never hinders its internal coherence.

2. Theoretical framework: intersectionality and obstetric violence in syndemic

Intersectionality is widely considered a fundamental theoretical framework in public health (Bowleg 2012). The multiple social categories which intersect in individual experience (the micro-level) are correlatively reflected in the functioning of the systems of privilege and oppression which exist on a macro-level. In this light, the intersectional perspective (Crenshaw, 1991) is therefore highly relevant with regards to healthcare issues such as abortion and pregnancy. Indeed, Bowleg (2012: 1267) has argued that "public health commitment to social justice makes it a natural fit with intersectional focus on multiple historically oppressed populations." Unfortunately, this recognition of the value of the intersectional approach has not been translated into comprehensive policies or practical measures, something that Julian Tudor Hart (in Editorial, 2021) denounced decades ago through the so-called 'inverse care law'. Hart described this as the glaring —and perverse— reality in which the availability and quality of medical or social care tends to vary inversely to the needs of the population served. The resultant inequity is closely linked to income; the richest people, according to international and national standards, tend to be less ill, due to nutritional, environmental and educational advantages; at the same time, they also enjoy a better access to high-quality care throughout their lives. This dynamic reveals the need for deep social changes in order to attain more acceptable levels of equity. As long as this need is not seriously addressed, the vulnerability of people in a disadvantaged social position is perpetuated.

In the case of pregnant women and early childhood, the vulnerability that affects them can be ontological and/or situational (Schweiger, 2019). Infant vulnerability is ontological because they have specific needs due to their developmental status, which requires great physical and emotional support. Additionally, infants and pregnant/puerperal women may share a situational vulnerability to the extent that they are exposed to particular social, political, and contextual circumstances which determine their health and wellbeing. From an intersectional perspective, both types of vulnerability can be understood in a relational sense. This point of view allows us to identify and to interrelate conditions and expressions of vulnerability in a richer way (Crenshaw, 1991; Kapilashrami, 2020). Intersectionality may reveal significant differences, usually invisible, by paying attention to common experiences and vulnerabilities of specific identity groups ('women', 'children', 'migrant', etc.). Regarding sexual and reproductive rights, an intersectional perspective may identify biases on the grounds of ethnicity, disability, socio-economic conditions, as well as other social inequalities, and thus yield results that can create a response more suited to their specific needs and interests.

Women and infants experience different types of vulnerability. For the purposes of this paper, however, we group them together as we are referring not to every woman (in every situation of her life) or every child (in any stage of their development), but particularly to pregnant women and mothers in their delivery and puerperium processes, as well as their babies (early childhood), since they are interdependent in this part of their lives. Therefore, the ways they can be discriminated against and their vulnerabilities are intrinsically connected. This relation has been structurally ignored, as the recognition of obstetric violence has clearly shown (Bellón, 2015). As intersectionality

has demonstrated, we need *new words* (concepts, notions) to describe experiences and practices that *have not had a name*, and, for this reason, have not "existed" (Crenshaw, 1991).

Obstetric violence has demonstrated how mothers' and babies' rights (human -sexual/reproductive-rights) intersect, which is to say that they are related in the same way that their corporalities are interconnected (Massó-Guijarro 2015a-b). There is scientific evidence enough to prove that the lack of lactation has crucial negative health consequences (in short-medium-long term) for both babies and mothers; the lack of a respected birth has high health risk for both babies and mothers, etc.[4]

Concern about growing vulnerability due to the pandemic has been much recorded. Clark (2021) points out its special severity in challenging contexts —as in the current situation— for women, children, and adolescents. She highlights that it is not only morally mandatory to attend to the needs of these segments of the population, but also an economic imperative of the agenda of the Sustainable Development Goals, which includes universal healthcare coverage. Apart from the difficulties posed by the lack of political consensus and leadership commitment required to undertake the goals, they are also often hampered by gender-based violence (Clark 2021).

