

The Impact of COVID-19 on Minority Disparities in Sexual and Reproductive Health Care in New York State: Perspectives of Frontline Providers during the Pandemic’s First Surge

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| | |
|---|----|
| • Executive Summary | 1 |
| • Introduction | 3 |
| • Racial Disparities in Reproductive Health and Health Care | 4 |
| • Pre-Existing Racial Inequities and Mitigation Efforts | 7 |
| • Prenatal and Obstetric Care | |
| ○ Theme 1: Fear and Concerns around Safety for Patients and Providers | 11 |
| ○ Theme 2: Confusion over Changing and/or Contradictory Protocols | 14 |
| ○ Theme 3: Tensions and Confusion around Policies for Birth Support Persons | 16 |
| • Birth Outcomes, Postpartum Health, and Outreach | 18 |
| • Abortion and Contraception | 22 |
| • Telehealth as an Adaptation to Care Provision | 25 |
| • Policy Recommendations | 28 |
| ○ Supporting SRH Care | 29 |
| ○ Telehealth | 30 |
| ○ Supporting Prenatal and Obstetric Care | 30 |
| ○ Supporting Postpartum Care | 31 |
| ○ Support Family Planning Services | 32 |
| • Works Cited | 33 |

Executive Summary

This report examines the impact of COVID-19 on sexual and reproductive health access for racial minority populations in New York State (NYS), as well as the effect of adaptations to care on low-income and minority communities. Between July and October 2020, we conducted in-depth interviews with 19 frontline sexual and reproductive health (SRH) providers and advocates working in largely minority-serving health care institutions. We contextualize these findings within contemporaneous data and analysis drawn from media sources and published articles, as well as white papers and webinars produced by the Guttmacher Institute, Planned Parenthood, and the New York State Department of Health.

Our interviews highlight that the pandemic exacerbated already-existing disparities in access to, and quality of, SRH care. Key findings include:

- Negative birthing conditions that were experienced disproportionately by those most vulnerable to poor maternal and birth outcomes. These included: denial of access to support persons; separation from newborns, and; fear of Immigration and Customs Enforcement and/or Child Protective Services
- Fear of COVID exposure at hospitals and of escalating anti-immigrant/anti-Asian political sentiment among minority and immigrant populations that led to avoidance of care or delays in accessing time-sensitive care such as prenatal care and abortion care services.
- Lack of coordination and communication at different levels—between NYS and NYC, between hospitals, between hospitals and local health departments, and between hospital administrators and frontline providers—that produced widespread

confusion about safety protocols and clinical policies and increased fear and anxiety for both patients and providers.

- Insufficient infrastructural investment for personal protective equipment (PPE), COVID testing, and pivot to telehealth in public hospitals and clinics. Inequities in quality of telehealth was particularly stark for non-English speaking patients and those with connectivity issues.
- Closure of important services during lockdown such as school clinics providing contraceptive and STI care to adolescents, as well as postpartum visitation services for low-income and at-risk families, that created troubling gaps in service that have not been fully addressed.

Despite these challenging experiences, it is notable that providers across SRH domains also underscored some positive outcomes of pandemic-driven care:

- For those able to use them, telehealth platforms streamlined care provision and resulted in higher-than-usual attendance at routine appointments such as contraceptive counseling. Providers universally supported the continued expansion of telehealth in the future.
- Numerous and creative initiatives by individuals and institutions to produce evidence-based guidance, ensure continuity of care, and deliver timely and compassionate care under extremely challenging circumstances.

Introduction

As with other realms of health care, the COVID-19 pandemic severely and negatively impacted the provision of sexual and reproductive health and healthcare (SRH) to racial and ethnic minorities in New York State (NYS). Despite several pre-pandemic state policy initiatives and taskforces aimed at addressing racially disparate maternal and infant health outcomes and SRH access, the providers and advocates that we interviewed agreed that the pandemic exacerbated already-existing SRH disparities in both health status and access to healthcare. Important executive orders issued during the pandemic, particularly from March to June 2020, helped to clarify SRH services as essential and provided guidance for providers and institutions. Yet they could not prevent an overall worsening of reproductive health and health care disparities within a national context of heightened racialized and anti-immigrant rhetoric alongside deep economic and health institutional drivers of precarity.

This report seeks to elucidate the impact of COVID-19 on sexual and reproductive health access for immigrant and racial minority populations in NYS, as well as the effect of pandemic-driven adaptations to care on low-income and minority communities. Given the limited statistical data available at the time of writing, it draws on the experiences of frontline providers who serve minority populations, including midwives, doulas, OB/GYNs, lactation consultants, labor and delivery nurses, as well as sexual and reproductive health (SRH) advocates. Their experiences and connections to minority communities are critical to understanding the impact of COVID-19 on disparities in SRH health and health care. We contextualize these findings with data and analysis drawn from media sources and published articles, as well as white papers and webinars produced by the Guttmacher Institute, Planned Parenthood, and the New York State Department of Health.

Racial Disparities in Reproductive Health and Healthcare: A Brief Background

It is as yet too early to obtain verifiable, comparable data on the impact of state policy initiatives on minority SRH status and health access, much less the specific timeframe since Governor Cuomo’s March 7, 2020 declaration of a state of emergency to contain the spread of the virus. According to statistics collected in 2016 or earlier, non-Hispanic Black women in NYS are two to three times more likely to die as a result of childbirth than non-Hispanic white women. In New York City (NYC), non-Hispanic Black women are twelve times more likely than non-Hispanic white women to suffer a maternal death (New York City Department of Health and Mental Hygiene, 2015). Although maternal mortality rates have remained relatively stagnant since 2010, the racial gap in maternal mortality rates has almost doubled, a consequence of a dramatic drop in maternal mortality for white women that has not been replicated for Black women. The maternal deaths of three young Black women in New York City between March and July 2020—Cordielle Street, Sha-Asia Washington, and Amber Rose Isaac—led to street protests and a demand to amend New York State Law § 2803-J Information for Maternity Patients to “include statistics and racial data on maternal deaths, third trimester fetal losses and stillbirths, and birth related injuries”¹ (Irizarry Aponte, 2020). Notably, the midwifery service at Woodhull Hospital in Brooklyn, where Washington died during an emergency caesarian, released an impassioned letter calling for systemic changes at the level of social supports and hospital policy to improve Black maternal and infant health outcomes.

