Equity In Care: Midwifery In Ontario During the COVID-19 Pandemic

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ABSTRACT

This article explores the impact of the COVID-19 pandemic on midwifery care in Ontario. Midwives faced unique challenges in delivering high-quality care while protecting themselves and their clients from infection during the pandemic. Our first objective in this study was to understand the general impact of the pandemic on midwifery practice to document the challenges midwives faced, and how they adapted their work. What information, resources, and support did they receive to deal with the challenges, and what strategies did they develop to maintain their unique model of care under such constraints? Our second objective was to look closely at how midwives worked to mitigate the pandemic's unequal burden on racialized and marginalized clients as COVID-19 laid bare and exacerbated existing divides in the healthcare landscape. How did they adapt care for vulnerable groups during a time of crisis?

RÉSUMÉ

Le présent article examine l'incidence de la pandémie de COVID-19 sur les soins sage-femme en Ontario. Les sages-femmes ont affronté des défis exceptionnels : elles devaient offrir des soins de haute qualité tout en protégeant leur clientèle et elles-mêmes contre l'infection. Le premier objectif de notre étude consistait à comprendre l'impact de la pandémie sur la pratique sage-femme en général et à prendre note des défis auxquels les sages-femmes ont fait face et des façons dont elles ont adapté leur travail. Quels renseignements, quelles ressources et quels soutiens ont obtenu les sages-femmes pour relever les défis et quelles stratégies ont-elles conçu pour maintenir le modèle de soins qui leur est propre sous de telles contraintes? Nous avions comme deuxième objectif d'examiner de près la façon dont les sages-femmes ont travaillé pour atténuer le fardeau inégal imposé à la clientèle racisée et marginalisée, alors que la COVID-19 mettait à nu et accentuait les fossés présents dans le paysage des soins de santé. Comment les sages-femmes ont-elles adapté les soins prodigués à ces groupes vulnérables durant cette crise?

KEY WORDS
Midwifery, COVID-19 pandemic, health services accessibility, Indigenous midwifery, reproductive justice

INTRODUCTION

This article explores the impact of the COVID-19 pandemic on midwifery care in Ontario. Midwives faced unique challenges in delivering high-quality care while protecting themselves and their clients from infection during the pandemic. Our first objective in this study was to understand the general impact of the pandemic on midwifery practice to document the challenges midwives faced, and how they adapted their work. What information, resources, and support did they receive to deal with the challenges, and what strategies did they develop to maintain their unique model of care under such constraints? Our second objective was to look closely at how midwives worked to mitigate the pandemic's unequal burden on racialized and marginalized clients as COVID-19 laid bare and exacerbated existing divides in the healthcare landscape. How did they adapt care for vulnerable groups during a time of crisis?

We partnered with the Association of Ontario Midwives (AOM) – the organization that supports midwives and advocates on behalf of the profession. The AOM and the social movement of midwifery, out of which it grew, has a long history of working to disrupt the routine medicalization of pregnancy and childbirth and to empower pregnant people by placing them at the centre of care and decision-making. This history of social and political activism, which has evolved towards a greater focus on equity and diversity within the profession and in delivering care, held the profession in good stead through the pandemic years, offering conceptual and practical tools upon which to draw on.. We found that midwives in our study strove for 'equity in care' throughout the pandemic by adapting care according to the needs of individual clients and by developing workarounds and new projects. We also found that midwives were better able to work equitably when the funding arrangements they worked within were flexible, when they had more options to expand or modify the midwifery scope of practice, and when interprofessional relationships were collaborative. Ultimately, we argue that the work of midwives towards greater equity in care during the pandemic can be understood as contributions towards reproductive justice, not only in an immediate sense for their clients but by demonstrating how to practice midwifery differently.

BACKGROUND

Midwifery emerged in the 1970s as a social movement devoted to the de-medicalization of pregnancy and childbirth; midwives sought and won formal integration within the healthcare system, and in 1994, midwifery became a regulated, fully funded health profession in Ontario.[1-4] Midwives are primary care providers who carry their own caseloads, have hospital admitting privileges, and consult with specialists when indicated. Midwifery care is publicly funded and legally accessible to everyone, regardless of immigration or health insurance status. The Ontario midwifery model of care has three central tenets that distinguish it from mainstream obstetrical care: informed choice, continuity of care, and choice of birthplace.[5] Informed choice requires that midwives facilitate, inform, and support their clients in a collaborative and non-authorian way. Continuity of care is intended to ensure that pregnant people are cared for by midwives known to them, fostering a relationship of trust that supports informed choice.[2,6] Choice of birthplace means that pregnant clients can choose to give birth at home, in a birth centre, or a hospital attended by midwives as primary care providers. These three tenets seek to place decision-making in the hands of childbearing people and promote pregnancy and childbirth as states of health and normalcy; these tenets embed social and reproductive justice into the very structures and practices of the profession.[1,2,7]

For many Ontario midwives, the profession's social movement goals have shifted over time from a primary emphasis on the de-medicalization and deinstitutionalization of pregnancy and birth toward diversity and equity: expanding access to the profession to individuals who identify as Indigenous, Black, or people of colour (IBPOC), and expanding services to racialized and marginalized communities, including immigrant communities, low income, undocumented, street-involved, and under-housed populations.[7-9] This agenda expands significantly upon the goals of the original predominantly white, middle-class social movement of midwifery. It also

addresses and redresses the exclusionary processes implemented on the road to professionalization.[3] Credit for much of this shift belongs to the often invisible work of groups within the profession: IBPOC midwives and midwifery students who have given voice to their challenges and demanded change from within (to midwifery education and admissions processes, for example) and who have created clinical peer support and new research agendas that attend to the experiences of racism and exclusion that have continued to be felt by Indigenous and racialized midwives and midwifery students.[10–12] These interventions productively trouble the narrative of a wholly progressive midwifery profession and point to the ongoing inequities within the profession both for IBPOC midwives and IBPOC clients, as well as to the work yet to be done (Note 1).

Although strides have been made in diversifying the profession and its clientele, recent research conducted by racialized midwife-scholars has found that the majority of Indigenous, Black, and People of Colour midwives have experienced discrimination and racism on the job; it also reveals unique challenges in providing midwifery care to IBPOC and undocumented populations in a society and healthcare system structured by white privilege.[10–12] Professional midwifery bodies in Ontario and Canada, responding to critiques from IBPOC members, are calling for more research on intersectional barriers to the profession and to the delivery of care: how these function, for whom, and what can be done to sustain and enhance equity in reproductive health care.[13–16] A body of research has begun to document patterns of racialized inequity in Canadian healthcare generally[17–22] and in maternal health specifically.[23–27] Media coverage has also reported on how disparities in healthcare access and outcomes have been magnified during the COVID-19 pandemic.[28-30]