As can be seen in other population subgroups (minorities, migrants, disable people), pregnant women and their infants are 'differently situated' (Gilson, 2018: 231)[5], in such a way that their lack of recognition contributes to make them more vulnerable to harm. Frequently, women are not considered as valid decision-making subjects due to their pregnant status (Massó-Guijarro and Villarmea-Requejo, 2015). As a result, they are unheard and others speak in their names, sneaking in the 'first person' and ignoring concepts such as *situated knowledge* and *inclusion* in policy and decision making, something that has been highlighted by such excluded groups by mottos such as the very ubiquitous 'nothing about us without us'. Infants do not have a public voice; women are often silenced. In this sense, Spivak (1988) reformulates Gramsci's original concept of subalternity as a particular status of vulnerability which inherently generates situated knowledge. Opposite the adage *Cogito ergo sum —I think therefore I am—*, there is another possible claim: *I suffer therefore I am*, and I am here to be heard and recognised (Modonesi, 2012), vindicating the experience of the 'Third World' in its critical sense of 'Third State', against the (epistemic) hegemony of the Western World.

Regarding vulnerability, authors like McRuer (2006) use this understanding of the human species as a substitute for the classical Western/Cartesian 'homo sapiens', whose experience is based on an apparently autonomous thinking: Independence and individual strength are not the keywords which define us, but *interdependency* and even fragility, as typical human experiences. This operates in the same sense that McRuer (2006: 194) uses when he invites us to imagine disability as a typical human experience rather than an atypical one, to promote practices of equality and inclusion and, finally, fulfil "the promise of a democratic order". Thus, based on the paradigm of intersectionality, which epistemically and ontologically connects these forms of oppression (e.g., being disabled, being Black, being gay, being a woman, being a baby...), we claim that the social condition of a woman and, particularly, of a pregnant woman, is neither an accident nor, an atypical situation, but something essential and structural to what it means to be human. In other words, as humans, women get pregnant, have abortions, and give birth to their children. Being a woman is as human as being a man, and, to that extent, it should contain recognised and stable intrinsic rights, even in a pandemic.

During the COVID-19 crisis, sexual, reproductive and early childhood rights have been violated in a specific way that is not contingent or accidental, but deeply rooted in the androcentric system on which obstetric violence is founded (Payà-Sánchez and Martín-Badià, 2018). Obstetric violence is a

[4] See latest information in https://www.who.int/health-topics/breastfeeding.

[5] Taken from Mezzanotti and Kvalvaag, in this volume.

multifaceted form of gender and sexual violence, linked to the limitation of sexual and reproductive rights of women and, correlationally, of infants (Adán, 2018). The term "obstetric violence" was first used in Venezuela in 2007, within "The organic law on the right of women to a life free of violence", followed by Argentina in 2009 and some Mexican states between 2007 and 2012. In April 2014, the Mexican national senate also approved amendments to several laws on violence against women to include obstetric violence as a punishable practice (Bellón, 2015).

Obstetric violence has been stipulated in these legislations as a type of gender-based violence that implies "the appropriation of the body and reproductive processes of women by health professionals, which is expressed in dehumanizing treatment, in an abuse of medicalization and pathologization of natural processes, bringing with it a loss of autonomy and the ability to freely decide about their bodies and sexuality, negatively impacting the quality of life of women" ("Organic Law of March 19, 2007, on the right of women to a life free of violence"[6], quoted in Bellón 2015). The WHO itself considers this issue of utmost relevance in terms of sexual and reproductive health, to the extent that curbing obstetric violence has been structurally related to the fulfilment of human rights[7].

From a feminist perspective, obstetric violence constitutes the fundamental praxis of the gynaecobstetric patriarchy, that is, the application in gynaecology and obstetrics of the patriarchal paradigm which still prevails in other realms worldwide (Bellón Sánchez, 2015). At the base of this patriarchy, lies a singular form of epistemic injustice, to the extent that neither the *knowledge* nor the *female account* (*testimony*) have been considered worthy of attention and recognition throughout history. In this sense, it is noteworthy that Adán (2018) has also linked this concept of obstetric violence to epistemic injustice.

Following Miranda Fricker (2017), an epistemic injustice occurs when a subject's ability to transmit knowledge and make sense of her social experiences is nullified. This has been extensively the case in the female experience, concretely and specifically in relation to pregnancy and childbirth, as well as childhood (Schweiger and Graf, 2015; Massó-Guijarro, 2021). This form of injustice and oppression has become more obvious by the generalised crisis caused by the COVID-19 pandemic, ostensibly showing its relationship with the hierarchies of recognition (Schweiger, in this same volume) and silenced epistemologies (Santos and Meneses, 2014). Faced with the 'banality of patriarchy' that Sarah Hawkes (2020) opportunely describes, in a clear analogy to the 'banality of evil' formulated by Arendt, we would like to identify and recognise this kind of violence, revealed in gender biases and especially visible from an intersectional perspective.

