COMMENTARY

Coronavirus disease in 2019-induced economic contracture and reproductive health

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ABSTRACT

The 2019 COVID-19 pandemic has made inequities in care, notably in reproductive health, even more pronounced. The effects of the financial crisis COVID-19 has caused on reproductive health, including as decreased access to contraception and prenatal care as well as unfavorable perinatal outcomes as a result of economic constriction, have received little attention. Therefore, in order to discuss how the current economic woes may affect reproductive health both now and in the future, we looked at the Great Recessio. There is compelling evidence to support the need for state and federal investment in comprehensive reproductive health care, according to the literature currently available on the effects of the economic downturn on reproductive health. Reproductive health is expected to be negatively impacted by policies that restrict access to programmes like Special Supplemental Nutrition Program for Women, Infants, and Children and Medicaid (WIC), extend Medicaid coverage to 12 months after childbirth, discontinue coverage for telehealth services, and lower access barriers through mobile care units.

Key Words: *Us Economy Women's Health, And Covid-19 Reproductive Health*

INTRODUCTION

The 2019 COVID-19 pandemic has made inequities in care, notably in reproductive health, even more pronounced. Beyond worries about health outcomes and structural injustices affecting people of colour and others with lower socioeconomic position, there is still ambiguity about indirect effects related to the pandemic's economic effects. There has been little discussion of how the financial catastrophe caused by COVID-19 has affected reproductive health outcomes, including limited access to contraception and prenatal care as well as unfavorable perinatal outcomes, despite the fact that many studies have examined the effects of the virus itself on reproductive health outcomes.

More than a year after the first cases in the United States were confirmed, the epidemic has had a significant negative impact on the economy. The unemployment rate in the United States reached a record high of 14.7% in April 2020, according to the U.S. Bureau of Labor Statistics. This rate dwarfs that of the 2008 Great Recession (the period of economic contraction from 2007 to 2009 also known as the 2008 recession) and approaches levels seen during the Dust Bowl era of the Great Depression. Despite making up over 80% of the health care profession, women have been affected by the majority of job losses. According to the U.S. Bureau of Labor Statistics, women lost 55% of the 20.5 million jobs that were lost in the country in April 2020 alone. Women also experienced job loss more frequently and more quickly than men. Even after controlling for factors like college degree, a study by Adams-Prass found that women in the United States had a higher chance than men of losing their jobs or reporting lower earnings during the pandemic in jobs that were comparable.

The National Bureau of Economic Research announced in June 2020 that the economic contraction caused by COVID-19, which started in February 2020, officially constituted a recession. The pandemic's economic repercussions are still evident more than a year after the initial surge in unemployment. The economy is showing indications of improvement as of March 2021, however only 57.8% of the 22 million people who lost their jobs in March and April 2020 had found new ones.

Millions of Americans are losing their employer-sponsored insurance and becoming eligible for public coverage through Medicaid as a result of chronically high unemployment rates. There aren't many statistics, though, about how the expansion of Medicaid eligibility affects the current Medicaid providers. According to the Kaiser Family Foundation, 79% of people who lose their employer-sponsored insurance are eligible for a public option, with Medicaid being the most common alternative. Pregnant women have always been given priority in Medicaid coverage, and in 2018, it provided funding for roughly half of all births in the country. States all throughout the country reported budget shortfalls in the hundreds of

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millions at the same time, which might result in Medicaid funding reductions. For instance, California declared in May 2020 that it would reduce spending on healthcare as part of its efforts to deal with a projected $53.4 billion deficit.

It's critical to assess how access to contraception and prenatal and birth outcomes may be impacted in the long run in light of the recent economic turbulence and potential COVID-19 effects. We look to the Great Recession to anticipate how the current recession may affect reproductive health in the years to come and how policy can have a lasting impact both during and after the COVID-19 pandemic as we consider the implications of this economic recession.

Prenatal care and maternal health

Prenatal care should be initiated early in pregnancy and should continue throughout the entire pregnancy. This reduces the risk of preterm delivery and improves birth weight. Prenatal care should be initiated early in pregnancy. However, numerous studies have revealed that pregnant women are more likely to put off or forgo prenatal care during economic downturns. Blakeney specifically examined the disparities in prenatal care utilization before, during, and after the 2008 recession among women of various racial and socioeconomic backgrounds, and they discovered that, as in previous recessions, women who entered prenatal care late or not at all tended to be young and less likely to have higher education. Even during economic downturns, it has been demonstrated that participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) reduces the use of late or nonexistent prenatal care. WIC is a federal grant programme that gives states money to support supplemental food and nutrition education for low-income pregnant women, postpartum women who are breastfeeding or not, and children under the age of five. Almost half of newborns born in the US were served by WIC as of 2018. 15 During the Great Recession in 2009, WIC membership hit an all-time high; however, enrollment has been progressively dropping ever since. Although more persons became eligible for WIC benefits as a result of the pandemic's higher unemployment rate, there was no comparable rise in participation. Misperceptions about eligibility, lack of access to transportation to reach WIC clinics, and unpleasant clinic experiences, including long wait times, are a few of the barriers to WIC enrollment that are frequently mentioned. 16 The United States Department of Agriculture announced the extension of flexibilities for WIC recipients in September 2020. These flexibilities include remote benefit issuance to all participants, flexibility with regard to the requirements for food packages, and authorization for enrollment without being physically present at a local office. 17 These waivers were a crucial first step toward lowering WIC participation obstacles, but they were only valid until December 31, 2021, or 90 days after the conclusion of the publicly declared public health emergency. An essential tool for policymakers to enhance WIC membership throughout the economic recovery could be the indefinite extension of qualifying waivers. Effective communication is also necessary to dispel myths regarding eligibility. These results imply that WIC, despite being severely under-utilized in its current form, may be a useful programmatic tool to increase prenatal care utilization, particularly in hard times.