THEORETICAL ORIENTATION

We begin with the premise that health knowledge, systems, and clinical care practices are more than matters of scientific evidence and rational practice. Instead, they are deeply embedded in social and professional norms and legal and regulatory structures that serve some interests more than others and can impact clinical outcomes.[31–34] This theoretical orientation has been applied in critical social science scholarship on the social movement of midwifery in Canada and its transition to a full profession within the public healthcare system,[1–4,35–37] the travails of the early years of the profession,[38–41] and how the midwifery model of care functions in practice.[42-44] The evolving social justice work of midwifery has been addressed in scholarly work that argues that the profession has maintained a counter-hegemonic force; as midwives continue the feminist work of promoting and supporting pregnancy and birth as "normal," they have also defined and pursued new social justice goals for the profession, including the expansion of diversity and equity.[7–9,45–49] While acknowledging the ongoing efforts towards equity within the profession, as we conducted this research, we consistently heard from our participants that the profession continues to reflect forms of white supremacy and racism that are embedded in all healthcare systems and about the efforts of Indigenous, Black and People of Colour midwives and students to make changes. Reproductive justice is thus an important concept for this project for the way it moves the conversation beyond the logic of choice and individual responsibility and seeks to transform the social and political context that shapes people's ability to fulfill their own reproductive trajectories, as well as to highlight how reproductive healthcare is structured within systems of power and privilege.[50–52]

A closely related concept, stratified reproduction, sees reproduction as situated within cultural and social structures that empower some people and disempower others in their reproductive desires and experiences.[53–54] Documented disparities in maternal and infant health and healthcare along racial and socioeconomic lines of difference and disadvantage illustrate the reality of stratified reproduction and the need for reproductive justice. Health disparity is generally defined as the disproportionate burden of disease between groups, which is not explained by differences in the underlying health of those groups. Disparities in maternal and infant outcomes along racial lines are well documented in the US and have gained greater attention in Canada as a direct result of the Black Lives Matter movement, forcing a reckoning with the reality that multiculturalism and universal healthcare coverage does not protect against disparities in maternal health status, access to and quality of care, or outcomes.[55–65]

The scant scholarly literature on the work of midwives in times of crisis globally documents how midwives must rapidly and dramatically alter their work in response to sudden resource constraints (such as disrupted supply chains); to comply with public health directives (such as infection control), and to ensure the safety of their clients and themselves.[66–68] This small body of literature suggests that how midwives are already integrated, respected, and resourced affects their ability to maneuver and improvise effectively within the healthcare system in times of crisis – a point that becomes relevant in our study. Strategies prioritizing midwifery-like approaches (e.g., judicious use of technology, home births, postpartum home visits) can also maintain access and safety. This literature also suggests that moments of crisis can mobilize systemic change and serve as a testing ground for the reorganization of care.

METHODS

Our research objectives and interview guides were generated collaboratively with our partners the AOM. Our methods were designed to capture the depth and breadth of the context and experiences of midwives during the COVID-19 pandemic to answer key questions about how the pandemic is affecting the social justice work of the profession. We conducted 16 interviews: nine with midwives practicing during the pandemic and seven with midwifery experts – individuals who held administrative, policy, or leadership positions within the profession. All but one of the midwifery experts we interviewed were former or practicing midwives. We recruited participants through purposive sampling and snowball technique, seeking those already doing equity work within the profession before the pandemic.

Our study participants were located in various settings: urban, peri-urban, rural, and northern. They were working in a variety of practice arrangements: Midwifery Practice Groups (MPGs) in which midwives' work is organized and paid per course of care; Expanded Midwifery Care Models (EMCMs), alternative practice models funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC) including salaried employees within Community Health Centres (CHCs) designed to serve marginalized communities; and in Indigenous-focused midwifery practices, some funded through the Indigenous Midwifery Program (IMP) of the MOHLTC and some practicing under the Aboriginal Exemption Clause in the Regulated Health Professions Act (Note 2). Most of the midwives in our study worked in practice groups that had chosen to work with vulnerable and racialized populations (low-income, newcomers, uninsured, street-involved, addiction). Two-thirds of our participant group identified as Indigenous or racialized, and one-third as white. While we were able to recruit a diverse group of participants for this study, we acknowledge that it is often extremely difficult to engage those working with the most marginalized communities and those experiencing the most marginalization within the profession themselves; these are the midwives who are least likely to have time to commit to interviews. We also acknowledge that the principal investigators' social locations as white researchers inevitably impacted the conversations we had and the data we collected. To preserve the anonymity of our study participants, we do not describe these individuals or practice settings in further detail.

Interestingly, when our study's midwives and midwifery experts were asked how they came to the profession, their answers spoke directly to issues of equity and reproductive justice – though they did not often call it that. They came to their roles to provide meaningful care during a meaningful experience, often highlighting feminism and anti-racism as the guiding principles for their motivation. One racialized participant said that when the racialized clients coming to her practice started asking for her specifically, it was a kind of political awakening (MW4:2). All research participants, in one way or another, saw advocacy on behalf of clients as inherent to midwifery and understood the importance of shaping the regulatory and policy context of the profession through public awareness raising and formal channels.

The interview schedule for participants was designed to elicit information, experiences, and personal reflections about how COVID-19 affected the work of midwives, the experiences of clients, and the profession overall, with particular attention to the social justice goals of equity, inclusion, and anti-racism. Semi-structured open-ended interviews provided opportunities for participant feedback and, in an iterative fashion, alerted us to new questions

we could then pursue in subsequent interviews. Interviews lasted between 60 and 120 minutes and were conducted by the principal investigators. All interviews were held over Zoom and audio-recorded with participants' permission. Transcripts of the audio recordings were automatically generated by Zoom and reviewed and corrected by a research team member. York University Office of Research Ethics granted research ethics permission.

Interview transcripts were reviewed and coded by both principal investigators. We developed and refined themes inductively during the initial reading of the data while applying critical theory from medical anthropology and sociology that health and health care are culturally constructed and negotiated within shifting webs of power and meaning.[69–73] It is important to note that our findings are situated and partial; they are interpretations shaped by time and place and our identities as researchers, rather than being a "view from nowhere."[74–75] Initial findings were validated and refined in research team meetings and with AOM partners. In order to build a strong understanding of the public and professional policy background and context of midwifery during the time of our research we also accessed media items, policy statements, clinical guidelines and directives by public health and government officials as well as COVID-19 Bulletins issued by the AOM to their members.

RESULTS

We begin our results section by describing what it was like for midwives to absorb and implement rapid changes to their work during a crisis while trying to preserve high-quality care and maintain the values that orient the profession. Our interviews took place between October 2021 and April 2022; at this stage, all of the midwives and experts we spoke with had worked through successive waves of the COVID-19 pandemic and were in the position to reflect on its impact. We begin by discussing the kinds of pandemic challenges and practical pivots that characterised midwifery work in the first several months of the crisis. We then turn to focus, in a second section called equity in care, on three themes within our data: 2.1) how midwives developed and productively tinkered with workarounds and sometimes "worked the system"; 2.2) how pre-existing alternative and expanded funding models served as a basis for effectively adapting and extending midwifery under pandemic conditions, and; 2.3) how midwives developed new projects to tackle specific challenges.

