Office of the High Commissioner on Human Rights: Working Group on Discrimination Against Women and Girls in Law and Practice

Submission from Global Respectful Maternity Care Council

Women's and girls' sexual and reproductive health and rights in situations of crisis

August 31, 2020

Within days of COVID-19 being declared a global pandemic by the WHO, stories immediately emerged of women's rights being withheld or violated during childbirth without scientific evidence nor any sufficient and transparently reasoned justification the restriction of those rights and choices were necessary for 'security, safety, or emergency resource management'[1]. In some cases, these rollbacks started as countries scrambled to prepare for a pandemic that had not yet reached them. The hasty imposition of these rights infringements and service suspensions within reproductive and maternal healthcare not only marked serious human rights violations and a gap in the understanding of how these rights ensure optimal outcomes for women and newborns, but present a risk that the precarious wins made thus far in reducing maternal mortality and asserting women's reproductive rights will disappear.

This submission by the Global Respectful Maternity Care Council (GRMCC) highlights women's human rights violations in reproductive and maternity care around the world during the COVID-19 pandemic. These violations included total suspension of emergency services for pregnancy and childbirth, facility closures, and unilateral denial of fundamental human rights such as right to bodily autonomy, informed consent and refusal, and right to not be separated from the newborn or other family members. This was not inevitable. There are concrete steps that country governments can commit to and implement immediately to prevent further harm to women and newborns while also ensuring that our post-COVID reality does not normalize women's health and rights as optional.

I. Background on the Global RMC Council

In 2011, the White Ribbon Alliance (WRA) convened a multi-sectoral group to launch a global campaign to promote clear standards for RMC rooted in international human rights norms and instruments. Together, the members of this community of concern produced a groundbreaking consensus document, the Respectful Maternity Care Charter: The Universal Rights of Childbearing Women (hereafter referred to as the RMC Charter), which demonstrates how fundamental human rights apply in the context of maternity care. (WRA 2011). The initial community of concern formed the Global Respectful Maternity Care Council (GRMCC). Today, GRMCC is a growing multi-sectoral group of 150 organizations, representing over 350 members from 45 countries around the world, including researchers, clinicians, technical advisors, program managers, advocates, professional associations, UN agencies, and donors. This submission represents the consolidated input of the Global RMC Council.

II. Challenges

A. Suspended Services

Since the beginning of the pandemic, women have reported a comprehensive suspension of reproductive health services worldwide, particularly in low- and middle-income countries. This suspension of services occurred as a result of intentional shifts within government budgets of resources - financial and human capital - away from the spectrum of sexual, reproductive, maternal, newborn and child health (SRMNCH)

to cover the funding demands for COVID-19 responses. Some of the most impactful service suspensions for women were:

- Health facility closures that dramatically increased the distance required to travel to reach facilities, even in cases of emergency and basic labor and delivery needs, which led to reports of women delivering babies on roadsides with no support, illustrating the scale to which already vulnerable women were abandoned in many settings;
- When women sought out care and did reach facilities, often the facilities did not have health workers, supplies, or medicines available to provide women with the healthcare they sought. Health workers who lacked adequate personal protective equipment (PPE) refused to attend to or touch women arriving for childbirth;
- The suspension of community maternity services that would enhance the ability of health workers and of women to comply with social distancing while maintaining continuity of care, including home birth and midwifery-led birth centers and restricted access to pain relief;
- A lack of the lifesaving antenatal (ANC) and postnatal care (PNC) provision due to women being discharged from hospitals and facilities too early and with insufficient follow-up from healthcare providers to ensure they can access the mental health resources, breastfeeding support, medical attention, and contraception they critically need. This gap in ANC and PNC results in rise in post-birth jaundice for newborns and has a negative impact on maternal mental health. There is evidence that prenatal maternal stress and lack of postnatal follow-up care has long term negative health effects for newborns well into childhood and adolescence.