¹ <https://www.change.org/p/andrew-m-cuomo-safeguard-the-right-of-all-laboring-people-during-covid-19-crisis/u/27230098>. Accessed October 17, 2020.

Severe maternal morbidity, defined as life-threatening complications during childbirth, rose in NYC by more than 25% between 2008 and 2012, with Black women more likely than non-Latina white women to suffer a life-threatening maternal event even after taking into account risk factors such as poverty and co-morbidities. Black women also disproportionately suffer inequities in birth outcomes as measured by rates of pre-term birth, low-birth weight, infant mortality, and NICU admission rates (New York City Department of Health and Mental Hygiene 2015, 2016). Further, recent evidence suggests that Latinx immigrant groups, previously identified by epidemiologists as having relatively good birth outcomes, experienced rising rates of premature birth both in NYC and nationally attributable to increased psychosocial stressors during the Trump administration (Gálvez, 2011; Gemmill et al., 2019; Krieger, Huynh, Li, Waterman, & Van Wye, 2018)

Racial disparities are also apparent in access to contraception and abortion care. Publicly funded family planning centers are the primary access point for SRH care for low-income and under/uninsured minority and immigrant women. Repeated attacks by anti-abortion rights activists and legislators against Planned Parenthood, the country's largest provider of SRH care, has thus had a disproportionate impact on racial minorities. In 2019, the Trump administration finalized the "domestic gag rule" that barred Title X funding—the only federal program dedicated to funding family planning services—to organizations that performed, or even provided referrals for, abortion care. Subsequently, approximately one in every thousand clinics withdrew from the Title X program, reducing the capacity of publicly funded providers by half and negatively impacting contraceptive access and availability particularly to low-income and uninsured women (Desai & Samari, 2020). According to Planned Parenthood, 78% of all people covered by Title X fall under the federal poverty line, and over half identify as Black or Latinx

(21% Black or African-American; 32% as Hispanic or Latinx).² Between 2010 and 2015, nearly 25% of adolescent and young adult women who received contraceptive care went to publicly funded clinics (Lindberg, Bell, & Kantor, 2020).

Abortion rates have declined in the past decade with the increasing availability of sexual education and safe and effective contraception (Guttmacher Institute, 2013). However, abortion is increasingly concentrated among low-income immigrant and minority populations who often have less access to reliable contraception and to comprehensive sexual education, as well as other reproductive health care. The federal Hyde Amendment bars Medicaid-covered women from using public insurance to cover abortion care except in cases of rape, incest, or life endangerment. In NYS, Medicaid funds cover the cost of abortion through state programs, and undocumented women are also eligible for abortion care through emergency Medicaid coverage. However, low-income women who do not qualify for Medicaid may struggle to pay for abortion care, and research shows that economically disadvantaged women who need abortion care will nonetheless piece together the required funds by diverting money from food, rent, utilities, and other necessities (Jones, Upadhyay, & Weitz, 2013).

Notable recent NYS initiatives to mitigate racial disparities in SRH include the Executive Order 184 (July 2018), which protects access to contraception, and the Reproductive Health Act (January 2019) that guarantees and extends access to abortion care. The Cuomo administration has also created a number of taskforces, backed with a commitment of funds, to address entrenched racial disparities in maternal mortality, morbidity, and birth outcomes. Despite these efforts, our research suggests that COVID-19 disproportionately impacted access to SRH services for low-income minority populations and compromised the

² <https://www.plannedparenthoodaction.org/issues/health-care-equity/title-x>. Accessed October 1, 2020.

effectiveness of many of the recent initiatives aimed at narrowing reproductive health disparities in the state.

Pre-Existing Racial Inequities and Mitigation Efforts

“Regardless of class ... Black women are not listened to, and now with COVID taking center stage, they sense that they'll be listened to even less.” – NYC-based Doula

It is now widely understood that COVID-19 has had a disproportionate impact on minority groups, measured both in morbidity and mortality rates and in economic consequences. Among Latinx populations, six out of ten households have members who have lost a job or had wages or hours cut as a consequence of the pandemic. Among Native American and Black households, four out of ten have suffered economic impacts. Additionally, one in five Black and Latinx households, and one in three Native American households, report serious problems affording medical care during the pandemic (NPR, Robert W. Johnson Foundation, & Health, 2020). Minority women have fared particularly poorly, with one report finding that 18.8% of Black female workers became unemployed between February and April 2020 (Gould & Wilson, 2020). The loss of a job does not only mean heightened economic insecurity; for those with employer-based insurance, it also means the loss of private health coverage and relationships with known and trusted providers.

It is also clear that the pandemic has exacerbated deep race and class inequalities in access to, and quality of, SRH care. The pandemic-related growth in numbers of women, disproportionately racial minorities, seeking SRH care through publicly funded hospitals and clinics has increased pressure on already-overburdened providers and institutions. Hospitals and clinics in low-income and minority areas are suffering the effects of decades of economic cuts, leading to resource scarcity and delays for care even prior to the pandemic. Since 2000, there has been a 20% reduction in hospital beds statewide, with some 20,000 hospital beds lost in New

York City alone (Campanile, Marsh, Hogan, & Hicks, 2020; Robinson, 2020). As one health policy expert noted during the 2016 hearings of the Commission on Healthcare Facilities, hospitals targeted for closure disproportionately served uninsured racial and ethnic minority communities, including undocumented immigrants (Robinson 2020). In Queens, the national epicenter of the pandemic in March and April, four hospitals had been closed between 2008 and 2012, making it the NYC borough with the fewest hospital beds despite its high proportion of low-income, minority, and immigrant populations (Brand, 2020).