Pandemic Challenges and Practical Pivots

The early days of the pandemic were chaotic; there was a flood of new and rapidly changing information about the virus and infection control, including information specific to midwifery practice. Little was known at that time about the effects of COVID-19 infection on pregnant people, fetuses, and newborns. Later, there was a similar lag in information on the safety and effectiveness of vaccines for these groups. Midwives and experts in our study reported that they relied greatly on the AOM COVID-19 Bulletins which were being sent out on a near daily basis and distilled and translated updated scientific information about the virus and public health directives from the MOHLTC and local public health units that were rapidly being revised. The Bulletins also suggested resources and best practices for how to reorganise schedules and clinic rooms, how to talk to clients refusing masks, how to procure Personal Protective Equipment (PPE), how to adapt equipment for home births (wipeable containers and ziplock bags!), how to manage when midwife and physician colleagues fell sick, to name but a few topics. The AOM also held webinars on advocacy and equity issues such as implications of COVID-19 response on IBPOC communities, equity, and ethics in the response of COVID-19, racism and oppression against racialized and 2SLGBTQI+ communities, caring for clients without health insurance, preserving client decision-making while staying safe. Midwives also received information and protocols from individual hospitals where they held privileges or from the CHCs with which they were allied. Many midwifery practices were proactive, consulting the World Health Organization (WHO) website for recommendations and the Canadian Association of Midwives' Facebook page to see what other practices were doing.

Absorbing the information and implementing changes took time, energy, and a lot of discussion. Not all midwifery practices meet the challenges in the same way. They had to respond to their own

particular communities, their practice groups, and the hospitals where they worked to craft appropriate and workable solutions. Clinic schedules and on-call time were reorganised and tinkered with, scrapped and started over, implemented on a practice-wide scale, before they were allowed to relax into individual patterns. Constantly shifting information and advice significantly increased the time burden of clinical and administrative work: more time to manage infection control, procure PPE, don and doff PPE, increased requests from late-to-care clients, clients wanting to shift to out-of-hospital births.

Sourcing PPE to comply with public health requirements to be masked and gowned at all times was a major challenge throughout the pandemic. Access to PPE was variable depending on the practice setting and the pandemic wave. Midwives working in CHCs or with formal interprofessional agreements with physicians were better able to access PPE than stand-alone midwifery practices. For example, while a rural midwife in an expanded scope practice described reusing N95 masks for weeks while waiting for the emergency request to be filled during the Omicron wave, another urban-based midwife remarked that working within a CHC facilitated steady access to such supplies. Midwives were not initially given access to the PPE stockpiles intended by the province for healthcare workers. Nor were midwives included in pandemic planning as experts who had something to contribute. Nor were they initially placed on the list of essential workers, leaving many midwives in our study to remark that this was another example in a recurring pattern of the midwifery profession being "overlooked" and "not recognised" by the province (Note 3).

Social distancing requirements required major changes to midwifery work's physical and temporal organisation and flow. Midwives moved many appointments online and reduced the number of appointments in the course of care (Note 4). They reduced the number of people in the clinic space at any one time; they eliminated the waiting room and asked clients to wait outdoors or in hallways or drive around the block until their appointment time; they prohibited partners and other family members from accompanying clients to clinical appointments and births; they shortened in-person appointments or did them in two parts; they held prenatal classes over Zoom; they discharged hospital birth clients – including those with C sections – earlier than in the past. They held practice meetings over Zoom. Midwifery practices also changed staffing to manage differing levels of vulnerability to infection. Almost all mentioned a midwife in their practice with underlying health problems or situational vulnerabilities being assigned safer work.

Experiences with these changes were mixed, but they were not all bad. Once implemented, some midwives reported that they, and many of their clients, liked having some remote appointments because they felt safer and more convenient. On the other hand, both midwives and clients were aware that remote appointments could diminish the building of knowledge and trust in the midwife-client relationship. In some cases, clients simply did not have cell phones, Wi-Fi access, or adequate bandwidth, so remote care was not a viable solution. Some midwives admitted that they liked wearing scrubs in the hospital as they were now required to do, yet many commented that they often had no designated change rooms. Some felt the pandemic afforded them a new-found respect in hospital settings when doctors and nurses could see the value of how midwives worked, while others reported feeling overlooked and invisible. For some, the pandemic provided a new context to creatively adapt care without working through long decision-making processes and debates with their colleagues: things just had to get done. Some midwives remarked that meeting on the phone and Zoom regularly had enhanced communication and cohesion in their practices. In contrast, others lamented tensions in collegial relationships as a result of not being physically together in a regular way. Amidst these varied impacts and experiences, our data reveal a number of strong themes about how midwives met the practical challenges presented by the COVID-19 pandemic.

Equity in Care

> I explained it to clients very much like I explain most things to clients: that we're in this together – that's a catchphrase right now – but we're in this together and like everything in your care, we navigate this with both of our expertise, and both of our best thinking.

> And so, everything from how many visits you should come to in person to how many visits we should do on the phone. We've talked about what makes the most sense amongst us midwives, but you're also part of that. And if something different makes sense to you, then I want to hear that, and we'll adjust it, right? (MW4:15)

This quote speaks to one of the primary values in the Ontario midwifery model of care: that client-centred care is built on shared information and mutual trust. It speaks to how midwives and clients thoughtfully tinkered with the model of care under COVID-19 to determine how to deliver the best care while staying as safe as possible. In this section we argue that while tackling myriad challenges, midwives worked towards equity in care, subverting, as they have long done, the logic and structure of equality - treating everyone the same – underlies the Canadian healthcare system. To do so, midwives, in their own words, were "agile," "flexible," and "creative" in their responses, and the activist history of the profession provided a solid base and ample tools for this work.

From the outset, midwives who worked with racialized, Indigenous, and vulnerable clients anticipated the multiple layers of the crisis. One midwife shared how she worried about the impact of negative stereotypes in the news on her Asian clients (MW8:5). Many spoke openly about the 'other' pandemic" that ran alongside COVID-19, exacerbating significant and simultaneous social upheavals. COVID-19 hit Ontario in March 2020, and George Floyd was murdered less than two months later. The Black Lives Matter movement shone a bright light on structural racism, including in healthcare, and a growing popular and political recognition of how the pandemic affected racialized communities differently. For example, many of the health protocols and mandates, such as masking, accessing testing sites, social distancing in workplaces, self-isolation within homes when positive, or just staying home, were much more challenging to meet for clients with intersectional experiences of discrimination and marginalization including low income, undocumented or refugee status, un- or under-housed, limited official language skills. For Indigenous and Black clients in particular, long-standing mistrust of the health care system based on past experiences of racism was an issue that midwives anticipated. Midwives knew that people who were vulnerable before the pandemic were going to be hit the hardest.

> In the early days of the pandemic, between 40 and 60 percent of our clients lived in the shelter system. We knew they were fucked. And I'm sorry to be swearing … but we knew this would likely spread like crazy in congregate living … And sure enough we were right. And our clients were in the first family shelter to have an outbreak, and it was, like, one of our clients was 37 weeks pregnant and she gave us a call. She paged us with a cough. (MW6:10)

For all of the midwives and experts we interviewed, caring for vulnerable communities was central to their work, and their advocacy orientation was already in place even if the specific challenges related to COVID-19 were new and rapidly unfolding. Midwives proceeded as they had done in the past, they just had to figure it out. As one Indigenous midwife reminded us:

> Indigenous midwifery is always operating in a time of crisis. Always finding ways to fly under the radar, or work within the system in ways that allow you to get done what needs to be done. This is the state of Indigenous midwifery all the time – so a bit of a false set up to call COVID a time of crisis – kind of just a different crisis, it deepens the crisis that is already there. But also because everyone is in crisis, there is now more room for flexibility perhaps, for people to work together. (E2:12)

As the pandemic intensified and health directives and information flooded their phones, emails, and practice meetings, midwives caring for vulnerable clients were troubleshooting daily on how to provide the best possible care. They frequently had different strategies and schedules for their most vulnerable clients. Crucially, however, while many of these strategies arose in response to the pandemic, they addressed challenges that had long existed. In this way, midwives' strategies were extraordinary and

mundane, new adaptations to crisis circumstances, and extensions of ongoing practices.

