



## CHAPTER 11

# Health Equity, Reproductive Justice, and Relational Autonomy: Ethical Nursing Care for Childbearing Individuals and Families

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*“[E]nhancing women’s power, choice, and control requires a shift in how nurses view women’s birth experiences and perinatal outcomes. These are not of women’s own making, but are shaped by the social, cultural, political, and economic contexts of care.”*

(Brown et al., 2011, p. 113)

**NURSES PROVIDE CARE** to women and gender diverse people along a reproductive continuum of care that encompasses prenatal counselling, contraceptive education, abortion care, and in vitro fertilization (IVF). This continuum of care occurs during decisions to prevent, terminate, or continue pregnancies; during admission to the neonatal intensive care unit; and into the postpartum period for parents and newborns. Nurses require ethical knowledge to support optimal birthing conditions involving physicians, doulas, midwives, partners, and families, and they do so within the broader socio-political context of preconception care, pregnancy, birthing, and parenting.

Advancing equity in reproductive health and childbearing contexts is fundamental to the moral obligations and ethical values of nurses within acute, community, rural, and urban settings. Nurses are well-positioned, by virtue of their social justice mandate, to advance reproductive health policy and practice in partnership with childbearing individuals and families. In this chapter, we focus on how social justice and health equity can orient the ethical care of childbearing individuals and families. We also demonstrate how integrating knowledge about reproductive justice, as well as feminist perspectives on relational autonomy (Baylis et al., 2008; Sherwin, 1992), can be translated into both practice and advanced practice nurse leadership roles. We integrate two Ethics in Practice case studies to illustrate how these theoretical ideas can be enacted in everyday ethical nursing actions and knowledge for nursing leadership.

## **A Social Justice and Health Equity Approach**

At the heart of nursing practice and leadership is a social justice vision to achieve health equity through safe, ethical, and effective care. A social justice ethic in nursing was strongly influenced by the World Health Organization's commission (WHO, 2008) on the social determinants of health (SDOH). The commission found that social injustice is a primary factor in health inequities: that is, unfair and avoidable differences in health status and quality of life are attributable to structural barriers<sup>1</sup> and social disadvantage (WHO). The Canadian Nurses Association (CNA, 2010) defines social justice

as “the fair distribution of society’s benefits, responsibilities, and their consequences.” It affirms nursing’s commitment by viewing social justice as “means to an end and an end in itself” (p. 13), and highlights its alignment with nursing values set out in the code of ethics (CNA, 2010; CNA, 2017). In 2010, Cohen outlined four key actions to enact a social justice mandate in nursing: (a) being knowledgeable of evidence related to health inequities; (b) deconstructing societal beliefs that assume individual responsibility for health; (c) advocating for an equity lens in health policy and program planning within nursing contexts and organizations; and (d) working to bring about social change. Van Daalen-Smith (2019) eloquently captured nursing’s relationship to social justice:

To seek out and name injustices and inequities *is* nursing.  
To be a vocal advocate for fairness, non-maleficence and dignity *is* nursing. To call into question harmful policies, practices or assumptions that impede the health and quality of life of the planet and its inhabitants *is* nursing. Our legacy in equity-based concerns is rich, but our work is not done. Social Justice Nursing ensures that Canada’s nurses avoid complicity, keeping central to our work the inherent rights of the individuals, families, communities and populations we are privileged to care for and partner with.  
(p. 1, emphases in original)

Health equity has been a central focus for ethical nursing practice and leadership for some time. In 1992, Stevens urged nurses to take action to address barriers to accessing care and overall health and well-being, working from the critical knowledge that access to health care and health outcomes cannot be disengaged from socio-political contexts. Nurses using a health equity approach work from the assumption that inequalities or disparities in health status require analyses of social, economic, political, historical, and material contexts (Doane and Varcoe, 2021). Addressing these inequalities makes it possible to move beyond the predominant neoliberal emphasis on individual health behaviours to the broader set of social conditions and structural factors responsible for the unfair and unjust differences that produce health inequities. In