The number of obstetric visits decreased significantly after state budget cuts, probably as a result of longer wait times and a reduction in the availability of appointments, according to a study of maternal outcomes for Medicaid enrollees in North Carolina during the Great Recession (April-June 2009 vs. April-June 2010). There is currently no research regarding how the COVID-19 epidemic and subsequent economic hardship influenced prenatal care utilisation in the United States; however, a 2021 survey of healthcare practitioners in the United Kingdom indicated that antenatal consultations were decreased in 70% of units. The Centers for Medicare & Medicaid Services increased coverage of telemedicine services to reduce virus exposure while maintaining prenatal care. Prior to now, only Medicare-insured patients who lived in rural areas could access telehealth services, but research has shown that telehealth is a secure substitute for in-person visits. In addition to reducing the need for high-risk obstetric monitoring office visits, a systematic review published in February 2020 found that telehealth interventions improved obstetric outcomes related to breastfeeding and smoking cessation while maintaining maternal and foetal outcomes.

During the COVID-19 epidemic, telemedicine was quickly deployed, and many healthcare professionals reported increased attendance at prenatal care appointments as a result of the removal of impediments to visits, such as lack of transportation and child care. Although useful, telemedicine has the potential to worsen inequality among patients who might not have access to the resources needed for sufficient visits (eg, home blood pressure cuff, foetal heart rate monitor, reliable Internet, or smartphone). One of the most significant and long-lasting changes to the healthcare system brought on by the pandemic may be the expansion of telemedicine. However, insurance coverage for telehealth is about to end unless lawmakers decide to make these reforms permanent. The American College of Obstetricians and Gynecologists' president pleaded with payers in June 2020 to keep expanded telehealth coverage policies in place indefinitely, noting that telemedicine addressed access barriers, decreased emergency department visits and readmissions to hospitals, and improved adherence to treatment guidelines.

Maintaining access to prenatal care during the economic recovery from the pandemic can be achieved in part through continued coverage of telemedicine. But regulations must be put in place to provide fair access to telemedicine services. For persons who have hearing difficulties, translator or closed-captioning services should be made available. In order for patients without access to a smartphone to safely access telemedicine services, audio-only services should be covered to the same extent as video services. To ensure that patients on low incomes can use telemedicine to the same extent as patients who can afford to buy this equipment on their own, insurance coverage of home devices like blood pressure cuffs and home scales is crucial.

Prenatal care is crucial to the health of both mothers and their unborn children, but it is also a service that is less frequently used when the economy is struggling. Important policy solutions that may enhance maternal and child health outcomes during COVID-19 economic recovery as well as upcoming periods of economic upheaval include increased WIC enrollment and equitable telehealth use.

Birth results

This was confirmed by a later paper from the same group, which demonstrated the same elevated risk for PTB even after adjusting for maternal factors that might have an impact on outcomes. 26 This conclusion has been supported by other studies

that have noted an increase in Foetal growth restriction and low birth weight, particularly in mothers with less than a high school diploma. According to earlier research, living in a low-income area is a persistent stressor that can affect the epigenome. Existing disparities have been shown to be further exacerbated by the COVID-19 pandemic's consequences. Hispanic and Black pregnant women have disproportionately higher rates of severe acute respiratory syndrome coronavirus 2 infection, hospitalization, and death because of social determinants of health like occupation and household composition that make social distance difficult.