For clients with complex and often intersecting experiences of marginalization, discrimination, or vulnerability in the health care system, midwives in our study recounted that they sometimes did not switch to virtual appointments and were, in fact, more likely to have particular clients come in person so that they could establish the trusting relationship essential to good midwifery care. One midwife explained equity as requiring some counterweight to universal health directives; for example, they felt that the 'no other person in the room' COVID-19 protocol needed to be approached with an equity lens. The person who speaks English and has a partner at home looking after other children might not be as deeply affected by that rule as a single mother newcomer for whom childcare is an expense and logistical challenge or for whom being accompanied by a family member or friend to interpret is essential. As a midwife in an urban MPG that serves many clients with intersectional challenges, including addictions, told us:

> We made a decision really early on that in intepret the case of our clients, that we would still see them with their partners or family members or friends, because they're at such high risk of losing their children – losing their baby – that we wanted to make sure we were protecting that support. And then, also, because we were going to places, like congregate living situations, shelters and jail – we, in our practice, we didn't have a lot of PPE – and we made some initial decisions that that's kind of where we would use our PPE. [MW1:6]

Another midwife discussed leaning in the opposite direction from public health advice to minimize face-to-face contact. She decided to provide *more* home visits for some clients, as this was the primary way to determine how her client and baby were doing. Though some of her colleagues felt she was over-using her resources when everyone was stretched so thin, it was how she felt she needed to work to ensure she was "providing good care" [MW8:11] to particular clients. While this midwife understood that not every midwife could or would work this way, she reflects the not-unusual stance that "there's a lot of good benefit to midwifery for folks who are often unseen, unheard, overlooked in healthcare." [MW8:11] In this instance, and as described by other midwives, time and mode of clinical interaction were adapted so that the devotion of limited resources was allocated based on equity.

Working Creatively Within the System

Midwives in our study described how they sometimes had to work creatively within the system and other times had to ''work the system" to optimize the care they wanted to deliver: they made calls to healthcare colleagues and city councillors to find isolation beds for pregnant COVID-positive clients; they called quarantine hotels to insist on extra food for postpartum nursing parents; they got telecommunications companies to provide free phones and pay as you go credit to their quarantined clients. One midwife had a dentist friend drop off PPE at her practice. Many mentioned groups of volunteers sewing masks and gowns to fulfill PPE requirements when no supplies were made available to them.

Midwives in our study spoke of the inflexibility of the healthcare system and hospital COVID-19 policies as a challenge in the delivery of care to vulnerable clients "that wouldn't account for the nuances of people's lives and the realities of supports that people needed," [MW8:10]. Midwives described a range of cases when they negotiated the boundaries of the system according to the logic of equity in care: permitting a support person to be in the delivery room of a 16-year old client, already part of the child welfare system; letting interpreter accompany clients for whom English was not their first language; making room for an elder to be present at a birth to perform an important ceremony. Negotiating the rules of the system was more easily enacted when midwives had control over the birthing space. Despite recommendations to bar additional family members from the delivery room in one birth centre, the midwives continued to allow two people to accompany the birthing person.

In rare instances, health institutions did make room for midwives to support their clients in ways that went beyond pandemic policies and constraints. In one hospital an Indigenous liaison

worked with midwives to ensure that "even during COVID" ceremonies could be held (E6:13), pointing to the Truth and Reconciliation Commission as an essential resource explaining to some obstetricians that this pandemic was going to hit Indigenous people particularly hard and that exceptions to standard operating procedures were going to be needed. Many midwives and experts in our study mentioned with appreciation the new provincial policy that waived fees for hospital care for uninsured and undocumented clients (though this policy has been discontinued).

The long-standing midwifery practice of finding creative and practical solutions to working within the inflexibility of large systems was a vital tool during the pandemic. Going out on a limb, expanding to meet the needs of clients, maneuvering to work in the grey zone to generate more equitable and just care for birth-giving people: these are the hallmark tools of midwifery as a social movement upon which many midwives in Ontario drew during the tumultuous years of the pandemic. In addition to reinforcing how the profession has sought to work through an equity lens, one midwife suggested that this practice also holds the seeds for radical change of the system:

> Midwives are chameleons. And we can function in all kinds of environments in very skillful ways, in ways that a lot of other clinicians do not feel comfortable. [...] There is a utility to us in the system that is incredibly undervalued, incredibly underused, and that we can just, like, pick up and do a thing. No problem. Just give us, like, some basics if we don't already have them and we'll do them. There are, like, midwives in the vax clinics now, midwives like, 'we're in now, finally in these systems in the healthcare system in a way that we've never been allowed.' And I think that as a profession we've really stepped up, and I think that this alone will allow us to explode the model. (MW6:21)

Building on EMCMs During the Pandemic

EMCMs were established by the Ministry of Health in 2017 and offer the opportunity for midwives to practice and deliver care in ways outside of the MPG course of care funding model, often to reach a specific (typically marginalized or under-served) population. Some EMCMs have been established within CHCs. Additionally, the new IMP, funded through the MOHLTC, supports Indigenous midwives in providing culturally appropriate care in ways that may not strictly follow the MPG course of care model. In this section, we show how expanded and alternative midwifery care models served as an important base for some of the most flexible and responsive adaptations to the new kinds of care that COVID-19 required and significantly offered more ground for reproductive justice.

Midwives working in CHCs and EMCMs had the mandate to work differently; they had greater flexibility to extend their care to meet the needs of their most complex clients, for example, those involved in the criminal system, people who are homeless or poorly housed, street-involved, or HIV+. One of our midwifery expert participants noted that the original model of care and how the province funds midwives assumes a particular kind of client – one that comes into care in early pregnancy, fits that picture of the motivated and responsible client, and stays in care until six weeks postpartum. But this is not always the case, so having a program already to provide care for a range of possibilities meant that midwives were already ready to extend and adapt their care.

Working in CHC interprofessional teams sometimes came with constraints. We heard that initially CHCs were against continuing home visits, and midwives had to push back, drawing on AOM guidance to demonstrate how this work could be done safely and insisting on maintaining in-person contact in the name of equity (E5). Midwives already working outside of the course of care MPG funding model could provide care to pregnant and birthing people who started falling through the cracks in the increasingly stressed healthcare system (E6:4). As obstetricians began to limit in-person contact and shift to virtual care, clients who had limited cell phone use (without minutes for talking or retrieving voice messages for example) were simply left out of care, missing ultrasounds and appointments. One Indigenous midwife recounted that her practice was picking up care for pregnant people who had previously been under obstetrical care but who had

not see their provider for several months inperson because of the pandemic (E6:4) (Note 5).