The closure of hospitals has different impacts on racial minorities in urban and rural areas: in urban centers such as NYC, the overburdening of public hospitals and lack of quality obstetric care in some hospitals is a likely contributor to findings that Black-serving hospitals have higher rates of maternal mortalities and severe maternal morbidities regardless of the patient's race or health profile (Howell, Egorova, Balbierz, Zietlin, & Hebert, 2016; Janevic et al., 2020). In rural upstate areas, the recognition of “maternity care deserts,” notably in Hamilton and Cayuga counties, had already pointed to a growing need prior to the pandemic for telehealth services and increasing options for maternity care in regions that lack providers (March of Dimes, 2020). The closure of hospitals also means that agricultural workers, largely Latinx and often undocumented, must at times travel long distances outside their communities for SRH care.

In addition to the significant resource inequities for minority-serving health institutions, there is growing evidence of the effects of medical racism on health outcomes (Hoberman, 2012). Even before the pandemic, women of color were more likely to report dismissive or even hostile medical encounters that resulted in poor quality of care and subsequent unwillingness to seek medical attention (Carpenter, 2017; Davis, 2019; Martin & Montagne, 2017; McClain, 2017; Oparah et al., 2018; Oparah & Bonaparte, 2015; Villarosa, 2018). Although data is not yet

available on patient attendance during the pandemic, the participants in our study perceived notable declines in numbers of minority patients accessing SRH care. Given that urban minority-serving hospitals were also more likely to have high COVID caseloads, such a decline is unsurprising. Although hospital/medical avoidance during March and April was widely shared across all groups, the decline for low-income minority populations is concerning as they were also less likely to be receiving care through telehealth or other services. In addition, our interviews suggest that the wider context of fear and uncertainty amid the rise of anti-immigrant political rhetoric on the national stage negatively affected immigrant families and may have contributed to decreased use of SRH care.

Mirroring the pandemic's disproportionate impact on minority communities, health care workers of color (including immigrants trained abroad) are also more likely to treat COVID patients, and to become infected and die from the virus (Renwick & Dubnow, 2020). This loss is consequential; one consistent recommendation made by minority SRH and birthing advocates is for the recruitment and training of more providers of color (NYSDOH Commissioner's Community Listening Sessions, 2018; Oparah et al., 2018). Supporting this recommendation, a recently released retrospective study based on 23 years of data from Florida hospitals found that "newborn-physician racial concordance is associated with a significant improvement in mortality for Black infants" (Greenwood, Hardeman, Huang, & Sojourner, 2020).

Early indications are that the pandemic and resulting budget impacts may stall recent efforts by Governor Cuomo's administration to mitigate disparate outcomes in maternal and infant health. In April 2018, the administration convened a Taskforce on Maternal Mortality and Disparate Racial Outcomes, which was followed in 2019 with an \$8 million commitment in the 2019-2020 Executive Budget to support implementation of the taskforce's top

recommendations. Despite the establishment of a Maternal Mortality Review Board, an implicit racial bias training program for hospitals, and a data warehouse on perinatal outcomes, these were in the earliest stages of formation when the pandemic hit and may be compromised by subsequent budget reductions. Despite the recognized need for more easily accessible comprehensive data, protocols for the collection and timely distribution of data are not yet in place. As we note in the section on prenatal and obstetric care, this made it difficult for providers to advise patients who wished to transfer birthing sites to areas with lower rates of COVID transmission. As one Albany-based SRH advocate stated, “We do not have a great system in this state to accurately and effectively collect data rapidly, and that proved really challenging. ... The hospitals kept it very close and they are the only ones that have access to real time data. Them and health insurance companies.”

NYS had also significantly invested into community health worker (CHW) services as part of recent mitigation efforts. However, in the context of the lockdown, these were shut down, meaning a complete loss of community-based services such as home visitation for new mothers. Pandemic-related budget shortfalls may also reduce the operating capacity of other programs that provide support for maternal and child health. One nurse touted the organization, Healthy Families, for its diverse, multilingual staff and provision of crucially needed case workers to vulnerable populations. However, according to an SRH advocate, this program is in line for significant funding cuts.

Community-based mitigation efforts have also been disrupted. Given evidence of the positive effects of community (racially concordant) doula care on racial inequities in birth outcomes (Kozhimannil, Vogelsang, Hardeman, & Prasad, 2016; Strauss, Giessler, & McAllister, 2015; Wint, Elias, Mendez, Mendez, & Gary-Webb, 2019) one community

organization in Albany sponsored a four-day training for 20 local women of color to become doulas last September 2019. Ongoing pandemic conditions, however, prevent them from carrying out their work. They have to contend with their own increased childcare needs, the inability to get follow-up training necessary for certification, and institutional policies that prevent them from attending prenatal visits or disallow shift work during lengthy hospital stays.

The following sections describe in more detail the effect of COVID-19 on the SRH health and health care access for racial minority groups in NYS. We discuss: prenatal and obstetric care; postpartum care and outreach, and; access to contraceptive and abortion care.

Prenatal and Obstetric care

“Providers are traumatized . . . Everything felt like you were reacting to things. The planning wasn’t there until something bad happened.”

Midwife, New York City public hospital

Theme 1: Fear and Concerns around Safety for Patients and Providers

Despite the immediate designation of prenatal and obstetric care as essential care, providers reported widespread fear and confusion among patients about access to, and safety of, hospital-based care. Messages by media and health officials about preventing the over-burdening of hospitals, combined with patient fears about COVID exposure, undermined important public health messaging about the importance of routine prenatal care. An obstetrician from a NYC hospital that served a 30 percent Asian population also described how their fear of blame for the virus and of consequent violence led them to avoid leaving their homes altogether. In all institutions, providers reported high levels of patient fear and anxiety and consequently higher

rates of delayed or intermittent care. A midwife working in a New York City public hospital that had been hard-hit by COVID-19 recalled that both providers and pregnant/laboring women had to pass by refrigerated morgue trucks in order to enter the obstetrics unit. “Was there no administrative foresight to say: ‘What are these women feeling as they’re coming into our unit?’ The fear was so intense.” Lack of prenatal care and delayed entry for labor and delivery compromised the ability of providers to identify and address the needs of those at higher risk of adverse outcomes.

