



**Recommendations to Address Gaps in Prenatal Care System
Report from the COVID-19 Prenatal Care Task Force**

January 13, 2021

Context

The Provincial Council for Maternal and Child Health (PCMCH) recently released the Maternal-Neonatal COVID-19 Pregnancy Care Guideline. Created by the PCMCH Maternal-Neonatal Prenatal Care Task Force (Task Force), this guideline addresses the immediate maternal-neonatal practice concerns relating to pregnancy care during the COVID-19 pandemic using the best scientific evidence available. Through the development of this guideline, the Task Force has identified a number of additional concerns related to the delivery of safe and equitable prenatal care for both patients and providers. The pandemic has further highlighted concerns that predate the pandemic and require system-level review and improvement. These concerns are outlined below and include recommendations that can help address gaps within the prenatal care system in Ontario. Many of the recommendations extend beyond health care delivery and into domains that impact broader determinants of health. As such, a multisectoral strategy is required to fully address these recommendations and close the health equity gap that currently exists in maternal-neonatal care across Ontario.

1. Race, vulnerable populations and Indigenous communities

In Ontario, there are diverse populations that require pregnancy care as well as a wide range of regulated health care providers that provide pregnancy care across a variety of settings. There are existing inequities in our pregnancy care provision which arise from system factors, provider factors, and above all, access and equity issues in varying populations. With the onset of the COVID-19 pandemic, these health inequities are magnified in vulnerable populations as well as Indigenous communities and nations across Ontario. Reluctance to collect race-based data across Ontario is a lost opportunity whereby knowledge about specific population health would have been valuable throughout this pandemic. As current announcements regarding the collection of race-based data begin to emerge, adequate consultation and development of processes to collect this data must be discussed within the populations the data will be collected from. The following is a brief high-level summary of areas where specific equity issues need to be addressed in relation to prenatal care specifically and reproductive health more broadly:

- Lack of investment in community-based perinatal care, particularly in rural and remote communities.
- Lack of engagement regarding community-based solutions to end the routine and blanket evacuation of Indigenous people from remote communities for birth.
- Lack of funding and health service infrastructure, including basic and primary care in marginalized communities, particularly in Northern, rural, remote and urban underserved settings.
- Lack of investment in an Indigenous cultural safety strategy for non-Indigenous health care providers resulting in fear of mistreatment and distrust in health care professionals and delayed health care seeking.

This has been created by historical factors affecting Indigenous populations, such as germ warfare, forced sterilization and coerced medical experimentation as well as ongoing systemic racism in the healthcare system [1].

Recommendation 1.1

Race-based data, data on Indigenous populations, and data related to marginalized populations must be collected, informed, and owned by these populations.

Recommendation 1.2

Gaps in health care access and services identified by the communities affected will require monitoring and tracking. Solutions introduced to remedy these gaps should be implemented and monitored in collaboration with the communities affected.

2. Access to Care for All

As an emergency measure early in the pandemic, Ontario made universal health care accessible to people without OHIP coverage and removed the three month waiting period for OHIP which were important steps to ensure that those without health insurance have access to care, including prenatal care [2, 3, 4].

Recommendation 2.1

During the pandemic, universal health care should continue to be provided, regardless of health insurance status. An evaluation of the impact of universal health care for these individuals should be performed following the pandemic to inform future health initiatives.

Access to prenatal care can be provided by family physicians, obstetricians, midwives, and other non-physician providers. It is important to recognize that existing referral systems do not empower midwives and other non-physician providers to facilitate necessary transfer. Midwives should be made part of the referral system so that seamless care can be provided for the pregnant person without adding additional burden to the provider. Midwives should also be designated as essential care providers. They are the only health care professionals who provide access to out-of-hospital birth. Requests for out-of-hospital births have increased during the pandemic and are expected to remain at these levels. Many physicians have asked midwives to provide postpartum and other kinds of support for their clients. This inequity must be addressed through the same mechanisms that have designated other health care providers as essential. An analysis of the additional resources required to provide midwifery care should be performed following the pandemic.

Recommendation 2.2

Midwives should be part of the referral system so a pregnant person can receive timely and seamless care.

3. Access to Virtual Care

Throughout the pandemic, care has been transitioned to alternate formats, particularly phone and video-based care. Many pregnant people lack adequate resources to access this model of care. This is particularly true of people living in poverty and experiencing homelessness, the Deaf/Hard of Hearing community and non-English speakers as well as pregnant people living in rural and remote communities with inadequate or no internet infrastructure.