The stress, added pressure, and workload on some midwives were significant. Some midwives were overtly called on – "begged" in the words of one of our participants – by interprofessional health care colleagues to step in and see clients (in this case postpartum clients who had not been in the care of midwives at all).

> Like there was nobody, there was nobody to provide care to do this. A lot of [physicians and nurse practitioners] were not going into the homes, you know, it's like well, we're fearless, we'll go. You know, somebody's got to see that poor baby, like that baby's not gaining [weight] … so we ended up just kind of doing it, and it did take you know, we were very stressed and it was very, very hard, yeah. (E6:6)

Starting New Projects and Filling Old Gaps

The third key theme to emerge from our data is how some midwives spearheaded their projects during the pandemic; they saw particular needs arise or existing needs deepen, and they created new solutions, rather than wait for the province or a hospital to set things up. In one practice, they set up both testing and vaccination clinics for Indigenous clients, who are confident in their ability to do both. Nobody asked them; they figured it out and 'worked the system' of already helpful colleagues and labs to gain access to the necessary supplies. Another Indigenous-focused practice built on an existing project in which non-clinical community birth workers were hired to share health information and health promotion with Indigenous clients and their families. When the pandemic hit they saw very quickly that the project was translatable to the COVID-19 situation and launched a new phone line staffed by midwives and community birth workers to expand the range of questions beyond midwifery care: where to get tested, what to do if you have symptoms, how to apply for the COVID Emergency Response Benefit.

Some midwives embarked on new interprofessional collaborations catalyzed by the urgency of the pandemic. For example, some midwives in rural areas were asked by Hospitals and Health Units to do COVID-19 testing while conducting face-to-face appointments, the rationale being that it would save clients and other health workers from multiple exposures. Several midwives told us that while many sexual and reproductive health clinics that offered STI testing and contraceptive services clinics were shuttered during the pandemic – their nursing staff redeployed to COVID-19 activities – midwives set up drop-in clinics in their midwifery spaces for folks to come in for pregnancy tests, STI panels, and long-acting reversible contraceptive injections (LARC), among other, on the medical directive of a physician (NOTE 6). As one midwife reflected on the emergence of these new projects:

> All of these things kind of started because of the pandemic, to fill in gaps, to be able to respond to gaps in the system. But they were gaps in the system that were pre-existing that were just made more obvious by everything going on in the pandemic, right? (E1)

She was careful to distinguish between the existence of services, and whether people were using them:

> If the service exists and people are not using it, then if it's not the access, then it's likely the system. And so, you need to be able to change the system to then actually have an impact. And so, the pandemic gave us a bit of an opportunity to demonstrate that. (E1:10)

In summary, the creation of new projects during the pandemic compensated for the uncertainty and shifting requirements of the system and allowed midwives to respond in ways that worked for them and their clients. Our respondents emphasized midwifery leadership in responding to the pandemic and the necessity of generating new and workable solutions, both practically and in terms of energy and morale.

ANALYSIS: TOWARDS REPRODUCTIVE JUSTICE

During the COVID-19 pandemic, midwives worked toward equity in care daily through practical pivots, creative workarounds and working the system. They prioritized time, in-person clinical contact,

and limited resources for those most needed. They adapted past norms and new COVID-19 guidelines to uphold the central tenets of their care model during a crisis. They were aided in some of these efforts by their professional association, other healthcare colleagues, and through contacts within the MOHLTC, as well as by friends, families, and community volunteers. Midwives in Ontario were well positioned to pivot and adapt in part because of the deeply rooted social justice orientation of the profession that finds them so often pushing for changes to the system.

As the pandemic unfolded, midwives and midwifery experts in our study adapted their work according to the needs of individual clients, expanded existing projects that addressed gaps in the system, and developed new initiatives to address emerging concerns – all to achieve greater "equity in care." Flexible funding arrangements and the opportunity to engage in pre-existing and improvised collaborative interprofessional relationships greatly facilitated this work. Midwives working outside of MPGs, such as in Birth Centres, CHCs, and in EMCM arrangements were especially well positioned to do things differently; they were already set up to serve vulnerable communities in interdisciplinary teams; they were networked differently than MPG midwives, and sat on regional boards discussing challenges sourcing PPE, setting policy and practice on a region-wide basis. As a result of these networks, midwives had opportunities to be heard and heeded on caring for pregnant clients during the pandemic. They also had direct access to supplies that midwives in many MPGs did not. In extended care practices, midwives were able to take on tasks outside the midwifery scope of practice, such as STI testing and contraceptive injections. Indigenous midwives working on and off reserve quickly began to work in collaboration with other Indigenous health services personnel – setting up testing and vaccination clinics, for example, offering sexual and reproductive health services, such as the administration of long-term injectable contraception shots.

We suggest that this work constitutes a kind of reproductive justice in action. Reproductive justice goes beyond offering good care and achieving good outcomes – though this is part of it; it goes beyond the logic of choice and individual responsibility that underlies so much of our health system and citizens' expectations.[76–78] Reproductive justice asks us to recognize the social and political context that shapes people's ability to fulfill their own reproductive trajectories and to transform them. During the pandemic, we see the work of midwives as contributing both in terms of care that supports good outcomes for the most marginalized and vulnerable clients, and in terms of the visibility it brings to their situation. In other words, in striving to provide equity in care during the pandemic, midwives in our study also made visible the inequities and the underlying problems in the system. Even small workarounds can be seen as demonstration projects to be replicated rather than as temporary fixes.

CONCLUSION

The findings of our study are consistent with other recent studies about the challenges of providing midwifery care to racialized, marginalized and vulnerable groups in Canada and the specific challenges of the delivery of care during the COVID-19 pandemic.[79] Our study points strongly towards the practical utility and equity-affirming power of alternative funding arrangements that permit midwives to expand and adapt existing projects and create new initiatives to fit client's needs and provide high-quality and equitable care to SES.[79–80] We also observed how interprofessional teams could pivot quickly to care for vulnerable people during the COVID crisis – something noted by scholars elsewhere.[81] Further, we have argued here that the social justice work that characterized midwifery – from its commitment to the de-medicalization and valorization of pregnancy and childbirth characteristic of its early social movement days to its increasing focus on diversity, inclusion, and anti-racist work in recent years, meant that midwives with an activist orientation had the tools of critique and invention at the ready and were already thinking beyond the idea of equality of care during the pandemic – a perspective that aided them in the practical pivots and workarounds to advance equity. Ultimately, we argue that midwives in our study describe modes of care that envision and practice what might be described as reproductive justice.

Our findings also accord with recent literature on maternity care in crisis in diverse locations which documents the necessity of midwives rapidly altering their work in response to new regulations and sudden, unprecedented resource constraints while trying to ensure the safety of their clients and themselves.[81–84] A notable aspect of this literature is the finding that how midwives are already respected and resourced within the healthcare system affects their ability to maneuver and improvise effectively at the time of crisis – this echoes observations about alternative models noted above. This literature also suggests that crisis times can mobilize systemic change and serve as a testing ground for the reorganisation of care.