Along a similar line, Pavarini et al. (2021) claim the need for innovative theoretical frameworks in bioethics and other related fields, appealing to the recognition of traditionally underrepresented groups in research and theory. Indeed, feminist bioethics conceptualises moral choices as embedded in their social context and relationships (Pavarini et al., 2021). In the matter at hand, these groups are pregnant women, puerperal mothers and their children. To that extent, we must remember that labour, birth and abortion are part of the same feminist approach of reproductive rights in an intersectional paradigm. This perspective shows how obstetrics and gynaecological practices —as well as their limitations— are strongly shaped by the patriarchy (Payà Sánchez and Martín Badià, 2018). Avoiding or forbidding an abortion, emotionally or physically manipulating and abusing women during pregnancy, childbirth, or lactation, are all forms of violence which render vulnerable

[6] http://venezuela.unfpa.org/doumentos/Ley_mujer.pdf

[7] See here for initiatives, conferences, videos, etc.: https://www.who.int/reproductivehealth/topics/maternal_perinatal/disrespect-during-childbirth-videos/en/

sexual and reproductive rights. They all dismiss women's agency and sovereignty over their (pregnant) bodies to either interrupt their gestational processes or give birth or breastfeed freely.

In our work, the previous reflection on intersectionality and obstetric violence should be interpreted in a *syndemic scenario*, which provides broader hermeneutics able to overcome the purely medicalized nature of the COVID-19 pandemic. The term 'syndemic' underlies a more social and complex biomedical paradigm than the classic epidemiological one aimed to deal with pandemics and epidemics, which is usually limited by a scientific and clinical understanding. This neologism, which unites the terms 'synergy' and 'epidemic', was coined by Merrill Singer in the mid-90s and later published in 2009 in his work 'Introduction to the syndemic' (Singer, 2009). It refers to the sum of two or more epidemics or concurrent diseases outbreaks considering that the final result is more than the sum of the parts. This perspective gives rise to important changes as a consequence not only of the disease and its medical response, but also of the social and political handling of the situation (Morin, 1994). This systemic understanding of the current crisis helps shed more light on many of its differential impacts, in general, and on gender, in particular.

Ultimately, syndemics occur under health inequity (Hart, 2021), caused by poverty, stress, or structural violence, among other possible factors. Broadening the limited pandemic framework shows how syndemic factors affect women and young children more severely, despite the greater impact of the COVID-19 epidemic on men's health (Bienvenu et al., 2020). In other words, the COVID-19 pandemic has a *direct*, *immediate* and harder impact on men, while the *syndemic as a result of COVID-19* has an *indirect*, *mediated* and harder impact on women and children, especially if they also belong to social, cultural, economic, ethnic, or otherwise disadvantaged groups. In a certain way, COVID-19 has become a paradigmatic syndemic of the Anthropocene in its ecological dimension, since the connections between the environmental crisis and climate-zoonotic changes are being proved crucial in its context (Skórka et al., 2020).

3. Abortion in times of coronavirus

Even in places where access to abortion is legally recognized, pregnant women have to face difficulties to get it before, as well as during the COVID-19 era. Administrative processes of variable duration, conscientious objection of healthcare professionals, the institutionalization of medical abortion,[8] and the need to travel to other regions or countries to undergo abortion procedures are frequent obstacles for women who wish to end their pregnancies (Triviño, 2018; Sethna and Davis, 2019).

These problems are more serious in the current context. The COVID-19 pandemic has increased restrictions on access to contraception and abortion around the world (IPPF, 2020). Limitation of movement has provoked restrictions on outpatient visits to healthcare centres —including those which embed contraceptive devices— and difficulties to reach a pharmacy. In some places, sexual intercourse has increased (Panzeri et al., 2020), as well as intimate partner sexual violence (Roesch et al., 2020; UN Women, 2020), both of which can lead to higher rates of unintended pregnancies. Additionally, the financial crisis caused by the COVID-19 has strongly hit many families, and the lack of economic resources is one of the main reasons behind many women's decision to undergo an abortion (Chae et al., 2017). The consequences of all these circumstances have an important impact

[8] Surgical abortion includes a variety of procedures at various stages of pregnancy; medical abortion uses pills to end pregnancy in the first trimester.

on the health, autonomy and lives of many women. Following the intersectional perspective that we have proposed, it is important to note that not all women are affected in the same way. Some of them are in a better position due to their privileged class or racial status. Others, instead, are worse off.