Additionally, all prenatal care providers must have access to secure virtual care options in order to ensure the equitable provision of prenatal services during the pandemic. Examples include access to nursing stations or hospital technology for virtual visits with distant providers. We are reminded that staffing has been a concern at nursing stations and not all care environments can provide access to this technology

during the pandemic. While the Ontario Telemedicine Network can be utilized by non-physician providers, many midwives and physicians who were not registered prior to the pandemic were impeded from using this service by administrative burden and excessive wait times.

Recommendation 3.1

Funding, privacy approval and technological infrastructure should be provided to all maternal and newborn health providers to enable them to access virtual connections with clients/patients in all settings and regions in Ontario.

Recommendation 3.2

Providers must be supported to provide virtual care to populations with limited access (e.g. translation services) and to provide in-person care to those who cannot access virtual care (e.g. with funding for increased PPE).

Recommendation 3.3

Concerted efforts should be made to improve access to and quality of internet for individuals in rural and remote settings, and those utilizing blended solutions that combine in-person and virtual care.

4. Considerations for Rural and Remote Areas

The realities of pregnancy and birth in rural and remote communities mean that pregnant people in these areas have reduced access to care and experience the cultural, financial and emotional burdens of travel for care. These stressors are amplified by the realities of the COVID-19 pandemic and all efforts must be made to ensure that pregnant individuals and their supports living in rural and remote communities have equitable access to quality prenatal care in face of changes in our patterns of care. Additionally, remote Indigenous communities frequently lack the necessary infrastructure to put in place transmission reduction and isolation procedures (e.g., access to clean water, housing which allows distancing). Pregnant people who have to travel for care, particularly those evacuated/flown out for birth and prenatal care, have had significantly increased costs and stress as a result of pandemic changes (e.g., finding accommodation to stay between appointments when hotels and other options are limited).

Recommendation 4.1

Rural and remote communities, especially Indigenous communities, must have funding for supports and have plans in place for those who do not have access.

Recommendation 4.2

Financial supports such as the Northern Health Travel Grant should reflect the increased costs experienced by pregnant people and their supports during this time.

In rural and remote communities, decreased access to COVID-19 testing and increased turnaround times will result in a longer time between testing and clearance. As a result, pregnant individuals may experience longer periods of isolation even when able to remain in their home community. Rapid and point-of-care testing, as they become more widely available, have the potential to reduce this impact.

Recommendation 4.3

As a reliable rapid point-of-care test for SARS-coV2 becomes available, it should rapidly be made available to rural and remote communities.

5. Access to Medications, Supplies and Testing

Drug shortages were common prior to the pandemic (e.g., oxytocin and erythromycin) and have only become more frequent due to, among other factors, disruptions in production and diversion to treatment of individuals with COVID-19. Pregnant people are particularly vulnerable to drug shortages as alternative treatments are often limited or unavailable due to known or potential fetal effects. While recommendations have been made to the public, prescribers, pharmacists and policy makers on mitigation strategies in face of drug shortages [5], the unique needs of the pregnant population are rarely considered [6].

Recommendation 5.1

When medication shortages are experienced due to the pandemic, the needs of pregnant individuals should be considered and prioritized *as part of essential pregnancy care*. Facilities, pharmacists and professional societies must rapidly develop strategies to guide response to drug shortages affecting pregnant people.

Access to supplies and testing has also been reduced during the pandemic. As prenatal care is essential, non-deferrable care, it is important that items such as PPE, swabs and testing capacity continue to be available [7]. The needs of the pregnant populations must be considered when rationing of resources must occur and all providers and care environments should have access to the necessary supplies. Due to the rapidity with which modifications in testing or treatment are being made during the pandemic, situations have arisen where regulatory restrictions may limit the ability for some pregnant individuals to access this alternative care (e.g. midwives are unable under current lab regulations to order the HbA1c for the modified gestational diabetes screening program).

Recommendation 5.2

The needs of the pregnant populations must be considered when rationing of resources must occur. When modifications are made to testing and treatment regimes, all care provider groups should be enabled to enact these recommendations through a timely and flexible approach to regulatory changes, when necessary.

Current evidence regarding COVID-19 outcomes in pregnant people shows that they are at higher risk for hospitalization, intensive care admission and mortality [8] [9]. Many drugs are now being repurposed and assessed for efficacy and safety in treatment of COVID-19; however, pregnant people are almost universally excluded from these clinical trials, even those investigating drugs that are already commonly used in pregnancy [10]. Similarly, pregnant people are typically excluded from participation in vaccine trials, even though vaccination in pregnancy has the potential to protect the mother, fetus and newborn.

Recommendation 5.3

Pregnant people deserve equity in access to therapeutic options that are informed by rigorous scientific data. Systematic exclusion of sick pregnant people from clinical trials leaves them vulnerable to limitations in access to off-label or compassionate use of therapeutics, or limits evidence-based care due to lack of information specific to pregnancy. Safe inclusion in COVID-19 clinical trials is required to provide pregnant people with equal access to treatments and vaccines during the pandemic.