nursing, a health equity approach requires ethical values and commitments to social justice: equity aligns with fairness and justice, both in terms of access to health care and health outcomes. Using a health equity approach helps nurses turn their attention not only to the conditions and contexts that produce unfair and unjust differences, but also to calls for action about ameliorating and changing structures, conditions, and policy barriers in order to achieve socially just health care. We join other authors in this book in arguing for a shift from a traditional notion of justice (focusing on how to redistribute resources in health care), towards one where nurses consider the socio-political conditions and contexts that produce the distribution of resources. These socio-political conditions and contexts ultimately determine health differences or outcomes. Drawing on Young's (2009) writings, we see the role of nurses as acting to change the conditions and contexts that impact unfair and unjust distribution of health care resources. This requires a focus on how power, agency, rights, and institutional relations influence equitable access to health care.

Considering our focus in this chapter is on childbearing individuals and their families, a health equity and social justice approach can assist nurses to enact their ethical obligations and provide nursing care across the continuum of reproductive health care and during childbirth and perinatal care. This means considering the broadest scope possible related to childbearing, childbirth, and reproductive health, while also deconstructing dominant social norms that create barriers to ethical care. One way nurses can take up this broad scope within their care is to challenge dominant gender norms as they relate to childbearing. For example, as Cohen (2010) argues, within maternity and perinatal care, childbearing is often aligned with biological sex and, when gender is considered, binary representations of gender are used (men/women).

Nurses provide care to women and gender diverse people along a reproductive continuum of care; from prenatal counselling, contraceptive education, abortion care, IVF, and during decisions to prevent, terminate, and continue pregnancies. Nurses are active in supporting optimal birthing conditions involving physicians, doulas, or midwives, and do so within the broader socio-political context of pregnancy, birthing, and parenting. Across this complex

continuum of care, we discuss in this chapter specific theoretical ideas and frameworks for ethical nursing practice and leadership that promote ethical and equitable care. We also focus on the role of nurses in reducing reproductive health inequities and promoting reproductive justice by specifically addressing how relationships, gender, and power intersect to shape the autonomy of women and gender diverse people during childbearing experiences.

Specifically, using a health equity approach helps nurses focus their analysis and action on the SDOH and contextual factors that shape maternal-infant outcomes. Nurses critically analyze policy and practice for impact on reproductive choices, decisions, behaviours, outcomes, and access to perinatal care. The SDOH (age, gender, ability, race, economic status, etc.) are also impacted by socio-political, historical, and economic factors that create and sustain unfair and unjust differences in reproductive health or childbearing outcomes. Taking both the SDOH and contextual factors into account means that nurses can situate specific experiences and realities of their patients in the broader context of their lives. For example, being a young mother is about more than age as a determinant of maternal health; it also about recognizing the historical, economic and socio-political factors that shape dominant norms and assumptions made about “young mothers” that can act as a barrier to accessing equitable and health-promoting care.

Using a health equity approach also means that nurses can ask questions such as how equitable reproductive and childbearing health outcomes can be achieved for *all*, while accounting for differences in peoples’ lives that matter (such as ability, experiences of trauma and violence, and racism). Using the health equity approach also turns nurses’ attention to what needs to change in order to support people in their life contexts at structural levels, such as in health care systems, policies, and practices. While nurses are oriented to these questions by using a health equity perspective, in this chapter we introduce a reproductive justice and relational autonomy framework to focus ethical knowledge and practices on promoting reproductive health equity for childbearing individuals and their families.

## Reproductive Justice

The concept of reproductive justice has existed in the social sciences for almost 30 years, yet nursing has been slow to adopt this concept in promoting maternal-child health. In both Canada and the US, women's health has tended to be conflated solely with childbearing. This has meant that less attention has been paid to the socio-political context of women's health overall, and to the wider context of reproductive care and childbearing. For nurses providing reproductive and perinatal care, there is now greater attention being paid to questions about fair and just access, care, and health outcomes. Nurses are asking how they can act to change conditions and contexts that undermine reproduction, pregnancy, and birth. Notably, for over 20 years, Indigenous women and women of colour have been advocating for a reproductive justice framework. Such a framework is required to provide the knowledge and skills for promoting equity at interpersonal and system levels with regards to reproductive rights and advocacy (McKenzie et al., 2022; Shaw, 2013; Solinger, 2013). For Indigenous women and women of colour, a framework for reproductive justice can be used to emphasize interconnected and diverse rights, including the (a) right to have a child; (b) right not to have a child; (c) right to parent one's children; (d) right to control birthing conditions; and (e) to advocate for the necessary enabling conditions to realize all of these rights (Shaw, 2013).