We hope that the findings from this study can contribute to a greater understanding of how midwives adapted during the COVID-19 crisis to protect their clients and themselves as front-line care providers and how their flexibility, creativity and commitment to equity can serve as an example for other healthcare fields. We also accord with more than one of our Indigenous interlocutors who insisted on the potential of combining the midwifery model of care and an Indigenous-informed approach to healthcare can "expand access and make healthcare a more dignified experience for many other people." We suggest that these are opportunities to serve as a model for other parts of the healthcare system. Thus we hope these research findings will resonate beyond the midwifery community.

As we near the end of the paper, we add a note of caution and a call for future research on what the pandemic reveals about the working lives of midwives. We are conscious of sharing the findings of this study and of overstating here the endless ingenuity and selflessness of midwives during the pandemic. We also heard a great deal about the crisis in the profession over continuity of care which was brought to the fore in an unprecedented way during the pandemic. One midwife in our study called it "the untenable tenet." An Indigenous midwife reflecting on burnout in her practice during COVID-19 commented on how the original three pillars of midwifery were rooted in a kind of privilege and set of assumptions about midwifery clientele and what's possible for midwives to do. COVID-19 and BLM together put a spotlight on the 'stress points' in the original midwifery model of care in an intersectional way; in other words COVID-19 made clear how the model itself may tend to ignore race and class and takes some deeply gendered scripts for granted. Midwives in our study often displayed a tireless devotion to their work, yet this took its toll, leading to burnout and collegial tensions – a theme noted elsewhere about midwifery work during the pandemic.[80] In the face of this we also heard how midwives also made moves to preserve their health and well-being, the integrity of their practices, and the profession in the face of endless need to care more. These critiques we heard about the tenet of continuity of care in midwifery call attention to this paper's goal to highlight racialized inequities and; the need to change the basic models of health care delivery.

In closing it is important to say that this research represents a partial story, one piece of the larger picture of midwifery in Ontario during the COVID-19 pandemic. We sought to capture the perspectives and experiences of midwives and midwifery experts at a particular time. Our analysis is influenced by our own subject positions as a team of racialized and non-racialized individuals with shared commitments to reproductive justice through research and practice. In the end, we hope to have illuminated the struggles, achievements and good work of midwives, while not rendering invisible the ongoing harms and challenges of Indigenous, Black and People of Colour midwives and clients in the past and present. The COVID-19 pandemic illuminated the hard work of change within the midwifery profession – and health care more broadly– and where there is tremendous equity work still to be done.

NOTES

1. Some of the specific actions to address and redress exclusions and harms on the road to professionalization and in the profession today include the McMaster Midwifery Education Program EDI Advisory Committee, a unique admission process for Black applicants to the MEP and much more.
2. The Ontario Midwifery Act permits Indigenous midwives who are recognised and regulated by their communities to provide traditional midwifery services and to use the title "Aboriginal Midwife". They are exempt from the Regulated Health Professions Act.

See: https://indigenousmidwifery.ca/reconciliation-regulation-risk/

3. The fact that midwives were left out of expert and essential worker consultation is an important finding that speaks loudly to the history of the marginalization of midwifery as a profession within the health care system in Ontario. This topic merits further research and discussion but is not within the scope of this paper.
4. World Health Orgnization (WHO) recommendations on the optimal schedule for antenatal care visits have changed over time. In 2016 the WHO replaced the long standing '4 visits' model, called Focused Antenatal Care (FANC), with an 8visit model. During COVID, however, a number of articles and position pieces published in medical journals recommended a revised ANC schedule that minimised in-person visits for low risk uncomplicated pregnancies by using video calls. For more information see. https://www.ontariomidwives.ca/expanded-models
5. While EMCM care formalised some of these new arrangements and opportunities, there are many ways in which midwifery in particular communities or contexts has never fit the standard funding model or even necessarily the standard midwifery model of care. Midwives practicing under the Aboriginal Exemption Clause, for example, may be caught between the guidance of their regulators (Band Councils) who understand the community and Indigenous context well, and perhaps not the midwifery context, and on the other hand, provincial midwifery and healthcare bodies (AOM, CMO, Public Health, etc) who may understand midwifery, but have less insight or knowledge of the Indigenous context of providing care (E6:4).
6. A medical directive allows physicians to delegate a controlled act to a midwife who cannot normally do so under their own authority. A medical directive can be a one-off request for an individual midwife at a particular point in time or a standing order at a Hospital that permits all midwives with privileges at the Hospital to perform that delegated task.

REFERENCES

1. Bourgeault IL. Push!: The Struggle for Midwifery in Ontario. Montreal and Kingston: McGill-Queen's University Press; 2006.
2. MacDonald M. At Work in the Field of Birth: Midwifery Narratives of Nature, Tradition, and Home. Nashville: Vanderbilt University Press; 2007.
3. Nestel S. Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery. Vancouver: UBC Press; 2006.
4. Van Wagner V. Why legislation?: Using regulation to strengthen midwifery. In: Bourgeault IL, Benoit C, Davis-Floyd R, editors. Reconceiving Midwifery. 2004;71–90.
5. Association of Ontario Midives. (AOM). What is a Midwife? [Internet] https://www.ontariomidwives.ca/what-midwife. Accessed June 11 2023.
6. McCourt C, Stevens T. Continuity of carer: What does it mean and does it matter to midwives and birthing women? Canadian Journal of Midwifery Research and Practice. 2005;4(3):10–20.
7. Burton N, Ariss R. The midwifery model of care: Structural support for diversity in health care. Int J Organ Divers [Internet]. 2013;12(4):15–23.
8. Burton N, Ariss R. The critical social voice of midwifery: Midwives in Ontario. Canadian Journal of Midwifery Research and Practice. 2009;8(1):7–22.
9. Burton N, Ariss R. Diversity in midwifery care: Working towards social change. Canadian Review of Sociology. 2014;51(3):262–87.
10. Aseffa F, Mehari L, Gure F, Wylie L. Racism in Ontario midwifery: Indigenous, black and racialized midwives and midwifery students unsilenced. Canadian Journal of Midwifery Research & Practice. 2021;20:10–22.
11. Aseffa F, Mehari L, Gure F, Ahmed S. Disrupting racism in Ontario midwifery. J Midwifery Womens Health [Internet]. 2023; Available from: http://doi.org/10.1111/jmwh.13541
12. Aseffa F, and Mehari L. 2020. Experiences of Racism Among Ontario BIPOC Midwives and Students. Association of Ontario Midwives. [cited 2023 Jun 8]. Available from: https://www.ontariomidwives.ca/experiences-racism-among-ontario-bipoc-midwives-and-students.
13. Association of Ontario Midwives. 2019 [2009]. Statement on Diversity, Equity and Inclusion. [cited 2023 Jun 8]. Available from: https://www.ontariomidwives.ca/diversity-equity-inclusion.
14. Canadian Association of Midwives (CAM). 2018. CAM Calls for Research and New Measures to Curb Systemic Racism in Healthcare. CAM. Last modified October 15, 2018. [cited 2023 Jun 8]. Available from: https://canadianmidwives.org/2018/10/15/curb-systemic-racism-in-healthcare/.
15. Abma S. Racism a barrier to prenatal health care, midwives say. CBC News [Internet]. Last Updated: October 18 2018 [cited 2023 May 24]; Available from: https://www.cbc.ca/news/canada/ottawa/midwife-racism-prenatal-health-care-conference-1.4867236
16. Tyson H, Wilson-Mitchell K. Diversifying the midwifery workforce: Inclusivity, culturally sensitive bridging, and innovation. J Midwifery Womens Health [Internet]. 2016;61(6):752–8.
17. Nestel S. Colour Coded Health Care: The Impact of Race and Racism on Canadian's Health. Toronto: The Wellesley Institute; 2012.
18. Hyman I. Racism as a Determinant of Immigrant Health. Ottawa: Public Health Agency of Canada; 2009.
19. Raphael D. Introduction. In Social Determinants of Health. Raphael D, editor. Toronto: Canadian Scholars Press; 2004.
20. Veenstra G. Race, gender, class, and sexual orientation: Intersecting axes of inequality and self rated health in Canada. International Journal for Equity in Health. 2011;10(3):1–10.
21. Rodney P, Copeland E. The health status of black Canadians: do aggregated racial and ethnic variables hide health disparities? J Health Care Poor Underserved [Internet]. 2009;20(3):817–23.
22. Black Health Alliance. Black Experiences in Health Care Symposium Report [Internet]. Google Docs. [cited 2023 Jun 8]. Available from: https://drive.google.com/file/d/1s1ErqLKuwxJWbHuqPePrWWL_Czr7NOP4/view
23. Boakye PN, Prendergast N, Bandari B, Anane Brown E, Odutayo AA, Salami S. Obstetric racism and perceived quality of maternity care in Canada: Voices of Black women. Womens Health (Lond). 2023 Jan-Dec;19:17455057231199651. Available from: http://doi.org/10.1177/17455057231199651
24. Khanlou N, Haque N, Skinner A, Mantini A, Kurtz Landy C. Scoping review on maternal health among immigrant