6. Workplace Concerns for Pregnant Individuals

While pregnant workers should largely be able to continue working during the pandemic, pregnancy related comorbidities such as gestational diabetes and gestational hypertension should be considered risk factors for more severe disease. In situations where work-related exposure is substantive or individual risk for COVID-19 related morbidity is high, pregnant workers should have access to accommodations or supported absence from work when accommodations cannot be provided [8].

Recommendation 6.1

Pregnant workers' access to accommodations and protection should be ensured when exposure risk or disease severity risk is high.

Workplaces should protect their workers. Disease-reducing activities such as screening, physical distancing, hand hygiene and adequate PPE need to be in place so risk of occupationally acquired infection is low and pregnant people feel safe in their work environments. Where these protections cannot be adequately provided, consideration should be given to possible reassignment of pregnant workers in consultation with their health care provider, as they appear to have more severe outcomes due to COVID-19 compared to non-pregnant people [9].

Recommendation 6.2

Workplaces need to provide pregnant people with a safe work environment including adequate physical distancing and PPE.

Household members may work in an environment that could be the source of risk for the pregnant individual; this is particularly true when household members work in health care environments. Care environment considerations should be made to limit the spread of COVID-19 at home for all family members.

Recommendation 6.3

Education should be provided to the pregnant individuals and their households about transmission reduction when a member of the household works in an environment with higher exposure risk [11].

If a pregnant individual cannot work due to the impacts of the pandemic, this may reduce their access to financial support or maternity leave benefits for the pregnant individual. For instance, a certain number of

work hours may be needed in order to be eligible to receive financial support for maternity or parental leave. If maternity and parental leave benefits are compromised, pregnant individuals may choose to remain in an unsafe workplace and/or may be required to return to work prematurely after the birth of their child.

Recommendation 6.4

Workplace absences brought on by the pandemic should not impact a worker's right to maternity and parental leave.

7. Health Equity Research

The work of the Task Force has underscored the need for further research on factors that influence health inequities in the province. Health outcomes are affected by various determinants such as social, economic, cultural and environmental factors. For Indigenous people, poor health outcomes can be traced directly to the multi-generational effects of colonization and the treatment of Indigenous people in the residential school system. A heightened awareness of these factors and inequitable distribution of health and wealth will enable the province to better respond to barriers that exists and limit individuals from receiving appropriate care.

Recommendation 7.1

PCMCH and other maternal child stakeholders should work together to better understand and respond to subpopulation disparities arising from: social determinants of health, barriers to access, racialization and other outcome clusters owing to intersectional experience of individuals.

Additional Recommendations

Through developing the pregnancy care guideline and subsequent recommendations for addressing the gaps in Ontario's prenatal care system, the Task Force recognized several factors that need to be addressed in terms of provincial committee organization and advising. These include:

- Indigenous and Equity (including Black, people of colour, LGBT2QS, differently abled) representation at sector, council, committee and decision-making levels;
- Engagement of lived experience advisors at all levels;
- Data-driven decisions including BORN, Social Determinants of Health, community outcomes and subpopulation outcomes;
- Equitable access to non-identifiable data for appointed PCMCH provincial planning committee members;
- Joint (sector/committee/stakeholder) policy development on equity issues to avoid misalignment and exhaustion for all contributing; and
- Appropriate resourcing for equity work at sector, committee and stakeholder levels.

Summary

In conclusion, these recommendations can support equitable care across the province which unfortunately have been further exacerbated for specific populations during the pandemic. Focus by this group is limited to prenatal, however these important equity issues could also apply to postnatal, infant and early parenting. By applying these recommendations, there is an opportunity to strengthen the delivery of the health care system for all pregnant people and their families. These recommendations will not only protect prenatal services but enhance them for better outcomes in the future.

Contributors on Behalf of the PCMCH COVID-19 Pregnancy Care Task Force

Ms. Ellen Blais, Director of Indigenous Midwifery, Association of Ontario Midwives

Ms. Elizabeth Brandeis, Registered Midwife, Midwives Collective of Toronto, Sinai Health System

Ms. Wendy Katherine, Executive Director, Health Nexus

Dr. Cynthia Maxwell, Maternal-Fetal Medicine Specialist and Division Head, Sinai Health; Equity, Diversity and Inclusion Officer, Department of Obstetrics and Gynaecology, Sinai Health System; Professor, University of Toronto

Dr. Katherine Miller, Lead Physician, Family Practice Obstetrics and Well Newborn Care at Guelph General Hospital; Assistant Professor, McMaster University

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