A reproductive justice lens is also grounded in intersectionality and interconnected human rights across the continuum of reproductive care, childbirth, and parenting (Ross & Solinger, 2017). Interlocking forms of social and structural oppression impact reproduction and childbearing experiences and access to care. Using a reproductive justice lens in practice helps to make visible particular people's experiences and how these experiences are shaped by oppressive forces and conditions. It can also help nurses see how systems such as child welfare can facilitate or act as a barrier for people to either engage with or avoid social welfare and health care systems (Boyer & Bartlett, 2017; Denison et al., 2014). Using a reproductive justice framework enables public health nursing actions for racialized women, girls, and gender non-binary people by uncovering systems of oppression, recognizing past

historical injustices, and advancing cultural safety in health promotion. Nurses can become more attuned to how power, history, oppression, racism, and unsafe systems of health care contribute to childbearing and reproductive health outcomes.

## Relational Autonomy

We now turn towards a discussion of how a reproductive justice and health equity lens can be translated into everyday ethical practices for nurses and nurse leaders in childbearing settings across the spectrum of care, from pre-conception to childbirth. We focus on the writing about relational autonomy by feminist bioethicists such as Sherwin (1992, 1998). Their work translates the theoretical concepts of reproductive justice, equity, and feminism into nursing practices to support the decisions of childbearing individuals as they journey through the myriad experiences from pre-conception to childbirth.

Beauchamp and Childress (2013), in their principle-based approach to bioethics, referenced the “ideal patient” when applying the principle of autonomy. In their view, this patient is seen as a standard reference point, but they did not consider the uniqueness of peoples’ contexts and histories; as nurses know, no such ideal patient exists. Nurses provide care to patients who differ drastically from the “ideal patient” Beauchamp and Childress described. There are, instead, patients who are unique and bring their lived experiences, histories, social and communal values, and expectations with them to each encounter.

Feminist philosopher Sherwin (1992, 1998) questioned the idea of an “acontextual patient” and developed the term “relational autonomy” as a way to understand the complexity of the concept of autonomy. In Sherwin’s view, context is integral; it includes not only a person’s individual context but also the broader socio-political context in which they live and receive health care. Taking a relational autonomy approach (Sherwin) can help nurses address these gaps in the principlalist view of autonomy—which remains dominant in health care today—by exploring what it means to be autonomous within one’s own context. While Sherwin has chosen the term “relational,” she is clear that she could just as easily have chosen the words “contextual” or “socially situated.”<sup>2</sup>

Using a feminist perspective of autonomy allows nurses to acknowledge the distinction between autonomy and agency. For example, if a patient makes a decision regarding a treatment option, but because of accessibility this option is not available to them, their agency has been constrained, although their autonomy—the ability to make that decision—has not. The converse may also be true; as Sherwin (1992) explains, when agency and autonomy are conflated, it becomes challenging to notice that what appears to be an autonomous choice is really nothing more than rational agency. An example is the case of a woman making a decision regarding assisted reproductive technology (ART) treatment within a pronatalist society. They are indeed making a rational choice to have a particular procedure, for example, IVF, and this choice fits with the dominant understanding of autonomy; however, as Sherwin clarifies,

when we limit our analysis to the quality of an individual's choice under existing conditions, we ignore the significance of oppressive conditions. Minimally, autonomous persons should be able to resist oppression—not just act in compliance with it—and be able to refuse the choices oppression seems to make irresistible. (p. 33)

Taking a relational approach to autonomy allows one to question the concept of self, recognizing that no individual is ever alone, and that selfhood is “an ongoing process, rather than as something static or fixed” (Sherwin, 1992, p. 35). Using this approach enables attending to the complexity of relationships, the social context of peoples' lives, and the historical and political factors that influence the decision-making processes. Using a relational understanding of autonomy requires that nurses question the structures and power that can enable or create barriers for a person to fully enact their autonomy. Once nurses can recognize and examine these structural enablers and barriers, they can then begin to engage in actions such as advocacy, research, and education to work towards structural change. This recognition of both structure and power is another significant deviation from the principalist approach to autonomy.