In the United States, for example, the closure of clinics where pregnancy terminations are practiced as a result of laws known as *US TRAP* (Targeted Regulation of Abortion Providers) is having a serious impact on women belonging to racial minorities, who already had difficulties before COVID-19 in accessing the services provided in these centres (Solazzo, 2019; Abrams, 2020). Governors in thirty-three states have established the interruption of both medical and surgical abortion, while governors and politicians in other states have ordered —or are about to— the cessation of surgical abortions (Raifman et al., 2020). The closure of abortion clinics has been justified by concern about the lack of personal protective equipment (PPE) for healthcare staff treating COVID-19 if patient volume increases (Bayefsky et al., 2020). According to this alleged precautionary measure, several states have classified abortion procedures as a non-essential use of PPE that would threaten public health (Raifman et al., 2020). However, the argument does not seem consistent. Women who cannot undergo an abortion will either remain pregnant, and then will need prenatal care and delivery support, or may look for other procedures to get an abortion on their own, without any healthcare guarantees. Both situations —unintended pregnancy or clandestine abortion—could not only result in contact with healthcare staff anyway, thus creating an even greater need for PPE (Bayefsky et al., 2020), but also override women's rights and autonomy and leave them unprotected. As the Committee on the Elimination of Discrimination Against Women (2017) has explained:

> "Violations of women's sexual and reproductive health and rights, such as criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, and forced continuation of pregnancy, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."

In the same vein, the Special Rapporteur on torture and other forms of cruel, inhumane and degrading treatment or punishment (2017) has highlighted that "the denial of safe abortions and subjecting women and girls to humiliating and judgmental attitudes in such contexts of extreme vulnerability, and where timely health care is essential, amounts to torture or ill treatment." Based on these considerations, it is possible to consider restrictive access to abortion as a form of obstetric violence.

Restrictions to abortion in the United States are not unique. According to research conducted by Caroline Moreau et al. (2020), since the beginning of the COVID-19 pandemic, abortions for non-therapeutic reasons have remained forbidden in six European countries[9] and suspended in one[10]. Surgical abortion has become less available in twelve countries or regions[11]. When women have had COVID-19 symptoms, services related to abortion have either not been available to them or they have had delays in eleven countries[12]. For example, in Romania, pregnancy interruptions are being performed only in emergency services, that is to say, they are reduced to those cases that professionals consider to need 'essential care' (EPF and IPPF, 2020). The rest of the cases are seen as

[9] Andorra, Liechtenstein, Malta, Monaco, San Marino and Poland.
[10] Hungary.
[11] Belgium, Estonia, Ireland, Finland, France, Germany, Norway, Portugal, Switzerland, England, Wales, Scotland and Northern Ireland.
[12] Belgium, Germany, Iceland, Latvia, Luxembourg, Netherlands, Montenegro, Slovenia, England, Wales and Scotland.

asking for a privilege or a luxury, which in pandemic conditions the system cannot afford to provide. This has also been the case in Hungary, which has banned non-life-threatening surgeries in state hospitals. This means that only *therapeutic abortions*, those required to avoid pregnant women's death or important physical harm, seem to have legal and ethical recognition under pandemic circumstances. The *elective abortions* are not considered legitimate enough to be *essential*. To some extent, the COVID-19 response makes more visible the common perception that not all the reasons to have an abortion deserve the same respect (Watson, 2018; Yesnosly et al., 2018). This reality confronts us with the lack of recognition of (pregnant) women as trustable epistemic agents (Massó-Guijarro and Villarmea Requejo, 2015). Additionally, if those women are racialized, disabled, or minors, their chance of being heard and trusted decreases (Havi and Kidds, 2017). As a consequence, it is *others* who have the power to decide which abortion is essential and which is not.

