Office of the High Commissioner on Human Rights
Special Rapporteur on the Right to Physical and Mental Health

Submission from White Ribbon Alliance
The right to sexual and reproductive health: Challenges and Possibilities during COVID-19

June 10, 2021

Invest in Midwives-- Trailblazers for SRHR during and beyond COVID-19

Introduction

COVID-19 has highlighted the challenges and pitfalls of maintaining the status quo health system. From the early days of the pandemic, it became clear that a facility-based model of care alone cannot meet the needs of all women and girls, especially those who have been historically excluded or discriminated against. COVID-19 laid bare many of the unique and exacerbated challenges confronting women and other vulnerable communities, which pre-date the pandemic. Midwifery and its model of care presents an alternative to facility-based care which is more resonant and necessary than ever during pandemics and times of crisis. However, midwifery is currently underfunded and under prioritized, reflecting the hierarchies within the global health ecosystem which are often rooted in patriarchy and white supremacy. To truly accelerate and ensure full enjoyment of sexual reproductive health and rights (SRHR) by women, girls, and birthing people in all their diversity, governments must invest in midwifery, ensure decent work for midwives, and enable midwife leaders at all levels of power and decision-making about healthcare.

Midwives, COVID-19 Challenges, and a Reimagining of Health Delivery

The near-immediate rollback of sexual and reproductive health rights and services at the onset of COVID-19, with no evidence to support those suspensions, quickly demonstrated the gaps and weaknesses of the current emphasis on facility-based care for the continuum of sexual, reproductive, maternity, and newborn (SRMN) healthcare. For example, maternity units were converted into exclusively COVID-19 centers, limiting the availability of maternal and newborn health services. Proven practices were altered, without evidence, through unilateral state and facility policies that required the mandatory separation of mother and newborn, restrictions on breastfeeding, and prohibited a companion during labor and childbirth.[1] These are just a few examples among many that increased medical risks for women and newborns, curtailed women's decision-making autonomy, and restricted access to care.[2]

Midwifery is "skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, post-partum, and the early weeks of life…[and] includes family planning and the provision of reproductive health services"[3]. Midwifery services are a core part of universal health coverage, and the practice of midwives reaches far beyond delivering babies and preventing death.

Midwives seek to provide health and wellness care. They could provide more than 90% of reproductive health needs by delivering a full scope of services, including:

- comprehensive reproductive, family planning, and contraceptive health services
- counseling
- prevention and treatment of certain medical conditions, like obstetric fistula
- abortions and pre-and post-abortion counseling and care

The services provided by midwives are delivered not only in hospital settings but also, critically, in communities—which can be a lifeline for those facing stigma and exclusion. Midwives are usually the last ones left to service the community in times of crisis due to their status as part of the community and ability to provide care without a lot of technological support. A midwifery model of care should be supported within and beyond crises settings to ensure that women and birthing people retain full choice in the care that they receive and that barriers to facility access do not prevent them from accessing critical and life-saving antenatal, labor and delivery, and postnatal care.

The midwifery model of care also ensures that care transcends borders for women living in current humanitarian settings, and to pre-empt future climate change challenges that are projected to yield a steady rise in climate refugees[4]. For midwives, 'community' need not be solely based on geography – it can be defined on the basis of identity, culture, and trust[5]. COVID-19 highlighted how the existing health system and a focus on facility-based care can exacerbate existing discrimination, inequalities, and gaps in access during a pandemic or crisis. By reimagining how and where care is provided, and how communities are defined, the midwifery model of care provides a unique opportunity for ensuring truly universal access to SRHR coverage.

History of Midwifery

The history of midwifery is a history of brave and intrepid practitioners showing up to be "with women" – despite threats posed by war, famine, pandemics, racism, sexism, violence, or discrimination. Midwives continue to be involved in social struggles around the world – often without recognition and while paying a high price.

Even as they have provided and continue to provide comprehensive community-based family health care, including SRMN health, there has been an intentional and systemic dismantling of black and indigenous midwifery based in white supremacist and patriarchal hierarchies. This dismantling can be tracked back to the Middle Ages when midwives were tortured by burning and hanging as heretics or witches. But this practice persisted through history, with many contemporary examples of harassment or diminishment.

For example, Black midwives in the United States were falsely discredited by physicians and routinely abused in their work even as Black midwives persisted in attending more than 50% of Black births through the early 1900s[6]. In the mid-to-late 1800s, the nascent medical profession, dominated by white men, urged the passage of laws criminalizing the practice of healing arts without a license to cement its primacy, leading to the criminalization of midwives. That criminalization persists to this day. Today, US midwifery has been pushed to the margins by a white-dominated, institutionalized healthcare system that has contributed to a racialized

maternal health crisis[7]. Yet Black midwives continue to persist in supporting women and communities, particularly in the South where culturally competent care is in high demand within Black communities where women fear becoming another maternal mortality statistic.