Under-resourced public and safety-net hospitals in both the city and rural areas also had much less access to PPE and COVID testing than did private institutions, putting providers and patients at greater risk. Given the fear of iatrogenic COVID transmission, both hospitals and individual patients sought to transfer prenatal and obstetric care to other institutions. Yet in at least one case in a NYC public hospital, when maternity beds were converted to infectious disease beds for COVID care, little information was provided to pregnant patients about where to transfer their care. In other cases, transfers of care were driven by patient desires to avoid hospitals, particularly those with high COVID caseloads. However, barriers to inter-hospital communication and the reluctance of administrators to share information with respect to COVID cases meant that providers and advocates found it virtually impossible to find the up-to-the-minute statistics necessary to guide their patients to hospitals with lower transmission rates. Pregnant people who sought to avoid hospitals entirely by shifting to home births often found that there were insufficient homebirth midwives to meet demand (De Freytas-Tamura, 2020). Several providers outside NYC reported an influx of what one provider called “COVID refugees”—people who relocated from the city to areas with lower COVID rates for the express purpose of transferring prenatal and obstetric care to institutions that continued to allow support

persons during pregnancy and/or did not require masks during labor. The ability to leave the city for care was clearly stratified by economic status; low-income immigrant and minority people seeking care at city safety-net hospitals usually did not have this option.

One of the recommendations of the COVID-19 Maternity Taskforce was the development of more midwife-staffed, stand-alone birthing centers that would address concerns around racial disparities in birth outcomes as well as COVID transmission. As of October 2020, two temporary centers had opened, one in Manhattan and one in a NYC suburb (Spring Valley, NY). However, it is not clear if these efforts translate to increased choices for all birthing people, particularly for low-income covered patients, or that they can rectify years of hospital closures that have led to “maternity-care deserts” in Black neighborhoods (Glass, 2020). Further, racial and ethnic minorities who disproportionately experience poor maternal and infant outcomes may not qualify for birth centers that pre-screen their clientele on the basis of “low-risk” status as well as verification of benefits by insurer.

Providers working in obstetric and postpartum wards, from obstetricians to midwives to nurses and lactation support teams, universally described an atmosphere of fear and chaos that they described as traumatizing and leading to burnout. In the early weeks of the pandemic, even nurses found that they were deprioritized for hospital-provided PPE and were banned from bringing personal PPE to work despite the shortage. One postpartum nurse expressed her sense of devaluation in the face of policies that effectively meant, as she put it, ‘We’re not going to provide for you’ but you also can’t provide for yourselves.’ As she further noted, “Nurses, particularly in the beginning, were very much feeling expendable.” Pointing out that PPE was initially saved exclusively for ICUs and ERs, another nurse said: “We [the nurses] were the last people to be protected. There were a few nurses who became positive because they weren’t

protected with the PPE.” Even after PPE was provided and/or personal PPE was permitted, providers reported having to re-use PPE for multiple hours or throughout a single shift regardless of their contact with COVID-positive patients. In September 2020, a social worker noted the continued lack of negative pressure rooms in their units as well as the rationing of PPE for clinical staff only. The best practice of full PPE provision and discarding PPE after exposure to each new patient was still not fully implemented in October 2020.

Theme 2: Confusion over Changing and/or Contradictory Protocols

“We had different policies day to day, sometimes even minute to minute.”

Postpartum nurse and lactation consultant, Albany

“We were going through periods where every six hours, the rules were changing. It made it, from the healthcare perspective, much more difficult to be able to interface and support patients.” –

Deborah Campbell, MD, FAAP, Chief, Division of Neonatology, Montefiore Medical Center
(NYS DOH COVID-19 & Maternal Equity Webinar)

Providers in a number of different facilities referred to the confusion caused by constantly changing safety protocols and the lack of clarity about authoritative sources of guidance and the proper chain of command. Referencing the fact that safety and birthing protocols changed virtually every shift, and even between attending physicians, one NYC midwife stated, “It’s like the Wild West in here. Everyone is doing their own thing.” Even as late as our interviews in August/September 2020—and despite guidance from the state—some providers were still reporting that only symptomatic pregnant women and women scheduled for elective caesarians were being tested for COVID (although other hospitals reported universal testing of pregnant/laboring women). The continued scarcity of rapid testing in some safety-net hospitals meant that neither asymptomatic women nor women needing an emergency caesarian

were being routinely tested for COVID-19. Further, some providers also indicated that there were still insufficient protocols and safe practices in separating patients into different areas according to COVID status (under investigation, confirmed positive, or confirmed negative), as well as designating staff for each group in order to control the possibility of iatrogenic transmission. Nurses spoke of the elaborate, ten-minute process of donning full PPE (masks, shields, gowns, gloves, etc.) and noted that in order to avoid the inconvenience, some nurses skipped less critical checks of a single positive patient if their round included mostly negative patients.

Policies and practices aimed at limiting COVID risk exposure also conflicted with best practices for maternity and postpartum care. Providers reported that pregnant patients were entering the hospital much later in their labor and leaving as soon as possible after delivery in order to minimize COVID exposure. Nurses from different institutions also described the enforcement of a pandemic guideline issued by the American College of Obstetricians and Gynecologists to more rapidly discharge patients—24 hours after a vaginal birth and 48 hours after a C-section. According to several obstetricians and midwives, this in turn put pressure on staff to compress procedures for discharge into a shorter period of time, which was one of many factors leading to provider burnout. They also noted higher-than-usual rates of inductions and C-sections in order to control time of delivery, provider exposure, and length of hospital stay, with an unknown impact on birth outcomes. For providers caring for at-risk and COVID-positive patients, the rapid discharge rule was of particular concern since it severely limited the amount of provider contact and capacity to connect patients to services, establish good breastfeeding practices, or discuss strategies to prevent transmission for COVID-positive new mothers, thereby compromising postpartum education and care. Some providers voiced a sentiment that the

quality of maternity care had been sidelined in the context of pandemic fears. Articulating her feeling that there had been a lack of comprehensive state response to maternity care in the early days of the pandemic, a midwife stated, “ They forgot about us almost until a group of us were, like, what are you going to do about maternity care, because this is also essential care even if it's not COVID related.” Such perceptions are of particular concern given the already poor outcomes for Black pregnant and birthing people in NYS.