Relational autonomy can be applied to any area of nursing practice and with any population; all nursing clients in all nursing contexts have relevant life contexts that are integral to ethical care. In this chapter, we explore a case related to infertility<sup>3</sup> (Ethics in Practice 11-2) to highlight the complexities that can be addressed when nurses use a relational autonomy approach to care.

### **ETHICS IN PRACTICE 11-1**

#### *Prenatal Care for Trans Indigenous Youth in a Rural Context*

Ramona lives in a rural community three hours north of Prince George, British Columbia, and has been seeking birth control since turning 14 years old and becoming sexually active. Ramona self-defines as gender non-binary. In conversations with youth clinic nurses, they have described significant barriers to accessing trans-youth-specific sexual health and contraception education. Living in a small town for their entire life has meant that privacy and confidentiality is often challenging when seeking care as a minor without parental knowledge.

At 17, Ramona becomes pregnant, and based on past experiences of trying to access reproductive care, determines that they will be judged about being young, trans, and pregnant. Ramona decides that carrying the pregnancy to term without relying on supports and prenatal care would feel safer than travelling to another community or urban primary care setting for health care. When Ramona's parents eventually learn of the pregnancy, Ramona starts to feel more supported and less alone as the birth approaches. However, at 32 weeks, Ramona experiences spotting and signs of early labour and the decision is made to send them to Prince George for a trial of bedrest. The admission is arranged and Ramona's parents prepare to make the drive to Prince George. However, the family faces significant economic barriers to secure funds for fuel, accommodation, food, and childcare costs for their other children so that they can leave home to be with Ramona until the baby's birth. There are no funds accessible in the community that the family can access in order to be able to accompany Ramona. They drive Ramona to the urban hospital, stay while Ramona is admitted and then leave for home. Upon Ramona's admission to the antenatal unit, the nurse undertakes an intake assessment focusing on social and pregnancy history, and starts by asking: "Why are you alone? Where is your support system? How do you plan to manage these weeks of bedrest?"

**REFLECTIVE QUESTIONS**

1. *What does using a reproductive justice lens draw attention to in this scenario?*
2. *How does using a reproductive justice lens help to determine what is ethical care for Ramona?*
3. *What should become the focus for action for nursing leaders in this scenario?*

Having introduced health equity, reproductive justice, and a relational view of autonomy and agency as critical knowledge to inform ethical care for childbearing individuals and their families, we now turn to two cases that illustrate how these concepts and theoretical perspectives can be translated into care for nurses in practice and leadership roles.

Considering the case scenario above, using a reproductive justice lens and considering intersectionality can help nurses determine what barriers in reproductive and birthing care need to be removed for equitable access to be in place. This means looking beyond the individual level—what Ramona can or cannot do—towards creating practices and policies that support optimal birthing and early parenting support for trans youth, who often face gender discrimination and even violence in non-responsive and unsafe systems. Ramona is both young and gender non-binary, and has faced significant barriers to accessing tailored and safe sexual health and contraception education, leading to their pregnancy, which was the outcome Ramona was seeking to avoid when trying to access services at 14 years of age. Being young and trans positions people in ways that being man/woman (binary) gender and older age do not—and these “positionings” have very real and tangible impacts on the right to sexual health and contraception education regardless of age, gender, or other features of a person’s social identity. Nurses are well positioned to uphold reproductive rights by becoming aware of how these intersecting barriers affect access to perinatal care. They can work to shift power imbalances so that interpersonal interactions are ethical, respectful, inclusive, and safe regardless of a person’s social identity.