Despite the previous examples, there are organizations which claim that access to abortion should be considered an essential service. For example, the *Royal College of Obstetrics and Gynaecology*, in the United Kingdom, along with other institutions, has defended abortion as an essential healthcare provision. It has appealed to the need for services to be organized in order to provide safe healthcare to women as a priority, including those who may be affected by COVID-19 (RCOG, 2020). Consistently with this position, the *American College of Obstetricians and Gynecologists* (ACOG) has declared that they do not support COVID-19 responses that cancel or delay abortion procedures (2020) and the American Medical Association (AMA) has supported access to abortion, defending the position that physicians, not politicians, should establish which procedures are essential (2020).

Under these circumstances, medical abortion reappears as an alternative that offers safe access to abortion during the first trimester of gestation (WHO, 2014), as it is performed outside of clinical spaces and with fewer legal restrictions, factors which make it a better option, particularly for migrant or undocumented women (Triviño, 2012; Calkin, 2019). Moreover, medical abortion may help women of more limited means to avoid unnecessary displacements (Upadhyay, 2017; Todd-Gher and Shah, 2020), while also falling in line with the "Stay at home" order and the necessity to avoid enclosed or crowded spaces where the risk of contagion increases.

Unfortunately, changes introduced to reduce in-person consultations have only been implemented in thirteen European regions; eight countries authorized medical abortion at home beyond nine weeks and thirteen regions up to nine weeks (Moreau et al., 2020). For example, in France, where medical abortion in healthcare centres was already possible up to seven weeks into pregnancy before the pandemic, the period has now been extended to nine weeks, although the government is expected to reverse the measure once the strongest mobility restrictions have been lifted (Elzas, 2020). In a similar vein, COVID-19 has led to the legitimisation of medical abortion, controlled through telemedicine, in the United Kingdom (Margolis, 2020). Women can have the treatment required for abortion at home during the first ten weeks of pregnancy after contacting their doctor, without having to travel to any healthcare institution. This measure is not only consistent with the difficulties of access to clinics (Margolis, 2020) and the general isolation scenario prescribed during the pandemic; it also allows women safe access to abortion, without unnecessary surgical interventions, while taking into account their potential disadvantaged conditions (Kapilashrami, 2020).

Medical abortion has not been an alternative during the pandemic in other countries like Spain, where it is a minority practice compared to surgical abortion that must be overseen in an authorised centre. This situation may have been an important obstacle for women living in places where there are no hospitals or clinics to perform abortions, such as Ceuta and Melilla, or for those women whose care responsibilities involve not being able to leave their homes. Access restrictions can be especially

disturbing for women in situations of greater vulnerability, such as those who suffer sexist violence and are confined with their abusers, minors who require the consent of their parents or guardians to have an abortion, or undocumented migrants (AAVV, 2020).

Together with guaranteeing access to medical abortion, there are other noteworthy access conditions which should be eased. In Europe, only six countries have provided abortion support using telemedicine (Moreau et al., 2020). For instance, in Spain, the possibility of not traveling for compulsory counselling before undergoing an abortion was established as a regional competence during the pandemic crisis (Carballar, 2020). Only Galicia and Catalonia have agreed to the proposal of the Association of Accredited Clinics for the Interruption of Pregnancy (ACAI) to substitute in-person counselling for remote instructions and support. In other Spanish regions, such as Madrid, political decisions regarding abortion have taken an opposite direction, as shown by the recent recognition of the unborn legal personality (Álvarez, 2020).

Poland is in a more worrying situation. It is one of the most restrictive European countries in sexual and reproductive matters, where a regulation was approved in the midst of the pandemic crisis to eliminate the possibility of abortion due to anomalies or incurable diseases of the foetus. The measure led hundreds of women to demonstrate against this restriction, defying mobility constraints (Bateman and Kaztelan, 2020). On the 27th of January 2021, the Polish government enforced this near-total abortion ban.

Time is a determining factor for a safe abortion and diligent care is essential to ensure the wellbeing and health of women. The consideration of abortion as an essential service, together with the possibility for it to be performed on an outpatient basis, is a long-standing demand that takes special relevance in critical times. The speed with which some governments have excluded abortion care during this pandemic highlights the extreme vulnerability of abortion access, especially for those women in underprivileged conditions, even in places where it is supposedly a well-established right. Apparently, the COVID-19 crisis has become yet another excuse to turn this right into a kind of luxury or a dispensable service (Bateman and Kasztelan, 2020; EP, 2020; UN, 2020).