In Mexico's Indigenous communities, women have long relied on traditional midwives and continue today to seek care and domestic violence support from midwives at dedicated Indigenous women's centers called CAMIs (Casas de la Mujer Indígena o Afromexicana). However, the government continues to undercut midwifery as a profession, citing austerity for underfunding, leading to a shockingly low 174 midwives in the public health system as of 2015[8]. As recently as a March 2021 legislative hearing on UCVPS-514-2021: *Inciciativa que adiciona el articulo 64 de la Ley General de Salud*, politicians also deployed discriminatory tropes against indigenous midwifery practices when justifying their opposition to the initiative – which ultimately did not pass - that would have established midwifery units as physical, autonomous spaces independent from hospital services using a midwifery care model.

These are just a few examples of the ways in which the historic and continued dismantling of midwifery has weakened the quality care available to historically marginalized communities, even as midwives strive to persist through systemic challenges and daily abuses to their personhood and their autonomy as a health worker. Indigenous women continue to experience worse maternal health outcomes than non-Indigenous women. In the United States, risk of maternal death is twice as high for Native women than white women, while in Australia the risk is four and a half times higher[9]. Black women in the United States face 3-4 times greater risks of dying of a cause related to pregnancy, are more likely to experience preventable maternal death, and are nearly twice as likely to suffer from life-threatening pregnancy when compared to white women. But supported and resourced midwives can and do improve the maternal health outcomes for Black and Indigenous women. For example, the JJ Way ™ is a midwifery-based model of care developed and tested in 2007 by midwife Jennie Joseph in the state of Florida. Through its culturally relevant and truly accessible care to women of color and low-income women, the JJ Way is proven to eliminate disparities in preterm deliveries and low birth weight, while increasing women's social capital and providing continuity of care beyond labor and delivery[10].

Invest in Midwives for full SRMNAH coverage

Though made more evident during the COVID-19 pandemic, an increased commitment to, and investment in, the health workforce is critical to improving sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH) delivery. The 2021 State of the World Midwifery (SoWMy) Report analysis indicates a "current global needs-based shortage of 1.1 million 'dedicated SRMNAH equivalent' (DSE) workers. There are shortages of all types of SRMNAH workers, but the largest shortage (900,000) is of midwives and the wider midwifery workforce. Investment is urgently needed to address this shortage. The gap between low-income countries and high- and middle-income countries is projected to widen by 2030, increasing inequality. To close the gap by 2030, 1.3 million new DSE worker posts (mostly midwives and mostly in Africa) need to be created in the next 10 years[11]."

When fully educated, licensed and integrated in an interdisciplinary team, midwives can meet about 90% of the need for essential SRMNAH interventions across the life course. Currently, however, midwives comprise just 8% of the global SRMNAH workforce. Boosting that percentage, as well as the overall number of midwives, could be transformative. Universal coverage of midwife-delivered interventions could avert two thirds of maternal and neonatal deaths and stillbirths, allowing 4.3 million lives to be saved annually by 2035.

For women and all people who need reproductive health services, midwives serve to uphold their basic human rights: to the highest standard of health and the ability to make decisions about their own bodies, free from coercion and harassment. In being present and supportive of newborn health, midwives stand as guardians of the specific human rights that begin at birth – including right to name, nationality, and care by their own parents. And in communities around the world, midwives play a key role in keeping indigenous wisdom alive and providing culturally relevant care for racialized or marginalized communities. As such, midwives are practitioners of reproductive justice and birth equity. They must be acknowledged for that role and given the freedoms to exercise those rights – for both themselves and for their clients.

Recommendations to Member States

Leadership
Recommendations:

- Based on country or context, midwives must have a clear educational and career pathway and a route to growth and development as health professionals and community leaders. A career pathway for midwives needs to be developed in every country, providing opportunities for growth and development, and to provide visible and effective role models for midwives and other young women. This would allow them to play a major transformative role in the profession and thereby contribute to gender equity in the workforce.
- Ensure that midwives who practice in their communities and outside of institutionalized health care systems are recognized for the critical role they play in promoting community health. Laws or policies criminalizing midwives or subjecting them to monetary fines or other punishments for serving birthing people and families should be abolished.
- Provide leadership training opportunities for midwives to enable them to both attain leadership positions and then be successful in those leadership positions – within facilities, professional associations, and in government – once they attain them.
- Invest in Midwives Associations to continue the critical work they are already doing to establish support networks among practicing midwives, establish professional pathways, and inform national health policies and programs.
- Establish a government position of Chief Midwife in every country. This position exists in England, Chile, Paraguay and Scotland, and its expansion to other countries will help elevate midwives as professionals equivalent to other medical practitioners involved in the care of women and newborns.

When COVID-19 hit Malawi and Namibia, health leaders failed to include midwives in the national response. That didn't stop young midwives Luseshelo Simwinga, Tekla Shiindi-Mbidi

and Sylvia Hamata from stepping up to help draft national policies and guidelines for caring for women with Covid-19 during pregnancy, childbirth and the postnatal period, serve on national committees for infection prevention and control, and conducting situation analyses and designing responses to issues self-identified by midwives[11]. In Malawi, it was midwives in leadership at both the Ministry of Health (MOH) level and within universities and civil society that led the development of the national Family Planning and Maternal and Newborn Health COVID-19 guidelines..