**ETHICS IN PRACTICE 11-1 (CONTINUED)***Prenatal Care for Trans Indigenous Youth in a Rural Context*

Two weeks after Ramona was admitted to the hospital for bedrest, a nurse practitioner mobilizes funding at the community level for Ramona's mother to come visit. During the visit, Ramona's mother, who is from the Takla First Nation, shares with the nurse that having Ramona home to give birth will be important for welcoming the baby in a ceremonial and traditional way. Ramona still faces another four weeks in hospital and is worried about preterm birth and an admission to the neonatal intensive care unit (NICU), which will add to time away from home and being isolated in the city. Ramona's mother indicates to the nurses that Ramona has lived with mental health issues for several years, and this time away from home worries their mother about the risk for postpartum depression and the possibility of problematic interactions with HCPs if the infant is in the NICU. Ramona's parents share with the NP that Ramona fears HCPs and how they will be treated given the racism they have experienced accessing care in their home community, living off reserve. Also, Ramona's parents don't want Ramona to be alone while giving birth, or to stay in the city if the newborn requires intensive care.

Multiple considerations about Ramona's social context and identity are important as we consider this case. These include that they live in a rural community and the potential need to leave home and be away from family can be stressful when admission to an urban hospital is required. Past experiences of barriers to care have been a reality, and Ramona has not been able to access sexual health education for fear of judgment. All of these experiences compound one another and are relevant for providing ethical care. Using an intersectional view can help nurses see that non-binary peoples may have negative, discriminatory experiences and face social judgment when accessing care. Understanding Ramona's past experiences of feeling judged by HCPs and not being able to access care can help nurses support their relationship. For example, if Ramona's baby is born preterm and requires NICU admission, approaching them using preferred pronouns, and inquiring about family support and economic needs while away from home (e.g., meals, accommodation) would reflect an understanding of their context.

In nursing care of childbearing families, there has been a historical tendency to overlook the diverse experiences of women-identifying individuals, particularly when these experiences

intersect with discrimination on the basis of ability, age, sexual orientation, race, and socio-economic status. To illustrate, Indigenous women's birthing experiences and inequitable outcomes confirm how historical and ongoing colonial oppression and racism, gendered violence, and intergenerational trauma impact perinatal health outcomes and Indigenous women's experiences of safe and respectful care within clinical settings (Brown et al., 2011; Sheppard et al. 2017; Varcoe et al., 2013). Indigenous women in Canada experience higher rates of preterm birth, low birth weight, and postnatal depression, among other maternal-infant health outcomes. These outcomes are indicative of how interlocking systems of oppression impact childbearing individuals and their families and communities (Sheppard et al.).

Using a reproductive justice framework offers ways to understand how reproductive health disparities, birthing outcomes, and maternal mortality are created through historical and ongoing colonial trauma. There are barriers to the SDOH that current reproductive policies do not address. Reproductive justice has applications for broad, diverse communities that could guide advanced practice nurses to better support racialized women in their reproductive years.

## Accessible Reproductive Care

We now turn to another Ethics in Practice case to further consider how nurses in both practice and leadership roles can work towards equitable access to reproductive care. In particular, we will discuss assisted reproductive technologies (ART) by integrating a relational view of autonomy and agency.

### **ETHICS IN PRACTICE 11-2**

#### *Equitable Access to Assisted Reproductive Technologies*

Kaelen and Jade, a same-sex couple, have decided they would like to pursue having a child together, and have started exploring their options. Along the way, they encounter a few challenges and discover that the donor sperm process is more complex than they