B. Suspended Rights

As services were suspended in the early days of the pandemic, women also saw their rights denied and in the name of preventing COVID-19 transmission without sufficient evidence nor justification that these rights violations were necessary or proportionate[3]. Such examples include:

- Banning birth companions during labor and delivery[4] rather than taking steps to manage risks and enabling the safe support from a companion of choice in the face of the tremendous evidence that birth companions improve the likelihood of safe childbirth[5].
- Forced medical interventions, caesarean sections, and inductions[6] under the misguided assumption that interventions would accelerate labor and delivery and minimize viral exposure for women and health providers and free up hospital beds more quickly[7] despite overwhelming evidence to the contrary.[8]
- Women were separated from their newborns to prevent transmission of COVID-19 if mothers were suspected to have the virus, even when appropriate precautions could be taken to prevent transmission and the negative effects of separation outweigh the risk of exposure to the virus.[9]
- Women were prevented from or discouraged from breastfeeding their newborns even though there was no evidence that COVID-19 could be transmitted through breast milk and the copious evidence of other viral risks to newborns without breastfeeding.[10]
- The restriction of movement due to the imposition and implementation of lockdowns and curfews by governments which left women without ambulances or private travel to get to and from hospitals and facilities for labor, deliver, and ANC and PNC appointments to access critical, lifesaving care for themselves and their newborns. When pregnant women managed to overcome the lack of transportation, they found themselves facing harassment by enforcement officials as they attempted to reach doctors and hospitals while under curfew, even in cases of emergency.
- Women who experience intersectional disadvantage beyond their gender identity[11], such as women with disabilities, migrant and refugee women, women living in rural and hard-to-reach geographic areas and settlements, and sex workers[12], reported being disproportionately affected by lack of

services, rights violations, and lockdown measures implemented without sufficient participatory mechanisms to obtain inputs from all communities.

III. Recommendations

There are specific actions that governments can take to prevent violations of women's rights that should never occur – even in the face of a pandemic. But there is equally a need for a post-pandemic vision and plan for action by governments to ensure that these rights and services do not remain the collateral damage of this pandemic.

The "Never-Again" Recommendations to Protect Human Rights and Prevent Loss of Life

A. Consistent, Evidence-based Information

Governments must deliver consistent, evidence-based messages on pregnancy, childbirth, postpartum and COVID-19 that are widely translated and tailored to pregnant women in their constituencies and to the general public.

There are countries, institutions, and organizations - such as the World Health Organization (WHO)[13] and the Royal College of Obstetricians and Gynecologists (RCOG)[14] that have put together evidence-based recommendations for the care of pregnant, birthing and postpartum women and their newborns in real time. This information needs to be used and shared across countries using message delivery methods that reach women where they live and where they seek care. This can be accomplished by using platforms that women already have access to and are engaged with, such as social media, texting, WhatsApp, or radio, and these platforms will vary by country, community, and socioeconomic status. In an evolving health crisis, it is critical to ensure that women have true access to the most up to date evidence-based information and that the government makes every effort to keep messaging consistent at all levels of government and facilities.

B. Essential Services

In every crisis and under all circumstances, countries must classify reproductive health services as essential and prioritize continuity of care in communities and facilities. Many countries already have existing protocols for sustaining services that are so classified and thus protecting reproductive health services under these protocols would mitigate the tragedies confronting women when they could not find the care they needed. The classification of reproductive health services as essential should at a minimum:

- Prevent closure of facilities/maternity wards or conversion of facilities[15] to COVID-response only centers;
- Ensure awareness for providers and women regarding continued ANC/PNC provision and importance during COVID-19;
- Exempt pregnant and postpartum women from curfews so they can access the emergency care and health appointments they need and prevent harassment by authorities; and
- Make available the necessary transportation to and from facilities and/or the necessary increased outreach services to reach women at home

C. Support Frontline Health Workers

COVID-19 made clearer than ever that a supported and resourced workforce of frontline health workers are key to not only to containing a health crisis, but to ensuring continued care for women. However, these health workers are not only hospital staff or facility doctors, but community-based providers and midwives,

who are often overlooked due to their professions being omitted from standard definitions - and the protections for - health professionals.

A lack of open communication among government and various sub-regional health management structures and with facilities and workers amplified the fear surrounding the pandemic that drove many unilateral decisions at the facility or district level to suspend services or rights. Governments must thus appropriately support health workers by:

- Ensuring water, sanitation and hygiene services and personal protective equipment is available to all providers;
- Ensuring adequate and equipped personnel coverage at the primary health care level;
- Not shifting midwives and other providers away from SRH care to COVID-19 response without adequate protection nor without maintaining the services they are being directed away from;
- Supporting continuity of care that can be flexible within communities and facilities, especially midwifery care, for its proven benefits for health outcomes and saving health resources across diverse healthcare settings and countries.