According to a study examining the relationship between "maternal social vulnerability" and neonatal outcomes, a higher vulnerability score was linked to a nearly 5-fold increased likelihood of positive neonatal test results. Social Vulnerability Index was calculated using the ZIP code of the mother's primary residence. SVI includes elements such as socioeconomic status, housing/transportation type, minority status/language, household composition/disability, and socioeconomic status. Although infants with severe acute respiratory syndrome coronavirus 2 appeared to have little direct evidence of illness, those born as a result of deteriorating COVID-19 symptoms were more likely to be premature or preterm, and necessitating resuscitation in the delivery room and/or requiring a longer stay in the hospital. This finding suggests that depending on how severely a community is impacted by the economic and social changes brought on by the pandemic, there may be long-term effects that last for generations. Medicaid pays for nearly half of US births, so state and federal legislative initiatives to increase Medicaid access and extend coverage to 12 months after delivery may help lessen the prevalence of adverse birth outcomes resulting from the economic downturn. Longer follow-up for pregnancy-related medical complications could be made possible with extended coverage. It could also encourage safer birth spacing by making contraception more widely available. Following the birth of a child, efforts should focus on achieving the ideal pregnancy spacing because levels of the short inter-pregnancy interval (18 months) are a risk factor for unfavorable outcomes like PTB and LBW. Since Appareddy particularly shown that low-income women earning less than $25,000 a year had inter-pregnancy intervals 6 months that were significantly larger, this population would probably have access to Medicaid and profit from expanded coverage. According to Brown et al., Medicaid expansions in the past have been effective in reducing PTB and LBW gaps, especially among Black newborns. In the past, states have had to go through a lengthy and time-consuming process to expand Medicaid coverage from 60 days to a year. But the American Rescue Plan Act's adoption in March 2021 made it easier for states to apply for the 12-month Medicaid extension. The risk of maternal and newborn morbidity and mortality may be directly impacted by this.

Contraception

Access to contraception was already restricted before the COVID-19 pandemic by factors like direct cost, insurance coverage gaps, and accessibility to doctors or pharmacies. These obstacles have been made worse with the implementation of stay-at-home orders by the rise in unemployment, a lack of child care, constrained transportation alternatives, the switch from in-person clinic visits to telemedicine, and the worry over prescription refills for contraception. Women are more likely than men to have lost their jobs, and since many of them also lost their work-related health insurance as a result, access to healthcare has decreased.

All American women aged 15 to 44 saw their fertility rates fall by 4% during the 2008 recession. Increased contraception use was probably a major cause in this drop, despite research showing that there were other contributing variables. According to one study examining contraceptive use during the recession, declining economic conditions among unmarried women led to increased likelihood of contraceptive use, more consistent use of contraceptive methods, and use of more effective contraceptive methods, particularly for women of lower socioeconomic status. This rise in contraceptive use was attributed by the Guttmacher Institute to fear related to economic stress, such as unemployment and foreclosure rates. 12% of women who were not already using long-acting reversible contraceptives (LARCs) said they were interested in switching to them during the recession. Despite an increase in contraceptive use during the 2008 recession, some research revealed that inconsistent use was also a result of economic uncertainty. According to the Guttmacher Institute, 42% of respondents who identify as women or menstruating individuals felt they could not afford to miss work in order to visit a doctor or clinic in order to obtain an effective contraceptive method, and 23% of those who menstruate or are women reported having a harder time paying for birth control than in the past.

Initial analyses of the COVID-19 pandemic's effects on women's sexual and reproductive health have revealed limited access to contraception and other SRH services, despite the fact that the full scope of the crisis's effects is still developing. Women and menstruating individuals aged 18 to 49 who participated in the survey reported that 33% of them had trouble getting birth control, 27% had increased worry about their ability to pay for contraception, 34% wanted to delay having children, and 23% were interested in LARCs as a result of the pandemic.

The impact of the pandemic has already had greater repercussions for reproductive health objectives and practises when compared directly to the effects that the 2008 recession had on SRH. Women are now more cautious than before when using contraception (39% vs 29%), and women are more concerned than before about affording contraception (25% vs 23%). More women reported delaying or cancelling contraception care due to the pandemic than the 2008 recession (39% vs 24%).

Continual enrollment of women in Medicaid and the use of LARCs through 6 months after childbirth increased significantly, according to a study looking at the effects of Ohio's Affordable Care Act Medicaid expansion. This could help lower the risk of unintended and short-interval pregnancies. While only about one third of the newly unemployed will receive Medicaid in the 15 states that have not expanded coverage under the Affordable Care Act.

CONCLUSION

It is difficult to extrapolate all the lessons acquired from the Great Recession to the current economic crisis and its effects on reproductive health, as it is with other health effects of COVID-19. A health crisis and an economic crisis at a level we have never seen before are combined in the pandemic. Additionally, the pandemic struck at a time when institutional injustices were already affecting access to reproductive health care, disproportionately affecting

women of colour. The rising maternal mortality epidemic is the most glaring example of this. It is crucial to recognize the differences as we draw lessons from the 2008 recession. The recession, which affected world markets between 2007 and 2009, resulted in high unemployment rates and unstable housing markets. On the other hand, the current economic crisis is a direct result of laws requiring social segregation during a pandemic. As a result, there were high rates of unemployment, unstable housing, and mortality. However, the body of research on recessions and reproductive health demonstrates unequivocally the need for state and federal funding for initiatives that guarantee ongoing access to comprehensive reproductive healthcare as well as for meaningful health policy that fosters SRH's beneficial and long-lasting effects.

DECLARATION OF INTEREST

None declared.