had anticipated. Living in a rural area of northern Ontario, they are accustomed to travelling to receive health care, so they aren't surprised to learn they will have to drive to access a fertility centre. What does come as a surprise is the distance they will need to go, as their more local health care options do not include fertility care. They find themselves driving five hours to the fertility clinic. Once they are patients of the clinic and have had a consultation, they decide that Jade will try to conceive first. Ready to begin their journey as parents, they are disheartened to learn that while fertility care is covered by the provincial medical plan (OHIP), fertility treatment\* is funded separately through the Ontario Fertility Program. Moreover, this program only covers specific fees for an insemination cycle, not all the fees incurred, leaving them to fund both the cost of each donor sperm sample and the fee required to prepare the sperm for insemination. This will mean that each month they want to try to conceive will cost them almost \$1,500. They are also advised that in order to increase the accuracy of the timing for the procedure, and thus their chances of conceiving, they should be monitored at the clinic with bloodwork and ultrasounds throughout their cycle, sometimes every day or two. Jade and Kaelen are at a loss as to how this could work for them, given the distance they are travelling and the time they would need to take away from work. Jade is a teacher, so while she knows she has some protected paid sick days, they will quickly run out depending on how long the process takes. Kaelen, though, works on a contract with the local college, and they don't have paid sick time. Also, given the contractual nature of their work, they worry that time away might jeopardize the next contract. Therefore, Jade will have to travel down to the city alone for the insemination process.

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\* Fertility care refers to the physician consult, appointments, and investigations such as ultrasounds and bloodwork used to assess fertility. Fertility treatment refers to the various assisted reproductive technologies (ARTs) used, for example, IVF and insemination.

Fertility care is most often offered in specialty clinics where access to a full suite of ARTs is available, from minimally invasive through to IVF. In Canada, there are 36 clinics that offer IVF, and in 2020, over 30,000 treatment cycles were undertaken (Canadian Assisted Reproductive Technologies Registry [CARTR] Plus, 2021). These clinics are situated mostly in large urban centres in their respective provinces, but in the case of the Maritimes, only Nova Scotia has a full-service IVF centre. Geographic distance alone can present a significant barrier to accessing ART. For instance, in British Columbia, no services currently exist outside the Lower Mainland (although at the time of writing two new clinics were announced, one in the Interior and one on Vancouver Island). In

Ontario, no clinics exist in the north to offer fertility services; all full-service clinics are further south in the Greater Toronto Area (GTA). Considering the Canadian context, where provinces and territories are large and populations are widely dispersed, significant geographical challenges arise for people seeking fertility care. But perhaps even more pervasive are the financial barriers to accessing fertility treatment. Health care delivery and decisions regarding health care spending are done at the provincial level, and so disparity is noted among the provinces. While all provinces fund fertility investigations through the provincial health insurance, at the time of writing, only three provinces provided funding for IVF, two of which were just announced in 2021 (Larsen, 2022).<sup>4</sup> Funding for procedures such as intrauterine insemination, which Jade and Kaelen are seeking, is funded differently across the provinces, and currently none cover the cost of the lab services, such as sperm washing required for the procedure, and none cover the cost of donor sperm.

If we then look beyond the direct financial cost, the added financial burden of fertility treatment becomes evident. Jade and Kaelen have a day's drive to reach the clinic; this requires time away from work, a working vehicle, gas, and food. If treatment is needed early in the morning, as many clinics require, then there may be the additional cost of staying overnight near the clinic, or the physical cost and risk of travelling through the night. This can create a significant barrier for those who are working in positions with little flexibility or no sick time. Those with precarious work are at risk of having to choose working over their fertility treatment, and so their goal of having a child may be impossible. Jade has the advantage of some paid time off that she could use, but she rightly is anxious about how long that time will last, given what she knows can be a lengthy treatment process.

As part of the LGTQ2S+ community, Jade and Kaelen may face additional barriers, such as questions about their choice to be parents, or feeling out of place in the fertility centre, where much of the care is geared towards treating infertility versus supporting the fertility of those who require donor gametes. Requiring donor gametes also means their financial burden is greater than it is for those who have all the required gametes within their relationships.

The emotional burden of fertility treatment is also significant (Domar, 2017; Greil et al., 2010).

#### **ETHICS IN PRACTICE 11-2 (CONTINUED)**

### *Equitable Access to Assisted Reproductive Technologies*

Jade and Kaelen go through multiple rounds of donor insemination without success, each one becoming more difficult for them. They begin to wonder if they should proceed with more aggressive treatment such as IVF, or whether perhaps Kaelen should try to conceive and carry. It is a difficult decision, and they struggle to find the right support to aid them in the decision making. They worry about the cost, the process of IVF, and the time away from home and work. In the end, they decide they will wait for Jade to have the summer off from teaching and then try again. They don't want to give up their desire and goal of being parents, but they believe they need time away from treatment, both emotionally and financially. They ask the nurse at the fertility clinic what they should do.