4. Childbirth and lactation in times of coronavirus

> ‘We don't want to give birth alone’[13].
>
> “The NICU experience is already stressful as it is, and then to force parents and babies to be separated — it's just devastating. How will babies [in NICUs] get the mothers' milk they so desperately need, if you're separating mothers and babies?” (Testimony of a midwife, in Furlow, 2020: 1).

“We don’t want to give birth alone” is the motto used for a petition on the platform Change.org to prevent women from being forced to face the delivery process without proper accompaniment, as a result of the COVID-19 crisis.

“Midwives denounce the Generalitat Valenciana for wanting to oblige pregnant women to give birth unaccompanied”; this is a headline from April 4th 2020 from a Spanish national newspaper (Martínez, 2020a). Indeed, the new protocol drawn up during that month by the Valencian Community Health Department prescribed the interruption of the monitoring of pregnant women in dilatation and delivery (AAVV, 2020b). As a result of these provisions, various groups such as

[13] Cf. https://www.change.org/p/jefes-y-jefas-de-servicio-de-obstetricia-y-ginecolog%C3%ADa-no-queremos-parir-solas

including the Nursing Council, the *Associació de Comares*, *El Parto es Nuestro*, or the Spanish Association of Midwives, mobilized to decry the protocol as a violation of human rights, the national laws and, above all, published scientific evidence which show the detrimental effects of this practice. This all occurred in the context of an environment already heated by a recent, pioneering UN condemnation of obstetric violence against a mother and her baby in Spain, which further motivated a specific Recommendation to the Spanish state from the WHO for its outrageous figures in this type of gender violence (EPEN, 2020[14]).

The astonishing speed and effectiveness of these scientific and civic associations led to surprisingly quick results: just four days later, the Generalitat Valenciana retracted the most severe provisions (Martínez, 2020b) and, not long after, the government of Andalusia published a "Protocol of companions for humanization during the period of the COVID-19 pandemic," aligned to obstetric recommendations and citizens' demands.

Authors have pointed out the negative consequences that the measures derived from social distance and confinement are having on women and minors[15], as well as the specific impact of COVID-19 on women (AAVV, 2020c), particularly in relation to perinatal care and obstetrics. If, as Morgan (2021) affirms, human beings are designed to *touch* and *be touched*– which in terms of the pandemic implies an emotional genocide of still incalculable effect– let us think of its greater severity for humans in the situation of greatest interdependence experienced in a life cycle: *birth*. Buekens et al. (2020) highlight such adverse effects linked to the abandonment of care behaviours at home (preventative for so many diseases), as well as increasing postpartum depression and other psychological ailments, appealing directly in doing so to the deleterious effects of the restrictions to childbirth care and its negative psychological impact on isolated women. As argued with the support of substantial evidence by Bartick et al. (2021), this alteration of the quality standards of maternal care is unnecessary and clearly associated with various forms of harm. This response also supposes an impairment of individual and community rights, and a depreciation of caring, an issue that Teresa Baron explores in this same book with regards to the ethics of care.

In relation to pregnancy and the impact of COVID-19, both the inexistence of a greater infection risk in pregnant women as well as the vertical transmission of SARS-CoV-2 from the mother to the baby have been proven, which latter represents a very low susceptibility to being damaged by the infection (Caparrós-González, 2020; Teti et al., 2020). Delving deeper, the data indicates that the neonatal immune system, despite its inherent immaturity, is capable of handling SARS-CoV-2 effectively, and the majority of infected newborns are asymptomatic or experience only mild illness (Götzinger et al., 2021).