Midwives often demonstrate such leadership due to the frequent need to stand up for themselves or stand with women and families for their right to health. But within the health system, midwives are highly under-represented and overlooked for leadership roles. This is a result of several factors. First, they face limited educational and career opportunities within the traditional healthcare settings where most work. Often, there is no direct promotion pathway for career advancement, and most schools do not offer post-graduate degrees in midwifery. As a result, midwives have few opportunities to take up decision-making positions - in institutions, facilities, or Ministries.

More broadly, midwives are often excluded from the leadership table because of the pervasive, and sometimes invisible, stigma and discrimination that arise from working in a highly gendered profession. While men do serve as midwives,70% of the global health workforce are women and over 80% are nurses and midwives[11]. Despite the majority of the workforce being women, male midwives are over-represented in the few midwifery leadership positions available. But without midwives in well-resourced leadership roles – in health facilities, in Ministries of Health, in national bodies like Parliaments – we can never achieve true reproductive justice or birth equity.

Decent Work and Pay Equity

Recommendations:

- Increase funding for more midwives: The world needs 900,000 more midwives, mostly in low-income countries and in Africa. Only 22% of countries have sufficient midwives for the care women and newborns need[11]. Member states should first establish a baseline of existing midwifery funding across a range of bilateral, multilateral, domestic and private sector sources, then set an ambitious target to increase it and supplement with domestic funding to improve SRMNH coverage.
- Ensure decent work and pay equity for midwives through legal frameworks and changes to patriarchal norms including through the adoption and ratification of women-specific policies and actions such as the International Labour Organization Convention 190, which specifically calls for protection against gender-based violence and harassment in the world of work.
- Support social dialogues which positively contribute to the development and reform of health services. Social dialogues bring governments, employers' and workers' organizations and other policy leaders and provide freedom for health workers, including midwives, to express their concerns and to organize as guaranteed in the fundamental rights to freedom of association and the effective recognition of the right to collective bargaining.

- Adopt the comprehensive and transformative policy frameworks, such as the International Labour Organization's 5R Framework for Decent Care Work, which calls for such a transformative policy environment by: recognizing, reducing and redistributing unpaid care work; rewarding paid care work; promoting more and decent work for care workers; and guaranteeing care workers' representation, social dialogue and collective bargaining. Midwives should be included under the protections and policy provisions of such Decent Care Work frameworks.

Midwives have long faced enormous challenges ranging from poor working conditions, limited resources to deliver needed care, social isolation from their families, and a lack of security and fear of violence – especially for those working in humanitarian settings. In a global World Health Organization report, *Midwives Voices, Midwives Realities*, documenting the voices and experiences of 2,470 midwifery personnel in 93 countries, 37% of midwives reported experiencing harassment at work including "verbal bullying and, at times, physical and sexual abuse."[12] Further, their voices were often dismissed or disregarded – with 36% of respondents noting a lack of respect by senior medical staff[12].

Despite their life-affirming role in providing care for women, midwives— a predominantly female workforce— also face persistent and gendered struggles in their economic rights, including pay inequity.. Midwives are among the least paid healthcare cadre within the health ecosystem of most low- and middle-income countries. Midwives report salaries so low that they sometimes must take up second or third jobs to survive, adding to their exhaustion and pressure.[12]

Conclusion

The Covid-19 pandemic has exacerbated pre-existing challenges in ensuring SRHR. In many ways, 2020 could be considered a harbinger of the impending reckonings for all societies and governments– climate change, food insecurity, inequality, and uncertainty. With the rise in unintended pregnancies and a decline in accessible, facility-based care during Covid-19, so too there is a rise in demand for midwifery services. Additionally, midwives are not prioritized for personal protective equipment (PPE) and are omitted from vaccine priority lists in countries where they are not considered formal health professionals. Yet, midwives cannot cease work, just as women's sexual and reproductive health needs do not cease during pandemics.

These challenges and the assured crises to come all promise to exacerbate the gaps in SRH coverage and delivery, particularly for women facing intersecting discrimination and barriers to care. Midwives stand with women even within the gendered and discriminatory world of work which uniquely affect them as health and care workers. By acting on the recommendations above to ensure that midwives are able to fully realize their own rights and stand up for the SRH rights of those who seek them, member states can begin to transform the power dynamics and conventions of healthcare that exclude historically marginalized groups and ensure SRHR for all, under all circumstances.

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Acknowledgments: Juana Berinstein, Association of Ontario Midwives

This submission was prepared by the White Ribbon Alliance (WRA), a locally led, globally connected grassroots movement advocating for the health and rights of women and newborns. WRA is comprised of a vast network of affiliated Alliances, networks, coalitions and individuals and actively works in partnership with women, men, their families and communities, professionals and practitioners from diverse fields and all sectors of government. WRA emphasizes the practice of amplifying and centering women and girls' voices in order to guide global health and rights advancements.

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