Jade and Kaelen decide that Kaelen will try to conceive. They are successful on their second round of donor insemination and are elated, until at their 8-week dating ultrasound they discover that the pregnancy is not viable; there is no fetal heartbeat, and the pregnancy is measuring small for gestational age. They are given a few options; first, wait for a spontaneous miscarriage, which could take a few days to a few weeks. Second, wait for a surgical procedure (a dilation and curettage [D&C]) to manage the loss. However, with current surgical wait times being lengthy and unpredictable, they are told it may be one to two weeks, and that they would need to be "on call" to come to the hospital. Third, they are told they could use a medication to induce the miscarriage, which is more challenging given their geographic distance from the hospital. Alternatively, they could pick up the medication at their own pharmacy and take it at home, resulting in a miscarriage occurring within 24–48 hours. They decide to proceed with the third option and leave the clinic with a prescription for Mifegymiso, a medication that will induce miscarriage. When they present to their local pharmacy to pick up the medication, they are told that the pharmacist "won't participate in abortions" and so doesn't stock the medication and will not order it in. The pharmacy technician does offer to forward their prescription to another pharmacy. Kaelen calls the fertility clinic nurse in tears to share their experience.

For nurses supporting people, couples, and families through infertility and fertility treatments, a relational approach offers a contextual, comprehensive, and nuanced understanding of the ability of childbearing individuals to enact autonomy and agency. This

would include an appreciation of the potential for the following complexities to impact autonomy and agency: (a) consideration of the social context of women's experience of infertility, and the stigma associated with infertility in a largely pronatalist society (Nouman & Zanbar, 2020; Sandelowski, 1990, 1991; Sherwin, 1992, 2018; van Balen & Inhorn, 2002; Worthington et al., 2019); (b) a woman's personal historical context such as her pregnancy history or history of attempted and successful or failed ART treatments to date (Zeiler, 2004);<sup>5</sup> (c) a woman's familial and community contexts and the importance of motherhood within those relationships (Inhorn, 1996; Öztürk et al., 2021); (d) the ability to refuse treatment when infertility is constructed as an illness or disease (Kalbian, 2005; McQuillan et al., 2022); and (e) a critical perspective on the medical approach to informed consent, which requires "adequate information" and most often only includes medical risks. Donchin (2001) describes the lack of information typically given regarding the emotional, psychological, social—and, we would add, existential risks—associated with treatment. Nurses should also pay attention to the power differentials at work within such a highly specialized and technological context (Kalbian; McLeod, 2017). When considering the challenges that Jade and Kaelen face as they navigate their fertility journey, it is apparent that the biomedical view of autonomy is insufficient.

Comprehensive reproductive care includes not only care of those seeking assistance with either contraception or fertility and pregnancy, but also management of early pregnancy, including miscarriage and ectopic pregnancy, as well as access to abortion care. With the recent reversal of *Roe v. Wade* in the United States (Savage, 2022), there is a spotlight on the various situations that could put women and those with a uterus at risk if they cannot safely access services. While abortion, medical or surgical, has been decriminalized in Canada since the 1980s, and covered just as any other medical procedure by provincial health insurance programs, recent events in the US about abortion laws have contributed to reigniting the conversation about abortion in Canada (BBC News, 2022).

Given that Jade and Kaelen's experience is not uncommon, there is a need for nurses to explore how more equitable, accessible, comprehensive, and compassionate reproductive care can be realized.

Nurses providing care to women and people with a uterus must be aware of and prepared to have conversations about the spectrum of reproductive care. Nurses have a long history of being advocates for women's health and reproductive choice (Haney, 2021). Unfortunately, the role of nurses to advocate for safe, equitable access to abortion care and reproductive choice is still greatly needed today (National Nurses United, 2022).