Theme 3: Tensions and Confusion around Policies for Birth Support Persons

Protocols around support persons, which varied widely by institution, were also a source of confusion and, for many patients, resentment. An obstetrician in an upstate hospital with relatively low COVID rates stated that support persons continued to be permitted at births throughout the pandemic. By contrast, one obstetrician from a NYC hospital with a near-14% COVID positivity rate noted that all support persons, including partners, were entirely prohibited from attending births at the start of the pandemic. A Change.org petition with over 600,000 signatures successfully ended this practice (Davis-Floyd, Gutschow, & Schwartz, 2020), but confusion around the number and type (credentialed doula or not) remained.

Community-based mitigation efforts designed to address racially disparate birth outcomes consistently tout the critical importance of having a trusted advocate and support person present during medical encounters. The inability to bring support persons to prenatal visits may thus have also contributed to the avoidance of prenatal care, particularly for non-English speaking pregnant people who often rely on family members for linguistic and emotional support in an unfamiliar medical context. One nurse stated, “For someone with a distrust of the medical community, especially women of color [who] hav[e] a rational fear of the medical

community, they're scared to go to these appointments anyway. But, going alone, I think we're seeing a lot more decreased prenatal care." Policies stating that support persons must remain confined in the birthing room and could not be readmitted if they left were especially consequential for low-income patients. A nurse at a public hospital in Albany noted that some patients had partners in jobs that require them to report physically to work and that have stringent penalties for unscheduled "no-shows," or who risk economic stress if they miss a shift. She felt that these policies prohibiting re-admittance unfairly forced low-income people to choose between economic stability or supporting their partner during the birth of their child.

Further, while doula care has been shown to improve birth outcomes, particularly for Black women (Bey, Brill, Porschia-Albert, Gradilla, & Srauss, 2019; Birth Justice Network and Forward Together, 2019), providers stated that initially doulas were largely excluded from birthing rooms (or were counted as the single allowable support person). An executive order by the governor's administration allowing doulas as additional support persons to attend hospital births lagged in implementation. Some institutions only changed their policies when pressured by community-based advocates. One such example was a letter-writing action and joint statement supported by seven community-based organizations in Albany demanding access to doula care and consistent policies across the region (Statement, *Reduce Barriers to Doula Support During Birth in the Time of COVID-19*). It is not surprising that confusion ensued for hospital administrators given constantly changing state directives. While the advocates cited an executive order on April 29, 2020 (202.25) allowing doulas as additional support persons in their statement, NYSDOH representatives with whom we spoke understood this change to have occurred pursuant Executive Order 202.44 (June 21, 2020). Once allowed to attend births, doulas described difficult working conditions in addition to the fear of COVID exposure. Like

other support persons, they were confined to birthing rooms for extended periods (27 hours in one case) and not always given ready access to food or an opportunity to rest. Unlike other support persons, they were required to present certification in order to be present at births. One hospital in NYC, after discussion of the disparity that inhibits many of their patients from affording certified doula-assisted care, decided to allow an additional support person without doula certification.

Birth Outcomes, Postpartum Health, and Outreach

Early reports of dramatic declines in premature birth in Denmark, Ireland, and the Netherlands after state-imposed lockdowns raised questions about the potential for indirect positive impacts in birth outcomes during the pandemic (Been et al., 2020; Hedermann et al., 2020; Philip et al., 2020). Some experts studying these trends worldwide surmised they might relate to decreases in non-COVID-19 infections and air pollution, both known to be strongly associated with premature birth. Yet they also question whether [these](#) sharp declines in preterm birth are in fact related to increased rates of fetal loss at pre-viable gestational ages (Brockway, Azad, & Burgner, 2020). More recent studies suggest a correlation between COVID positive mothers and preterm birth/fetal loss, and our study participants also tentatively noted their perception of higher rates of fetal loss and postpartum hemorrhage during COVID (Delahoy, 2020; Khalil et al., 2020; Panagiotakopoulos, 2020). More research is required to confirm this perception, as well as to determine whether such outcomes are directly related to COVID infection or to social conditions such as stress, fear, and delay or avoidance of prenatal care. Providers also described lower thresholds of tolerance for signs of maternal or fetal distress that led to an uptick in Caesarian sections in at least one safety-net hospital in NYC. Given higher rates of negative birth outcomes for Black mothers in non-

pandemic conditions, such perceptions, even if anecdotal, are troubling. It will take time and concerted study to understand the factors that correlate with changes in rates of in preterm birth where they occur. The impression of one advocate with access to deidentified data from three hospitals in the Albany area and 13 hospitals making up the NE region of New York, however, is that the rate of premature birth declined marginally, if at all, but remained largely unchanged since March 2020. Another policy level advocate spoke of a statistically insignificant increase in preterm birth in the state during the pandemic.

Postpartum nurses and advocates noted that rapid discharges, whether initiated by hospitals or by patients, often resulted in insufficient discharge preparation, such as connections to supportive services. Follow-up lactation services and hospital-based breastfeeding support groups were suspended, likely impacting rates of successful breastfeeding for new mothers. While some hospitals continued to allow newborns to room in with COVID-positive mothers to facilitate bonding and breastfeeding, in one hospital, administrators initially resisted the implementation of a protocol to inform COVID positive patients about safe breastfeeding options. Lactation consultants took the initiative to not only conduct research (using CDC, WHO, and La Leche League guidelines among others), but also to draft protocols for providers and patients advocating for their implementation until higher ranking administration conceded.

