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The Disproportionate Impact of COVID-19 on Already Marginalized Communities: Considerations for Sexual and Reproductive Health Care

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Data emerging from the coronavirus disease 2019 (COVID-19) pandemic demonstrate that racialized communities and those with pre-existing socioeconomic marginalization have faced disproportionate rates of infection, severe disease, and mortality.1-4 Ontario, for example, has identified higher rates of COVID-19 infection, severe disease, and mortality in more ethno-racially diverse neighbourhoods.1 Infection rates were three times higher in the most diverse neighbourhoods than in the least diverse neighbourhoods.1 Hospitalization rates were four times higher, intensive care unit admission rates four times higher, and death rates two times higher.1 Higher rates of infection and severe disease were also revealed for neighbourhoods with higher levels of poverty.2

Pregnancy-specific data are still limited for Canada, but other countries have seen specific groups experience higher rates of severe morbidity and mortality when infected with COVID-19 in pregnancy. Unsurprisingly, many common medical comorbidities are associated with greater risk from COVID-19 (i.e., asthma, obesity, pre-existing diabetes, pre-existing hypertension, heart disease, and maternal age over 35).3 It is noteworthy that many of these conditions are strongly influenced by the social determinants of health.3 There is also emerging evidence from other high-income countries that significant racial health disparities exist for pregnant individuals with COVID-19. For example, in the United Kingdom, among 427 pregnant individuals with COVID-19 admitted to hospital, 56% were Black, Asian, or from another ethnic minority background.5 In comparison, these groups only represent 13% of the general population.4

When scrutinized, obstetric and gynaecologic outcomes have long been worse among marginalized people in Canada, before the COVID-19 pandemic. This is particularly true for Indigenous, Black, and newcomer populations, as well as those with lower income and education levels. We are concerned that already marginalized patients in Canada are experiencing intersecting risks and disproportionate harm during the pandemic.

CONSIDERATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH CARE

There are practical steps we can take to recognize patients who may be more vulnerable to COVID-19 infection or to worsening marginalization during the pandemic. At a minimum, we must review social histories, including housing, food security, income, employment, immigration status, extended health benefits, and social support. Many patients now have scarcer access to these critical resources. When concerns are recognized, we can offer to connect our patients with supports that they may wish to access, or advocate for them.

Consider who in your practice may be at greater risk for harm during the pandemic, due to either increased medical or social susceptibility to COVID-19. Some patients work in occupations with barriers to social distancing, without paid sick days, or without adequate personal protective equipment (e.g., low-wage frontline essential workers, sex workers, migrant workers, or workers with precarious immigration status). Some patients face barriers to social distancing due to crowded housing, caregiver responsibilities, emergency shelter use, or incarceration.

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Virtual health care is benefiting some patients who previously struggled to attend in-person appointments, perhaps due to transportation difficulties or childcare. However, not all patients have adequate internet or phone service to facilitate virtual visits or accessible translation support to overcome language barriers.

Intimate partner violence has increased during the COVID-19 pandemic, potentially due to increased physical isolation and potential economic changes within the home. For perinatal mood disorders, social isolation and financial strain may affect some people disproportionately. Amid potential service disruptions, we must also ensure ongoing access to contraception and abortion care so that patients can maintain control over their sexual and reproductive health through the pandemic, based on their preferences.

**POLICIES THAT ADDRESS HEALTH INEQUITIES EXACERBATED BY COVID-19**

Beyond the level of individual patient care, many systemic changes are needed to mitigate health inequities. During the pandemic, some jurisdictions in Canada have disaggregated data by race, income, and other social factors to identify inequitable distribution of harms among marginalized people. These analyses should be applied in all jurisdictions to analyze COVID-19 disease trends and vaccination rates. These improvements to data collection should continue beyond the pandemic to identify health inequities more widely in sexual and reproductive health care and enable action.

Certain jurisdictions have expanded health care access for uninsured individuals during the pandemic, and these changes should be embraced in all provinces and territories. We should evaluate these unprecedented efforts to decrease health care barriers for the uninsured to see how access can be maintained through and beyond the pandemic.

Overdose-related deaths have increased since the onset of the COVID-19 pandemic. We should continue to advocate for a safer drug supply, decriminalization of use, continuation of harm reduction services, low barrier access to opioid agonist therapies, and accelerated expansion of supportive housing to protect our patients who use drugs during the pandemic.

YWCA Canada and the Institute for Gender and the Economy at the University of Toronto have jointly researched and proposed “A Feminist Economic Recovery Plan for Canada.” They analyze the intersection of gender, other forms of discrimination, and historic power imbalances, relative to public policy and national priorities beyond the pandemic. This proposal has gained some attention, but stronger commitments are needed to redress intersectional and exacerbated marginalization from the pandemic as we move towards recovery.

**CONCLUSIONS**

As health care professionals providing sexual and reproductive health care to women and gender diverse people across the lifespan, there are many ways we can adapt care for our patients during the COVID-19 pandemic. Disruptions to health care have been challenging for everyone but have greater potential for harm among those already marginalized. The COVID-19 pandemic is exacerbating socioeconomic inequalities, in addition to conferring greater risk from the virus itself.

This pandemic reminds us that we must engage in the complex work of addressing systemic racism, the ongoing legacy of colonialism, and the myriad effects of poverty on our patients’ health. This requires us to humbly acknowledge the multifaceted nature of our own privilege as health care providers, as well as the privileges that come with other identities we may have. We must seek guidance from affected communities to understand what changes are needed. A sustained and collaborative effort is needed to improve care for marginalized patients, during and beyond the pandemic, if we are to contribute to meaningful reconciliation within our communities.

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