## **Implications for Ethical Practice for Nurses and Nurse Leaders**

When nurses and nurse leaders use a health equity and reproductive justice approach in providing ethical care to childbearing individuals, it provides them with the knowledge about how to contribute to optimal reproductive, pregnancy, birthing, and neonatal outcomes by supporting autonomy, agency, and access to care. Core strategies for all nurses in perinatal, neonatal, and reproductive care settings include (a) asking questions about peoples' histories, experiences accessing care, and how to support their agency and autonomy while challenging dominant social norms related to childbearing; (b) using gender-inclusive language; and (c) creating respectful, responsive, and safe care. Taking a relational approach allows for an exploration and understanding of complex structures, power, and contexts that patients bring with them, and impacts how they navigate health, reproductive, and neonatal care. This relational understanding can assist nurses, not only to better prepare for and provide care to their clients and their pregnancies and newborns, but also to enact their role as advocates to work towards recognizing and addressing barriers that restrict autonomy and agency.

Nurses have longstanding commitments to equity and social justice. Realizing both as a means and an end in everyday nursing practice requires critical analysis of structural barriers to care and the social determinants of health, as well as action to dismantle multiple intersecting sources of oppression that occur across the continuum of reproductive care. Nurses who are gender-inclusive and anti-racist can be better positioned to see how ability, class, and age also shape the experiences of childbearing individuals and outcomes of

reproductive, perinatal, and neonatal care. Nurses in leadership roles are exceptionally well-positioned to advance a reproductive health equity agenda within policy, practice, and education contexts. In so doing, they can transform organizations and social structures to create environments and systems where childbearing individuals can navigate their reproductive decision making, pregnancy, and birthing experiences with safety and dignity.

### **QUESTIONS FOR REFLECTION**

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1. *Some provinces fund IVF for infertile women of childbearing age. Should other provinces follow this lead and fund IVF? Why or why not?*
2. *Given your role as an advanced practice nurse, how might you use a relational approach when caring for pregnant individuals and their families?*
3. *Think about your own practice context. How could you be involved in ensuring that families with limited resources are able to access the continuum of reproductive care?*

## Endnotes

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- 1 Structural barriers refer to the broad structures and systems in our society, including (a) institutions and policies, which shape life opportunities; (b) access to resources; and (c) how we are positioned in the social fabric of our society.
- 2 This clearly distinguishes Sherwin's use of the term "relational" from those of others who use the term to refer more to interpersonal relationships.
- 3 Infertility is broadly defined as the inability to conceive, or the inability to carry a pregnancy to term after 12 months of trying. In Canada, it is estimated that one in six couples will experience infertility (CFAS, 2022). Infertility is defined as a "disease" with a variety of causes, some of which can be addressed medically or surgically, and some of which require fertility treatments to circumvent the underlying cause. The host of treatments available are referred to as assisted reproductive technologies (ARTs), the most costly and invasive of which is in-vitro fertilization (IVF). Individuals may also seek fertility care, as shown in Ethics in Practice 11-2 in this chapter, when requiring access to third party reproductive care (for example, donor sperm, donor eggs, or a gestational carrier).
- 4 Funding models vary by province. PEI and New Brunswick (NB) require the recipient to pay out of pocket up front and will reimburse them after the treatment has performed to a lifetime maximum of \$5,000 in NB and up to \$10,000 in PEI dependent on income. Of note, Manitoba and Nova Scotia offer a tax credit for fertility treatment costs. Only Ontario and Quebec offer funding structures that reimburse the clinic so the recipient does not have to pay out of pocket up front. This funding comes with restrictions and limits; for example, in Ontario, only one IVF cycle per person is funded; likewise with the funding in PEI. Quebec has a unique history with funding, as it was for some time the only province to offer funding, and offered unlimited cycles to those under age 42. With a shift in governments, that funding was stopped as part of austerity measures. The Quebec government has now reintroduced funding with a limit of three cycles per person.
- 5 The ability to act as an autonomous agent can be diminished in the face of repeated trauma. Multiple failed ART cycles can lead to such situations for women (Zeiler, 2004).

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