Similarly, the *Inter-Agency Working Group for Reproductive Health in Crises* (Tran et al., 2020; see also Hall et al., 2020) have pointed out in different guides for sexual-reproductive health elaborated in relation to COVID-19 that provisions to protect childbirth and puerperium should never lead to an increase in obstetric violence. Thus, the increase in preventable caesarean sections or the limitation of the 'skin-to-skin' practice –a scientifically-endorsed human right– resulting from the unnecessary separations of mothers and their babies should be monitored (Teti et al., 2020). This surveillance is also required regarding the lack of support in the puerperium period, especially with breastfeeding as it has a crucial impact on maternal and child health. Lactation is a fundamental public health

[14] See the full document of the CEDAW: https://www.elpartoesnuestro.es/sites/default/files/public/blog/cedaw-c-75-d-138-2018_spanish.pdf

[15] See, for example, data from the Global Health 50 / 50- COVID-19 sex-disaggregated data tracker: http://globalhealth5050.org/covid19/.

measure with consequences in the medium and long term, among further implications which have been explored in other works (Massó-Guijarro, 2015a-b).

It is with all this in mind that it becomes clear that the issue of breastfeeding, part of the human exterogestation process, deserves special attention. Only individualistic and mechanistic approaches explain it separately from the process of reproduction (both biological and cultural in the human species), while the anthropology of kinship, for example, analyses it as part of the very process. Philosophy itself grants it a status of ontological relevance not recognized until now. Regarding the possible limitations to breastfeeding in cases of contagion, the absence of SARSCoV-2 has been contrasted in samples of breast milk, amniotic fluid and umbilical cord blood from new-borns of mothers with COVID-19 (Caparrós-González, 2020). No significant evidence of mother-to-child transmission of SARS-CoV-2 through breast milk has been found (Kumar et al., 2021; Thanigainathan et al., 2021); on the contrary, the robust immune response of the maternal body to COVID-19 with the passage of antibodies against SARS-CoV-2 through milk has been continuously demonstrated, with some researchers even stating that "Exclusive breastfeeding during coronavirus disease (COVID-19) pandemic is vital for survival of neonates" (Thanigainathan et al., 2021).

Experts have highlighted how disruptions in breastfeeding during the pandemic increase infants' risk of suffering aggravated diseases while also damaging the intimate relationship of the perinatal sphere which revolves around the mother's and infant's wellbeing (Furlow, 2020). The importance of maintaining a safe supply of human milk through donation to banks has been reviewed by the *Virtual Collaborative Network of Human Milk Banks and Associations*, considering its greater relevance in the pandemic context (Shenker, 2020). Since SARS-CoV-2 is not transmitted through human milk, breastfeeding is more necessary than ever, especially in large premature infants and babies with congenital anomalies or neurological disorders. For these reasons, the WHO (2020) has prepared specific documentation to advise breastfeeding during the pandemic[16].

With regards to the practice of separating the mother from her newborn, the analysis by Teti et al. (2020) points to the need to guarantee both autonomy and informed decision-making for mothers and/or parents. Given the proven negative consequences, unilateral decisions about mother-baby separation are strongly discouraged. The guideline is aimed to limit the separations to exceptional cases, in which the mother has accepted this last resort measure, always respecting her final decision and supporting her in the decision-making process (for example in relation to both delayed or straight breastfeeding).

The injustice and gender bias regarding reproductive health, as well as the lack of relevant gender and other intersectional indicators in the realm of health (Kapilashrami, 2020; Law and Green, 2020), is revealed even in the question of vaccination of lactating mothers in claims for the need for contrasted data and additional evidence. The NCoV-19 coronavirus vaccine has been rated as "very low risk for lactation" on the *e-lactation* platform, but this information does not reach many places (Mena, 2021). As Mena points out, women continue to be a "second line of attention for policy and research," in a way clearly detrimental to sexual and reproductive health as well as harmful to areas of holistic health as important as lactation.

It is thus that, although the need to improve maternal and neonatal care has been part of the political and research agenda for decades, today more than ever it is necessary to improve the quality of care (Brizuela and Tunçalp, 2021). Ultimately, there is a general and unanimous concern

[16] Groß et al. (2020) detected the presence of SARS-CoV-2 in human milk in an isolated case, although they state that is not clear the mechanism of transmission to the newborn. In general, the consensus about the desirability of breastfeeding is widely maintained, also its full compatibility with the different vaccines.

about gender inequality in matters of health and well-being –especially after the advent of the pandemic (Levy et al., 2020)– observed in the interruptions in the provision of health services, even as these seem to have devastating effects on the health of mothers, new-borns, and infants. Hobday et al. (2021) highlight especially the urgency in preventing postpartum haemorrhage at home: it is the leading cause of maternal mortality in low-income countries and has increased dramatically in the times of coronavirus.

