Reproductive Justice during the COVID-19 Pandemic: A Call to Action from Midwives

Recommendations for governments, policy makers and healthcare professionals
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The Canadian Association of Midwives (CAM) and the National Aboriginal Council of Midwives (NACM) are the national organizations representing midwives and the profession of midwifery in Canada. As primary health care providers, midwives are experts in normal birth and community-based care. NACM and CAM advocate that a reproductive justice framework during the COVID-19 pandemic, and at all times, be applied to all perinatal care services.

Indigenous, Black, racialized, and 2SLGBTQ midwives have long advocated for reproductive justice and work tirelessly to support our communities to heal from historical and ongoing trauma and violence experienced within health care settings. A reproductive justice approach to care is community responsive. It recognizes that overlapping systems of oppression, histories, and trauma have an enduring impact on access to health care and the ability of all people to make free, informed, self-determined health care decisions.

Recommendations: Centering a Reproductive Justice Approach during COVID-19

Marginalized groups (including but not limited to Black, Indigenous, racialized, newcomer, differently abled, refugee, 2SLGBTQ, homeless, incarcerated, sex workers, people with addictions, and people with low socio-economic status) continue to advocate and resist persistent injustices and inequities, calling for recognition, representation, reparation, and reconciliation. NACM and CAM recommend that governments, policy makers, and healthcare professionals undertake the following actions:

1. Engage directly with leadership and recognized representatives of marginalized communities for decision-making around COVID-19.
2. Provide universal access to reproductive health care for all people in Canada regardless of immigration status or documentation.
3. Ensure equitable and timely access to all sexual and reproductive health (SRH) care, including abortion care.
4. Prioritize access to COVID-19 testing, contact tracing, and treatment for communities where access to health care is limited or nonexistent.
5. Ensure adequate, culturally, and linguistically appropriate infrastructure for self-isolation practices for marginalized individuals.
6. Increase flexibility in funding so that midwives can care for additional clients and provide broader (SRH) care, including pregnancy termination care.
7. Redirect clients who are evacuated from remote communities to give birth to out-of-hospital sites or hospital units that do not provide acute care to COVID-19 patients.
8. Provide culturally safe postpartum support services for people who have been evacuated for birth.
9. Prioritize family cohesion and cultural humility in the context of child protective services and ensure that families and workers are protected and supported to maintain this essential service.
10. Prioritize mental health support for marginalized clients accessing SRH care.
11. Mandate the safe and community-informed collection, analysis, and use of socio-demographic and race-based data in health and social services as it relates to COVID-19.
12. Prioritize research and planning on social determinants of health to address COVID-19 co-morbidities that are more prevalent in marginalized communities.
13. Reduce unnecessary legislative barriers to providing SRH care via digital technology.

What puts marginalized communities at higher risk of sexual and reproductive health inequity during the COVID-19 pandemic?

Marginalized communities are at the front lines of inequitable systems, policies, and structures. People whose human rights are least protected are likely to experience compounding difficulties and carry heavier personal burden during a crisis situation like COVID-19.[1] [2].[3] Because of historical and ongoing racism, colonialism, and oppression, Indigenous, Black and racialized communities in Canada face higher rates of COVID-19 co-morbidities, poverty, homelessness, child protective services, incarceration, and overcrowded and unsafe housing. They are also over-represented in front-line healthcare jobs and low-paying, precarious, and informal jobs. Marginalized groups routinely face greater risk and have less access to sexual and reproductive health care than other groups. During the COVID-19 pandemic, marginalized communities have been further marginalized through:

- Inadequate, ill-intentioned, and delayed consultation with recognized community leaders and representatives.
- Lack of clear, culturally appropriate, and context-specific public health messaging.
- Centralization of services in inaccessible spaces resulting in lack of continuity of care with trusted health care professionals.
- Reduced access to routine screening and wellness care, contraception, and SRH medications.
- Lack of collection of disaggregated data needed to support informed decision-making around resource distribution.[4]

In addition, specific **equity issues within the health care system are further amplified during COVID-19, such as:**

- Lack of investment in community-based perinatal care, particularly in rural and remote communities and the routine and blanket evacuation of Indigenous people from remote communities for birth.[5]
- Lack of funding and health service infrastructure, including basic and primary care in marginalized communities, particularly in northern, rural, remote and urban underserviced settings.
- Historical factors, such as germ warfare, forced sterilization and coerced medical experimentation as well as ongoing systemic racism in the health care system that results in fear of mistreatment and distrust in health care professionals and delayed health care seeking.

Conclusion

The impacts of pre-existing health and social inequities are further amplified during COVID-19. Reproductive rights and freedoms are best protected when the most vulnerable peoples have access to resources, spaces and opportunities to live self-determined lives without fear, discrimination, or retaliation. **The rich history, strength and resilience of this movement must be recognized and supported as we collectively resist threats to reproductive health during this pandemic.**

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[1] Stidham Hall, Samari, Garbers, Casey, Dixon Diallo, Orcutt, et al. (2020) Centring sexual and reproductive health and justice in the global COVID-19 response. The Lancet, vol. 395, issue 10231, pp. 1175-1177.
[2] Flanagan, R. April 15, 2020. CTV News. Does COVID-19 Discriminate? This is how some Canadians are harder-hit. https://www.ctvnews.ca/health/coronavirus/does-covid-19-discriminate-this-is-how-some-canadians-are-harder-hit-1.4897298
[3] Waakebiness-Bryce Institute for Indigenous Health. COVID-19 Update. March 27, 2020. http://www.dlsph.utoronto.ca/institutes/wbiih/
[4] Nasser, S. April 18, 2020. CBC News. Early signs suggest race matters when it comes to COVID-19. So, why isn't Canada collective race-based data? https://www.cbc.ca/news/canada/toronto/race-coronavirus-canada-1.5536168
[5] National Aboriginal Council of Midwives. (2019) Position Statement on Evacuation for Birth. Available at : https://indigenousmidwifery.ca/wp-content/uploads/2019/05/PS_BirthEvac.pdf