and refugee women in Canada: Prenatal, intrapartum, and postnatal care. J Pregnancy [Internet]. 2017;8783294. Available from: http://doi.org/10.1155/2017/8783294
25. McKinnon B, Yang S, Kramer MS, Bushnik T, Sheppard AJ, Kaufman JS. Comparison of black-white disparities in preterm birth between Canada and the United States. CMAJ [Internet]. 2016;188(1):E19–26. Available from: http://doi.org/10.1503/cmaj.150464
26. Scott N. Disparities in maternal and newborn health across populations in Canada. Canadian Journal of Midwifery Research and Practice. 2018;17(2):36–41.
27. Smylie J, Fell D, Ohlsson A., Joint Working Group on First Nations Indian Inuit, Métis Infant Mortality of the Canadian Perinatal Surveillance System. A review of Aboriginal infant mortality rates in Canada: striking and persistent Aboriginal/non-Aboriginal inequities. Can J Public Health [Internet]. 2010;101(2):143–8. Available from: http://doi.org/10.1007/bf03404361
28. Martis EE. Why Black women fear for their lives in the delivery room [Internet]. HuffPost. 2020 [cited 2023 May 24]. Available from: https://www.huffingtonpost.ca/entry/black-maternal-health-canada_ca_5ed90ae3c5b685164f2eab93
29. Bero T. What it's like to give birth while black [Internet]. Chatelaine. 2019 [cited 2023 May 24]. Available from: https://www.chatelaine.com/living/black-birthing-experience-canada/
30. Miller S, Wherry LR, Mazumder B. Estimated mortality increases during the COVID-19 pandemic by socioeconomic status, race, and ethnicity. Health Aff [Internet]. 2021;40(8):1252–60. Available from: http://doi.org/10.1377/hlthaff.2021.00414
31. Baer H, Singer M, and Susser I, editors. Medical Anthropology and the World System. Westport, CT: Bergin and Garvey; 1997.
32. Farmer P. Pathologies of Power. Health, Human Rights and the New War on the Poor. Berkeley: University of California Press; 2005.
33. Lindenbaum S, Lock M. Knowledge, Power and Practice. The Anthropology of Medicine and Everyday Life. Berkeley: University of California Press; 1993.
34. Kleinman A. Writing at the Margins. Discourse Between Anthropology and Medicine. Berkeley: University of California Press; 1997.
35. Bourgeault IL, Benoit CM, Davis-Floyd R, editors. Reconceiving Midwifery. Montréal and Kingston: McGill-Queen's University Press; 2004.
36. Daviss B-A. Reforming birth and (re)making midwifery in North America. In: Devries R, Benoit C, Teijlingen E, Wrede ES, editors. Birth by Design: Pregnancy, Maternity Care and Midwifery in North America and Europe. New York: Routledge; 2001. p. 70–86
37. James S. Regulation: Changing the face of midwifery? In: Shroff F, editor. The New Midwifery: Reflections on Renaissance and Regulation. Toronto: Women's Press; 1997. p. 181–200.
38. Sharpe M. Exploring legislated Ontario midwifery: Texts, ruling relations and ideological practices. Resources for Feminist Research. 2001;28(3–4):39–63.
39. MacDonald M. Postmodern negotiations with medical technology: the role of midwifery clients in the new midwifery in Canada. Med Anthropol [Internet]. 2001;20(2–3):245–76. Available from: http://doi.org/10.1080/01459740.2001.9966195
40. MacDonald M. Gender expectations: Natural bodies and natural births in the new midwifery in Ontario. Medical Anthropology Quarterly. 2006;20(2):235–56.
41. Schroff F. The New Midwifery: Reflections on Renaissance and Regulation. Toronto: Women's Press; 1997.
42. Handa M, Sharpe M. Shifting paradigms in women's health care: From informed consent to informed choice. Women's Health Bulletin. 2015;2(2):1–5.
43. Van Wagner V. Risk talk: Using evidence without increasing fear. Midwifery. 2016;38:21–8.
44. Zenith K. Midwives and medwives: An analysis of the use of technology among Canadian midwives. Canadian Journal of Midwifery Research & Practice. 2019;18(1):35–9.
45. Burton N, Bennett N. Meeting the needs of uninsured women: Informed choice, choice of birthplace and the work of midwives in Ontario. Women's Health & Urban Life. 2013;12(2):23–44.
46. Goldberg J, Ross L. Attitudes of midwives towards lesbians: Results from a systematic review of literature on midwives' attitudes towards sexual and gender minority people. Canadian Journal of Midwifery Research & Practice 2022;21:8–20.
47. Aseffa F, Mehari L, Gure F, Wylie L. Racism in Ontario midwifery: Indigenous, black and racialized midwives and midwifery students unsilenced. Canadian Journal of Midwifery Research & Practice. 2021;20:10–22.
48. Rostami M, Charland P, Memon A, Hus Z, Suter E. An early feasibility study of midwifery services in a vulnerable population. Canadian Journal of Midwifery Research & Practice. 2021;20:35–46.
49. Darling E, Macdonald T, Nussey L, Murray-Davius B, Vanstone M. Making Midwifery Services Accessible to People of Low SES: A Qualitative Descriptive Study of the Barriers Faced by Midwives in Ontario. Canadian Journal of Midwifery Research & Practice. 2020; 19:40–52.
50. Ross L, Solinger R. Reproductive Justice: An Introduction. Oakland: University of California Press; 2017.
51. Valdez N, Deomampo D. Centering race and racism in reproduction. Med Anthropol [Internet]. 2019;38(7):551–9. Available from: http://doi.org/10.1080/01459740.2019.1643855
52. Rapp R. Race & Reproduction: An enduring conversation. Med Anthropol [Internet]. 2019;38(8):725–32. Available from: http://doi.org/10.1080/01459740.2019.1671838
53. Colen S. 'Like a mother to them': Stratified reproduction and West Indian childcare workers and employers in New York. In: Ginsburg F, Rapp R, editors. Conceiving the New World Order: The Global Politics of Reproduction. Berkeley: University of California Press; 1995. p. 78–102.
54. Ginsburg F, Rapp R. Conceiving the New World Order: The Global Politics of Reproduction. Berkeley: University of California Press; 1995.
55. Alhusen JL, Bower KM, Epstein E, Sharps P. Racial discrimination and adverse birth outcomes: An integrative review. J Midwifery Womens Health [Internet]. 2016;61(6):707–20. Available from: http://doi.org/10.1111/jmwh.12490
56. Braveman P. Racial disparities at birth: The puzzle persists. Issues in Science and Technology. 2008;24(2):27–30.
57. Bridges K. Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization. Berkeley: University of California Press; 2011.
58. Perry JC. The black maternal mortality rate in the US is an international crisis [Internet]. The Root. 2016 [cited 2023 May 31]. Available from: https://www.theroot.com/the-black-maternal-mortality-rate-in-the-us-is-an-inter-1790857011
59. Davis D-A. Obstetric racism: The racial politics of pregnancy, labour, and birthing. Medical Anthropology. 2019;38(7):560–73.