Further, resources for post-discharge support for low-income COVID-positive mothers was almost completely absent. In some cases, nurses felt that immigrant families, particularly those from less-commonly spoken linguistic groups, were not provided sufficient information about the virus. In other cases, information was provided but the familial lack of resources meant that they were unable to implement recommendations. Hospital policies of providing only two masks for positive patients was a major obstacle in these cases. One nurse recalled discharging a

monolingual Spanish-speaking mother who was COVID-positive. Although a translator was called to underscore the importance of hand hygiene and mask-wearing when handling the newborn, the nurse noted that everyone on the floor was aware that the family did not have the financial resources to purchase a consistent supply of PPE to protect the newborn or other family members from transmission. In this case, the nurses banded together to donate masks to the family; nonetheless, she and a fellow nurse both commented, “I definitely felt like we could have all done better by her.”

Both providers and advocates in this study also expressed concern about the effects of the shutdown of CHW services, especially postpartum visitation, as well as visiting home nurse services. Several described feelings of helplessness when faced with situations in which new mothers were discharged from the hospital to home conditions that providers knew to be economically precarious. Without home visitation, they could not be sure these new mothers could access needed resources such as: subsidized brands of formula, which were in short supply during the early months of the pandemic; masks for COVID positive patients wanting to safely breastfeed, the ability to access timely checks on the weight and health of newborns, or; appropriate screening for postpartum depression. According to our study participants, these services have been slow to recover and are currently only partially operational, contingent upon the same telehealth and HIPAA compliance challenges faced by hospitals.

Finally, some advocates and providers in our study expressed concern about policies at some hospitals that required newborns to be brought back to clinics for in-person checkups 24 to 48 hours after birth. Some new mothers had expressed reluctance to do so, citing fear of transmission either on route (e.g. use of buses or taxis) or at the clinic site. Providers reported cases in which mothers were threatened with Child Protective Services if they did not appear for

these newborn visits. By contrast, they noted that local Departments of Health in some counties had circumvented this requirement by sending scales home with families and using telehealth for newborn pediatric appointments. While we cannot speak to the frequency of such punitive measures, it is clear that these actions are more likely to be taken against low-income minority and immigrant mothers. Moreover, such responses by clinicians and hospital administrators to understandable fears further undermine community trust in health providers and institutions. In the context of the pandemic, CPS consults take much longer to resolve and patients are required to remain in the hospital, sometimes for days, until CPS can clear them for discharge. Besides the infliction of unnecessary trauma, the requirement to remain at the hospital poses serious difficulties for patients with other commitments such as other children at home.

Fears were also exacerbated in the context of what some providers noted as the “dehumanizing” effects of PPE. One nurse stated, “We’re reminding them of our names very often because they don’t see a face. I had one situation with CPS and a baby being taken away and the mom’s so scared. There was a point that I stepped back and I pulled my mask down so she could see my face because it was the scariest moment of her life, I was just this random white lady with a mask on in a uniform. We all have the same color scrubs and it’s even more intimidating than it ever has been.” Several other providers, while acknowledging the necessity of PPE, spoke about the additional challenges to communication and building trust created by the physical barrier between them and their patients. One doula who connected to her clients via WhatsApp during the prenatal period underscored the difficulty of personalizing care during the pandemic: “Utilization of technology is counterintuitive to the hands-on support that doulas are known for.”

Abortion and Contraception

Early studies suggest that the pandemic has exacerbated pre-pandemic racial inequities in access to contraceptives and abortion care. According to a national survey conducted from April 30 to May 6, 2020, 33% of women reported that they had to delay or cancel a reproductive health care appointment or had difficulty getting birth control. Barriers to care were more common among Black (38%) and Hispanic (45%) women than among white women (28%), a finding which is significant particularly given that Black and Hispanic women were also more likely than white women to indicate that they intended to delay or limit childbearing as a consequence of the pandemic (44% and 48% vs 28%) (Lindberg, VandeVusse, Mueller, & Kirstein, 2020).

In New York State, providers at some public hospitals reported drastically diminished capacity for in-person gynecological and contraceptive services in the first weeks of the pandemic due to administrative uncertainty about whether contraceptive care was designated an essential service. While private health institutions pivoted quickly to telehealth appointments with contraceptives dispensed by pharmacy, many public institutions did not have the infrastructure in place for this rapid shift. The result was a lapse in coverage since patients were severely limited in their ability to set up in-person appointments to obtain contraceptives over the weeks or months that it took to establish telehealth services.

Although guidance from the Governor's office on April 8, 2020 clarified that contraceptive services were essential services, the backlog of patients at public clinics resulted in significant delays in scheduling appointments for renewal of contraceptives. Decisions by some public institutions to limit in-person care by reducing numbers of new and walk-in patients also presented obstacles to care. In addition, for uninsured patients, very low-cost contraceptives are typically dispensed through hospital pharmacies rather than through local pharmacies. Given

fears about travel, particularly on public transportation, providers reported that this represented a further barrier to contraceptive access. These were consequential: one abortion provider at a public hospital reported providing abortion care to at least five women who became pregnant after being unable to renew their oral contraceptives in March and April. Providers expressed the opinion that the requirement for an in-person visit for renewal of oral contraceptives for publicly insured or uninsured women was both medically unnecessary and risked putting patients and providers at greater exposure for COVID exposure in the clinics.

Teenagers were at particular risk for contraceptive lapses during the pandemic since school closures essentially prevented their access to condoms, STI treatment, and other SRH care. This was particularly detrimental to young people without private insurance and/or who wanted to keep their sexual activity private from their families. Some teenagers found their way to public clinics for care, often without the knowledge or support of their families. Although contraceptives can be purchased outright at pharmacies, low-income young people—like many low-income adults—did not have the required \$10 and therefore needed the free contraceptives provided at public clinics. As a result, providers at some public clinics perceived an increase in numbers of adolescents and young adults requesting contraceptive care during the early months of the pandemic. However, it is likely that there were many other adolescents who were either unaware of these free services or unable to seek care during conditions of lockdown with their families.