In short, it is a question of considering mothers and babies as political subjects with full rights, in the very sense we have specified in the theoretical framework regarding their intrinsically related (in an intersectional approach) vulnerabilities. Furthermore, as highlighted by Pavarini et al. (2021), *embodiment*, *context* and *narrative* must be integrated in moral decision-making, which takes on special relevance for traditionally underrepresented groups, through the eco-cultural approach to early childhood development (Wadende and Zeidler, 2021). In this regard, the claim by Altavilla et al. (2021) that we ought to strengthen children's participation in their own health is particularly pertinent, entailing the finding of an appropriate balance between protection and autonomy through research on new initiatives in the Council of Europe.

Finally, while these issues are related to the right to health and equity in care, they have farther reaching consequences. They also have to do with a non-individualistic conception of the human being and her needs, a much more symbiotic and collective conception, of which the mother-child dyad —in gestation, childbirth, and exterogestation— is a notable and significant example, probably of the greatest ontological value to the human being. This, together with the structural ecological dimensions of the pandemic (according to its Anthropocene understanding), leads us to the irreducibly biocultural dimension of our species.

5. Conclusions: COVID-19 as an opportunity to improve sexual and reproductive rights

As we have been showing throughout this chapter, the current pandemic has led to redefinitions of and restrictions towards what can be considered 'essential care' in times of crisis. In this sense, the need to pay attention to sexual, reproductive and puerperal health is being contested and has become a subject of debate. COVID-19 has already been classified literally as a 'risk factor' for obstetric violence (Sadler et al., 2020) and there is incontrovertible data regarding the tragic impact of the pandemic on women and children (Menendez et al., 2020; Roberton et al., 2020). While isolation and other restrictions have been set up for pregnant women during delivery and infants' breastfeeding, women requesting abortions have not been subjected to analogous measures. They have been forced to attend in-person appointments in order to attain the procedures, going against the 'Stay at home' rule and without being offered the possibility of medical abortion. In the case of minors, undocumented migrants and other women in situations of vulnerability, such measures may undercut their reproductive rights as a result of fear of police control and fines, as well as their particular conditions in terms of health, capabilities, family relationship, housing, working, etc.

These measures —based on the need for social distancing, one of the most symbolic responses to the pandemic aimed at avoiding contagion— demonstrate a failed and contradictory management which goes against scientific evidence and women's and infants' specific needs.

In other words, this is a result of the dominant paradigm of patriarchy. An African proverb says that "When elephants fight, the grass gets trampled," a statement whose wisdom has become globalised since its popularisation during the 1960s decolonial process in Africa. When there is a global

pandemic, the prism of intersectionality helps us understand why it is "the grass" —pregnant, postpartum women and minors— which gets trampled, which *suffers* (the most).

The right of women to freely choose how to give birth and have an abortion —in short, the exercise of their bodily sovereignty— implies guaranteeing their access to these services based on scientific evidence, paying special attention to those who are in a vulnerable situation due to the intersection of their social and/or ontological conditions (race, ethnicity, age, disability, socio-economic class, etc.). It is also urgent to address the dramatic effects that the pandemic is having on maternal and child mortality on a global level, as well as the negative consequences of confinement conditions for children (Fore, 2020).

Sexual and reproductive rights have been formally recognised for decades in many countries around the world. However, even in those places where there are laws and services to implement them, they are frequently under threat. Depending on hidden ideological prejudices and strategies, they are *close* to being effective but, disappointingly, are continuously proven to be too *far* for women to get proper access to them. COVID-19 should not be an excuse to restrict and deny care related to childbirth, lactation, and abortion based on ideological premises.

The worldwide response to the pandemic crisis, its contradictions and the alternatives proposed, can become an opportunity to review institutional prejudices and inertias about the delivery process, practices linked to the mother-child bond, the need for procedures such as compulsory counselling prior to abortion, or the conditions to undergo a medical abortion outside healthcare centres. An intersectional approach can contribute to a better understanding of women and their infants' needs, which may differ depending on their (un)privileged conditions. It is through such an approach that the rights of women, infants and young children can be fortified and established as what they are: far from being a luxury, they are a necessary condition for both equity and equality.

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