60. Institute for Health Metrics. US one of only eight countries where child and adolescent health improved but maternal mortality worsened since 1990 [Internet]. Healthdata.org. [cited 2023 May 31]. Available from: http://www.healthdata.org/print/7000
61. Roberts DE. Killing the Black Body: Race, Reproduction, and the Meaning of Liberty. New York: Pantheon Books; 1997.
62. Mullin A. Reconceiving Pregnancy and Childcare: Ethics, Experience, and Reproductive Labour. Cambridge: Cambridge University Press; 2005.
63. Mullings L, Wali A. Stress and Resilience: The Social Context of Reproduction in Central Harlem. New York: Kluwer Academic/Plenum Publishers; 2001.
64. Yoder H, Hardy LR. Midwifery and antenatal care for black women: A narrative review. Sage Open. 2008;January-March:1-8.
65. Bryant AS, Worjoloh A, Caughey AB, Washington AE. Racial/ethnic disparities in obstetric outcomes and care: prevalence and determinants. Am J Obstet Gynecol [Internet]. 2010;202(4):335–43. Available from: http://doi.org/10.1016/j.ajog.2009.10.864
66. Davis-Floyd R, Gutschow K, Schwartz DA. Pregnancy, birth and the COVID-19 pandemic in the United States. Med Anthropol [Internet]. 2020;39(5):413–27. Available from: http://doi.org/10.1080/01459740.2020.1761804
67. Davis-Floyd R, Penwell V, Lim R, Ivry T. Sustainable birth care in disaster zones: Low-tech, skilled touch. In: Gutschow K, Davis-Floyd R, Daviss B-A, editors. Sustainable Birth in Disruptive Times. New York: Springer Nature; 2021.
68. Ivry T, Takaki-Einy R, Murotsuki J. What disasters can reveal about techno-medical birth: Japanese women's stories of childbirth during the 11 March, 2011 earthquake. Health Risk Soc [Internet]. 2019;21(3–4):164–84. Available from: http://doi.org/10.1080/13698575.2019.1643827
69. Lock M, Scheper-Hughes N. A critical-interpretive approach in medical anthropology: Rituals and routines of discipline and dissent. In: Sargent C, Johnson TM, editors. Medical Anthropology: Contemporary Theory and Method. Westport: Praeger; 1996. p. 41–70.
70. Scheper-Hughes N, Lock M. The mindful body: A prolegomenon to future work in medical anthropology. Med Anthropol Q [Internet]. 1987;1(1):6–41. Available from: http://doi.org/10.1525/maq.1987.1.1.02a00020
71. Singer M, Baer H. Critical Medical Anthropology. 2nd ed. Amityville, NY: Baywood Publishing Company; 1995.
72. Lather P. Getting Smart: Feminist Research and Pedagogy With/in the Postmodern. New York: Routledge; 1991.
73. Oakley A. Gender, methodology and people's ways of knowing: Some problems with feminism and the paradigm debate in social science. Sociology. 1998;32(4):707
74. Haraway D. The science question in feminism and the privilege of the partial perspective. Feminist Studies 1988; 14(3): 575-599.
75. Clifford J. Introduction: Partial Truths. Writing Culture, edited by J Clifford and GE. Marcus, Berkeley: University of California Press; 1986. p. 1–26. https://doi.org/10.1525/9780520946286-003
76. Crawford, R. The boundaries of the self and the unhealthy other: reflections on health, culture and AIDS. Social Science & Medicine 1994; 38(10), 1347–1365. https://doi.org/10.1016/0277-9536(94)90273-9
77. MacDonald M. The Making of Informed Choice in Ontario Midwifery: A Feminist Experiment in Care. Culture, Medicine and Psychiatry. 2017; 42(2): 278-294
78. Mol A. The Logic of Care: Health and the Problem of Patient Choice. Routledge; 2008.
79. Darling E, Macdonald T, Nussey L, Murray-Davius B, Vanstone M. Making Midwifery Services Accessible to People of Low SES: A Qualitative Descriptive Study of the Barriers Faced by Midwives in Ontario. Canadian Journal of Midwifery Research & Practice. 2020; 19:40–52.
80. Memmott C, Smith J, Korzuchowski A, Tan HL, Oveisi N, Hawkins K, Morgan R.' Forgotten as first line providers': The experiences of midwives during the COVID-19 pandemic in British Columbia, Canada. Midwifery. 2022 Oct;113:103437. http://doi.org/10.1016/j.midw.2022.103437
81. Rocca-Ihenacho, L. & Alonso, C. 2020. Where do women birth during a pandemic? Changing perspectives on Safe Motherhood during the COVID-19 pandemic. *Journal of Global Health Science*, 2(e4).
82. Davis-Floyd R, Gutschow K, Schwartz DA. Pregnancy, birth and the COVID-19 pandemic in the United States. Med Anthropol [Internet]. 2020;39(5):413–27. Available from: http://doi.org/10.1080/01459740.2020.1761804
83. Davis-Floyd R, Penwell V, Lim R, Ivry T. Sustainable birth care in disaster zones: Low-tech, skilled touch. In: Gutschow K, Davis-Floyd R, Daviss B-A, editors. Sustainable Birth in Disruptive Times. New York: Springer Nature; 2021.
84. Ivry T, Takaki-Einy R, Murotsuki J. What disasters can reveal about techno-medical birth: Japanese women's stories of childbirth during the 11 March, 2011 earthquake. Health Risk Soc [Internet]. 2019;21(3–4):164–84. Available from: http://doi.org/10.1080/13698575.2019.1643827

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