The closure of many clinics and doctors' offices also negatively impacted access to SRH care in rural areas with few providers. Providers in the Capital region reported that rural populations, particularly low-income white residents and Latinx immigrant laborers, had few healthcare options. For people without ready access to transportation or who feared traveling

long distances (for undocumented workers), obstacles to care were considerable. In addition, migrant farm workers often did not have stable access to internet connections, putting telehealth visits out of reach. Given these technological inequities, providers at one public clinic had implemented a rural health practice that involved staff members driving to farms with an iPad or tablet and creating an internet hotspot to allow Latinx workers to access SRH care from providers in Albany. Despite such impressive commitment to caring for marginal groups, it is clear that such programs drain clinic resources and staff time, and are difficult to sustain without financial support.

Abortion care in New York City (the only area where we have data) continued largely uninterrupted due to the early designation of abortion services as essential surgeries. Providers developed no-touch protocols for dispensing medication abortions (for first-trimester abortion care). However, despite the demonstrated safety of medication abortions, then-current regulations still required them to be dispensed directly to the patient through an in-person provider visit rather than through a telehealth visit combined with a pharmacy dispensary or mail service (In April 2021, the FDA announced that abortion medication could be provided through mail service for the duration of the pandemic). For many women, the fear of contracting the virus at clinics and hospitals, anxiety about the safety of public transportation (particularly in NYC) and, for immigrant women, the general fear of ICE and escalating xenophobia all combined to make accessing abortion care extremely stressful. Women seeking abortion often delayed care, particularly in March and April 2020, resulting in later-gestation terminations that carry higher maternal risk. In addition, it appears that the closure of some SRH services during the first months of the pandemic continued to shape perceptions about the availability of care. Given the lack of effective channels to communicate the (re)opening of services, women often

unnecessarily delayed both contraceptive and abortion care on the assumption that services were closed.

Telehealth as an Adaptation to Care Provision

For many private health institutions, patient concerns around continuity of care during the pandemic were alleviated by the pivot to telehealth. Indeed, the providers that we interviewed universally described the pivot to telehealth as one “silver lining” of the pandemic and advocated for the formalization of telehealth protocols and reimbursement rates after the pandemic ends. They reported that telehealth medical appointments streamlined care for patients by avoiding the long wait times typical during medically unnecessary in-person visits, as well as long travel times for patients in rural areas. Some also reported that patients were more likely to attend appointments since they did not need to secure childcare or transportation that often present obstacles for care. One OB/GYN in a Black-serving public hospital stated that she had long advocated for the ability to provide routine care (for example, prescription renewals or responding to patient queries) over the telephone to deliver more timely care. However, administrators had denied this request since telephonic visits were reimbursed at far lower rates than in-person visits, even though in-person visits sometimes meant waiting weeks for an appointment. In this context, she saw telehealth during the pandemic as an opportunity to demonstrate the effectiveness of this approach. At the same time, however, providers also underscored that some patients prefer or need in-person SRH care, pointing out that a robust response to pandemic conditions must include the ability to offer care through multiple modalities. This is particularly true in contexts when patients lack access to the tools (such as weight scales, blood pressure cuffs, glucose meters) to inform their providers with important measures prior to a telehealth visit.

Reflecting pre-existing disparities in resources and infrastructure, public providers that serve racial minority populations are less likely than private institutions to have access to video-based telehealth platforms. In at least one public hospital in NYC, all family planning appointments were conducted by (audio-only) telephone. Moreover, since many providers did not have access to an office telephone, they were required to use their personal mobile devices for telephone appointments. Such adaptations to care that require the investment of personal resources for patient care underscore resource disparities that disproportionately affect minority patients. Further, although an executive order currently states that telehealth visits must be reimbursed at the same rate as in-person visits, this rate of reimbursement will end once the state of emergency lifts (and telephonic visits continue to be reimbursed at lower rates than video visits). As previously noted, telehealth visits also currently require that prescriptions are submitted to a pharmacy where individuals must pay full cost rather than the free or very low-costs medications available through public clinics. Providers and advocates across all domains thus strongly supported legislation that would reimburse telehealth, including telephonic, visits at the same rate as in-person care.

Patients most likely to benefit from telehealth medical visits were those with a permanent and stable phone number and/or stable internet access; comfortable in English; in a supportive family environment, and; who expressed confidence and trust in their provider. Telehealth visits were more difficult for women without access to a landline or who lacked stable access to a mobile telephone because they did not own a smart phone or because they had phones with insufficient space, data, and/or minutes to support telehealth apps. One obstetrician noted that the lack of internet infrastructure in many areas of rural upstate NYS forced patients to seek access points outside their homes, where they often attended appointments while parked in their cars.

The expansion of telehealth also does not address issues of linguistic competence, especially in linguistically diverse urban areas. Telehealth apps are currently available exclusively in English, which means that non-English proficient patients experience difficulty in setting up and using them. This requires providers to devise labor-intensive workarounds, such as having Spanish-speaking staff individually call monolingual Spanish-speaking patients ahead of their visits to assist with downloading the app and logging into their provider visit. Despite these efforts, the frustration involved, especially for speakers of less common languages, sometimes meant that providers resorted to audio-only care or that patients simply did not show up for telehealth appointments. Such linguistic disparities underscore the need for translation services and telehealth apps in diverse languages.

Providers also noted the difficulty of telehealth care provision for patients who lived in crowded households with few opportunities for privacy or for those simultaneously managing childcare. In some cases, patients preferred audio-only visits for technological or privacy reasons. However, providers found that it was more difficult to establish trust and rapport in audio-only visits, especially with new patients discussing often-sensitive SRH concerns with a new provider. Difficulties in establishing rapport were particularly pronounced for non-English speaking patients; although translation services are typically used for non-English speakers, providers reported that these three-way connections were often of poor audio-quality and that the lag time and delays as translations were provided often produced backlogs in providers' schedules and led to less satisfactory medical encounters.