Long Term Recommendations: The post-pandemic plan

A. Accountability and Actively Seeking a New Standard

Governments should be held to account for the rapid breakdown of safe, rights-based maternity services in the context of COVID-19, and for the abuses that took place in the name of reducing infection rates without proof that this was the result. The tragedy of these abuses is that they were preventable had governments prioritized available global scientific evidence demonstrating the negative effect of these shifts against the COVID-19 risks they purported - often baselessly - to mitigate.

Beyond initial acknowledgment of this negligence and active harm done to women, true accountability requires countries to re-examine the existing standards for and delivery of maternal and reproductive care for women.

- An international symposium should be convened to examine the fundamental underlying weakness in the current provision of maternity care in countries of all economic levels, around the world, that led to service breakdown for pregnant, laboring, and postnatal women and their neonates. This symposium should allow for a radical consideration of the issues of power, control, attitudes and beliefs that underpinned this highly gender-specific collapse. Ideological positions should be acknowledged, and put to one side, in the search for a better and more resilient way of ensuring safe and positive maternity experiences around the world, both routinely, and in situations of crisis.

B. Research and Evidence

Pregnant women are already vastly under-represented in medical research. However, the sheer scale of predicted indirect consequences and the degree to which fear and misinformation drove decision-making at the start of the pandemic underscores the need to change this damaging norm immediately by committing to research the unique direct and indirect effects of COVID-19 on pregnant women including:

- Collecting and analyzing the lessons from the existing and emerging pockets of positive practices[16] to adopt the proactive policies[17], protocols[18], and resourcing that successfully ensured safe and positive pregnancy, birth, and postnatal experiences and to inform how systems can be rebuilt to mitigate the negative outcomes for women and newborns that have been reported in other settings;

- Promoting evidence-based information and facilitate research for reproductive, maternal and newborn health including
    - Research on COVID impacts on pregnant women by teams that have expertise in both pregnancy/maternal health and COVID-19;
    - Reinstate and bolster suspended inquiries into direct and indirect causes of maternal and neonatal mortality based on existing best practices in non-blame, confidential inquiries[19];
- Convening representative teams of analysts to proactively assess possible consequences and advantages of alternative pathways for post-pandemic health delivery such as:
    - Extending research into the potential positive effects from a reduction in forced medicalization and the environmental changes due to quarantine conditions such as the initial studies noting an initial reduction in early (first trimester) prematurity[20].

C. New participatory policy and decision-making processes

While current calls for 50-50 representation on COVID-19 country task forces are an important component to reducing direct and indirect harm to women during the pandemic, it is possibly even more critical to institute participatory and representative policy-making and decision-making processes in the post-pandemic recovery planning.

The current pandemic may be unprecedented, but the economic fall-out that countries will face in the coming years does indeed have prior ominous precedent for reproductive, maternal, and newborn healthcare. There are already indications that governments will begin to pull funding from RMNCH budgets in the name of austerity measures, and this was similarly reflected in 2009 following the global recession.[21]

There are processes and steps we can take now to avoid repeating the costly mistakes of past recovery measures and instead use this opportunity to ensure an equitable recovery for women through the following recommendations:

- Include maternal and neonatal health advocates and experts representing diverse and intersecting identities and communities in response task forces
- Include mechanisms for ongoing input[22] and participation from women in communities/constituencies that will be affected by policies enacted and ensure these mechanisms are not tokenistic but truly participatory so that women see their needs reflected in policy and practice;
- Invest in public services: In the economic hardship that results from the crisis, it is imperative that reproductive healthcare services and rights are not defunded or deprioritized as patriarchal norms and policymaking processes

IV. Conclusion

Despite the seeming unpredictability of the spread of COVID-19 from week to week and as new data emerges constantly, the time to act is now. By listening to the painful stories shared by women worldwide and committing to act on the short-term and long-term recommendations above, we have an opportunity to prepare and enact a flexible plan for the remainder of the pandemic and beyond. To truly build back better, countries must learn lessons and seize opportunities from an unprecedented pandemic to take unprecedented steps to reset the status quo, save the lives of women, and protect them henceforth in all health circumstances.

For more information, please contact:

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