Patients managing childcare or sharing rooms with others during their appointments were also less willing to talk openly about sexual and/or reproductive concerns. This was particularly true for teenagers sheltering in place with parents. Prior research has established that adolescents

and young adults who have concerns about confidentiality are less likely to access sexual and reproductive health care, including contraceptive counseling (Lindberg, Bell, et al., 2020). This reticence was exacerbated by the pandemic, where adolescents were forced to seek SRH counseling without privacy from parents and other family members. In one case, a provider spoke of meeting a patient prior to standard clinic hours so that an adolescent could receive care while her parents slept.

In conclusion, the potential of telehealth to significantly expand access to healthcare even during non-pandemic times is thus currently limited by deep digital divides and technological inequities that disproportionately impact minority populations.

Policy Recommendations

It is clear that the coronavirus pandemic exacerbated a pre-existing crisis in SRH care for low-income racial and ethnic minorities. For both providers and patients, sexual and reproductive health disparities were experienced as another form of racial violence that damages their health and well-being. Faced with massive challenges, participants in our study relayed stories of trauma for both patients and providers, as well as individual and collective efforts to stem the fallout for the vulnerable populations they serve. Given the chronic resource scarcity in public health care, this demanded effort and resources on the part of providers that was not always recognized or financially compensated. As one OB/GYN provider in NYC stated, “There was a lot of creativity, and what’s interesting is that it was not driven by profit [...], it was really driven to what people need and, even though we didn’t have the resources, people were extremely creative with being responsive.”

In addition to underscoring the need for broad structural change to prevent loss of health coverage due to unemployment, as well as the bolstering of other safety-net measures to improve health and well-being, providers offered a number of specific policy recommendations:

Supporting SRH care

- Prevent gaps in care due to changes in insurance status that result from loss of employment or patient movement across state lines.
- Extend pregnancy-related Medicaid coverage for uninsured birthing people from 60 days to 12 months in order to facilitate access to necessary postpartum care, as well as contraceptive and other SRH care.
- Include pregnant women in medical research generally, and in research related to the treatment of COVID in particular.
- Improve co-ordination and guidance between state and individual counties/cities.
- Increase support for publicly funded clinics that are absorbing higher patient loads.
- Continue to allow out-of-state providers to practice across state lines, and to practice via telehealth platforms to the extent of their license.
- Permit free or low-cost SRH medications, including medication abortion, to be dispensed at local pharmacies rather than requiring travel to hospital pharmacies
- Encourage facilities to maintain an updated “pandemic preparedness plan.” At minimum, a pandemic preparedness plan should:
 - Specify safety protocols for patients and providers in the event of pandemic as well as essential services.
 - Identify mechanisms to disseminate locally-specific information about open/closed services and clinic safety protocols, particularly at safety net hospitals, to encourage patients not to delay medically necessary care.

- Ensure allowable support persons during labor and create guidelines to facilitate their entry and ability to provide support.
- Create avenues for faster input from community members to ensure that such protocols and services will be responsive to the needs and constraints of low-income and minority populations.

Telehealth

- Make permanent the executive order requiring that telehealth appointments are reimbursed at the same rate as in-person visits, and ensure that telephonic health appointments are included in this order.
- Improve internet infrastructure as well as access to the blood pressure cuffs, weight scales for babies and adults necessary to facilitate telehealth.
- Invest in the rollout of telehealth platforms for publicly funded health institutions, particularly in languages other than English.

Supporting Prenatal and Obstetric Care

- Identify alternative birthing options available to women of diverse socio-economic and insurance status, such as stand-alone birthing centers and safety-net hospitals offering significant separation between obstetrics and infectious disease wards (such as separate entrances, dedicated staff, etc.), that can be quickly publicized in the case of future pandemics.
- Support insurance coverage of doulas through both private coverage and Medicaid, particularly those who work with communities of color.
- Support the establishment of rapid data sharing between facilities and health departments so that pregnant people and their providers may be fully informed about the infectious disease risk in their area.

- Support transparency and rapid data sharing on racial disparities in maternal and birth outcomes, including maternal deaths.
- Invest in rapid testing for safety-net hospitals to ensure that all women admitted in labor are tested.

Supporting Postpartum Care

- Support the development and health insurance coverage of postpartum home visitation, especially given policies of rapid release from hospitals.
- Invest in organizations that provide resources and support to new mothers and families.
- Facilities should have in place a robust plan for postnatal service provision. At minimum, this would include:
 - Guidance about how to connect patients to needed services, such as postpartum support and home visitation, in the event of further lockdown.
 - Guidance about conditions for offering remote pediatric visits.
 - Explicit policies about the conditions that merit calling CPS during pandemic conditions. Reluctance to bring a 24-hour newborn back to the hospital during a pandemic should not in itself be considered a risk of child endangerment.
 - Discharge protocols in cases where a new mother or a household member is COVID positive but unable to afford PPE. Discharge packets should include a reasonable supply of masks to allow them to return home and care for their newborns while minimizing risk of transmission.
 - Guidance and access to mental health services for pandemic induced and exacerbated anxiety.

Supporting Family Planning Services

- Ensure continued access to contraceptive and sexual health care, particularly for adolescents and young adults affected by school closures and Medicaid-covered women. Such plans should consider the distribution of sexual health education through school, social media, and public health channels when schools are closed, as well information about the location of health clinics able to provide confidential and free/low-cost sexual and reproductive health care.
- Authorize pharmacies to provide medications to uninsured women without additional cost.
- Eliminate restrictions on low-risk services that can be provided through telemedicine, including abortion medications
- Invest in public providers to minimize the impact of the loss of Title X funding and to support care provision to low-income and minority populations.
- Allow advanced practice providers to perform minor procedures like STI testing, pap smears, birth control, and provision of medication abortions.

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